Brief Interpersonal Psychotherapy for Eating Disorders (IPT-ED): Therapist’s Manual
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Brief Interpersonal Psychotherapy for Eating Disorders (IPT-ED)

In its goals, strategies and structure, brief interpersonal psychotherapy for eating disorders (IPT-ED) closely resembles IPT for depression (Weissman et al., 2000). The brief IPT-ED described here is an adaptation of interpersonal psychotherapy for BED as described by Wilson and colleagues (2010). In addition, some of the structure, methods, and text used in this manual were taken directly from the individual IPT protocol that has been used to treat bulimia nervosa (BN), a treatment that was originally formulated and evaluated by Dr. Fairburn in Oxford (1993). The PI's of this proposal have received Dr. Fairburn's permission to use portions of his treatment manual in the current treatment manual. All therapists trained in this approach are encouraged to study the applications of IPT for depression (Weissman et al., 2000), binge eating disorder (IPT-G: Wilfley et al., 2000), and bulimia nervosa (IPT-BN: Fairburn, 1993; 1997).

This manual serves as a supplement to the in-person training in the principles and practice of brief IPT-ED in which all therapists will participate. It does not provide a session-by-session protocol for the delivery of brief IPT-ED. Instead, the present manual is principle-driven, emphasizing the strategies of brief IPT-ED so that therapists working within different clinical settings and with different constellations of eating disorder symptoms may conceptualize treatment from an IPT perspective, and flexibly apply brief IPT-ED to the needs of their student clientele. The typical phases of IPT and the specific strategies and tasks associated with IPT (Weissman et al., 2000) are described in more detail below.

Treatment Approach

IPT is a non-interpretive, time-limited form of individual psychotherapy. Although the therapeutic style is less directive in IPT than in cognitive and behavioral approaches (i.e., less didactic/prescriptive), the therapies are similar in terms of their active, current focus on specified target areas. Brief IPT-ED assumes that the development of eating disorder symptoms (e.g., recurrent binge eating, purging, excessive weight and shape concerns) occur in a social and interpersonal context and that the onset, response to treatment, and outcomes are influenced by the interpersonal relations between the client and significant others.

IPT is similar to many other therapies at the level of techniques and stance but is distinct at the level of strategies. Its well-defined treatment strategies are aimed at resolving problems within four social domains: grief, interpersonal role disputes, role transitions, and interpersonal deficits. The IPT therapeutic stance is one of warmth, support, and empathy. The IPT therapist is active and supports and advocates for the student rather than remaining neutral.
The Initial Phase

The Initial Phase of IPT usually occupies the first three to four sessions, but in brief IPT-ED this phase can be completed in as few as 2 sessions. The goals of the Initial Phase are outlined below:

1. Describe the rationale and nature of brief IPT-ED
2. Identify current interpersonal problems
3. Establish the relevant problem area(s)
4. Collaboratively develop a set of interpersonal goals with the client that relate to their problem area(s)

Describe the rationale and nature of brief IPT-ED. The therapist explains to the student that in order to help people break out of self-perpetuating problems, such as eating disorders, it is necessary to find out what is keeping these problems going and then to address the maintaining factors in treatment. In addition, the therapist tells the student that interpersonal difficulties are common in individuals with eating disorder symptoms although many students have limited awareness of them because of preoccupying thoughts about eating, shape, and weight. These interpersonal difficulties play an important role in maintaining eating disorder symptoms through a number of mechanisms; for example, many binges are precipitated by interpersonal events and circumstances, such as having an argument or feeling lonely.

The therapist may say something along the following lines: “Students who binge-eat often describe themselves as ‘stress eaters’. Indeed, according to reports by persons with eating disorders, negative feelings are the most frequent trigger for binge eating. In addition, after binge eating, many individuals avoid social situations. This withdrawal may lead to increased negative feelings, especially loneliness, which may, in effect, trigger other binges, promoting a cycle of negative feelings followed by binging followed by negative feelings and so on. Interpersonal psychotherapy will help you learn to deal more effectively with negative emotions and relationship difficulties that may lead to ‘stress-induced’ binge eating. By learning to identify, manage, and express your reactions and feelings, you will be less likely to turn to food to soothe and comfort you. That is, by developing a better relationship with yourself (learning to tune in and identify what you are feeling versus numbing yourself out with food) and by developing better relationships with others, you will be less likely to use food as a way to manage your negative feelings and/or difficult relationships. The more you are able to successfully manage your feelings and your relationships with others, the better you will be at eliminating your problems with binge eating. In fact, the relevance of relationships to eating disorder symptoms has been highlighted by the results of two treatment studies, which have shown that a treatment that modifies current interpersonal problems can reduce, if not eliminate, binge eating.”

It is further explained that in brief IPT-ED the emphasis is not on the student’s eating problem, except during the interpersonal inventory. Instead, the focus is on the student’s
interpersonal difficulties. This is because focusing solely on the eating problems tends to distract the student and therapist from dealing with the interpersonal difficulties that perpetuate problems with eating. Students may also be told that IPT has three distinct phases, which are quite different in character (see Table 1). In the first, which occupies the first one or two sessions, the goal is to help the student identify those interpersonal difficulties that are involved in the onset and/or maintenance of their eating problems, which will become the focus of treatment.

The therapist may say: "This first phase of treatment will involve a detailed review of your past and present relationships, and I will take the lead in asking you questions. The goal of this phase of treatment is to help us make connections between your eating problems and the way in which you have coped or managed with difficult interpersonal situations. This initial phase will end with our agreeing upon the interpersonal problem area(s) and establishing some goals that will be the focus of treatment. Thereafter, our sessions will change in style. The second phase, will be the time when you are going to be actively working on your interpersonal goals—the ones we identify together in the first one or two visits. During this second phase, you're likely going to notice changes in your eating problems, in your outside social life, and in how you relate to other people. During this phase, you will become largely responsible for the content of the sessions, and I will take more of a facilitating/guiding role. Gradually we will learn more about your interpersonal difficulties. Your role will not only be to explore these difficulties in our treatment sessions, but you must also experiment with ways of changing. Doing so will shed light on the nature of your problems, and may potentially help to alleviate them. In the final phase of treatment, our last one or two visits together, we will be wrapping things up and helping you to solidify what you've learned and prepare you for the end of treatment."

It is important to stress the time-limited nature of the treatment. Therefore, even at the outset, it is possible to give the student a good idea of when treatment is likely to end. The fact that the treatment has a limited number of sessions helps the therapist stress the importance of working hard at each contact: "This is an opportunity to change - an opportunity to break out of what has been a long-standing problem. It is essential that you make the most of the opportunity by giving the treatment priority in your life. Not doing so is likely to limit the progress that we can make." Other ground rules or clinic procedures may also need to be explained during this phase (e.g., that sessions will always end on time and that it is the responsibility of both the therapist and student to ensure that they start promptly).

**Identify Current Interpersonal Problems.** Three sources of information are used to identify current interpersonal problems: (1) a history is taken of the interpersonal context in which the eating problem developed and has been maintained. This helps identify current interpersonal problems. It also highlights links between changes in the eating problem and the occurrence of interpersonal events, thereby stressing the importance of interpersonal factors to the eating problem. This helps the student see the relevance of this form of treatment. Several areas are assessed by taking this history. First, the therapist and student review the eating problem and how it has evolved. Key events and dates are noted - for example, the ages at which the student first began to diet and binge. The timing of major changes in weight is noted,
as is prior experience of treatment. The second area involves an assessment of the student's significant life events and interpersonal functioning prior to and since the development of the eating problem. Relationships with family and peers are especially relevant here. The third area to assess involves problems with self-esteem and depression. This history-taking may culminate in the creation of a "life chart" in which separate columns are allocated to each area assessed. An example of a life chart is shown in Table 2 (Due to the time-limited nature of therapy in the college counseling setting, it may not be practical for the therapist to create an actual chart. However, due to the large amount of information gathered, it is advised that the counselor at least take notes for him/herself).

The student should be encouraged to play an active role in the history-taking. The whole process usually takes one long or two shorter sessions. During this review, changes in relationships are illuminated that were proximal to the onset of symptoms (e.g., the death of a significant other, changing to a new job, increasing relationship discord, or disconnection from a friend). This review provides a structure for elucidating the social and interpersonal context of the onset and maintenance of binge eating symptoms and delineates the focus of treatment; (2) an assessment is made of the quality of the student's current interpersonal functioning. This involves asking about the student's social network. Inquiries should be made about family members, the student's boyfriends or girlfriends, confidants, classmates, co-workers, and acquaintances. The topics to be addressed include frequency of contact, positive and negative aspects of each relationship, mutual expectations, intimacy, and reciprocity; (3) the precipitants of eating disorder symptoms are identified. In each of the first one or two sessions, the therapist asks whether there have been any eating disorder symptoms, and, if so, inquires about the circumstances preceding them. These interpersonal events then serve as "markers" of current interpersonal problems. Symptom relief starts with helping the student understand that these problematic symptoms are a part of a known syndrome, which responds to several treatments and has good prognosis.

Establish the relevant problem area(s). By the end of the first or second session, the nature of the student's interpersonal difficulties should be clear. Usually they belong to one of the four standard "problem areas" described in the IPT manual (Weissman, et al., 2000) - namely, grief, interpersonal role disputes, role transitions, or interpersonal deficits (see Table 3). The next step is to decide which of the problem areas should become the focus of the remainder of treatment. This decision should be a mutual one. When more than one problem is identified, progress will be facilitated if the therapist suggests the order in which they should be tackled. In general, it is best if the most readily solvable of the problems is addressed first; for example, unresolved grief can often be tackled relatively quickly, in part because it does not generally require others to change. Tackling the less challenging problem first also has the advantage that progress on one front often leads to progress on others. Not only are the student's morale and overall sense of competence enhanced when progress is made on a problem, but barriers to progress in other areas may be eroded or removed.

Collaboratively develop interpersonal target goals. After the major interpersonal problem area associated with the onset and/or maintenance of the eating problem is identified,
the therapist makes a specific treatment plan with the student to work on this problem area. That is, several target goals (that are directly related to the identified problem area) are developed. To the extent possible, target goals should include reference to specific persons, specific events, and specific interpersonal themes. This helps to ensure that target goals are expressed in language that is as specific and personally meaningful to the student as possible.

Following identification of a goal, the therapist will want to create concrete ideas for change, collaboratively identifying the specific steps the student will take to improve relationships and socialization. Prior to the end of this Initial Phase, each student should be given a written summary of their goals that will serve as a treatment contract and guide their work for the remainder of treatment. An example of target goals for a student with BED can be found in Table 4.

Also, toward the end of the Initial Phase, the therapist reminds the student that the treatment will now change in character: "As we discussed at the outset, from this point on the nature of our sessions will change. Your task at this point will be to focus on the goals that we have just identified; think about them each day outside of our meetings. In this way, you will come to a better understanding of them. A key part of this process is thinking about what changes are possible and how you could bring them about. You will need to consider all the possible alternatives, together with their pros and cons. And it is important for you to experiment with ways of changing. By doing so, not only will you get a better idea of the nature of the problems, but you may well be able to influence them."

The principal shift between the Initial and Intermediate Phase has to do with the depth of the work. In the initial stage, the goal is recognition of important problem areas and associated target goals that need to be addressed. The individual is prepared to move on to the intermediate stage if he/she has a clear understanding of his/her problem area and goals and has begun to take a productive role in the sessions by bringing in relevant material regarding successes and difficulties in daily application.
The Intermediate Phase

The goals of the Intermediate Phase are outlined below:

1. Implement the IPT strategies as outlined by Weissman et al., 2000
2. Facilitate the student’s work on the identified goals
3. Assist the student in recognizing the connections between eating disorder symptoms and interpersonal events during the intervening time between sessions
4. Work with the student to identify and manage negative and/or painful affects associated with their interpersonal problem area
5. Redirect issues about eating, weight, or shape to the interpersonal context

The bulk of the work on problem areas will occur during this phase. The therapist introduces the IPT strategies specific to each problem area to help the student achieve his or her goals. The strategies can be introduced in the context of the ongoing therapy discussions as appropriate, but they should be specifically addressed.

In structuring the Intermediate Phase the brief IPT-ED therapist takes a moderate position between the extremes of being highly active and merely reactive to the student’s concerns. In keeping with the goals of IPT, the therapist is somewhat active in helping the student focus on bringing about improvement in current interpersonal problem areas. The therapist actively guides the student to cover material that is relevant to the treatment goals. If the student does not bring in material, the therapist may elicit an update or more detailed information in one of the agreed-upon problem areas and goals.

The need to change is stressed at regular intervals. It is important to note that this constitutes general encouragement to change, rather than pressure to take a specific course of action. Meetings during the Intermediate Phase should not pass without reference to the interpersonal problem areas and attendant goals. In session, unfocused conversations are redirected to central themes of treatment, and abstract and vague discussions are minimized in order to maintain focus. Therapists avoid asking questions that elicit general or passive responses, such as general inquiries about the student’s week. Instead, sessions open with questions such as “What would you like to work on today?” and “How have things been since we last met?” These questions keep the student focused on discussing recent interpersonal events and eating disorder symptoms, which the therapist attempts to link together. The student is encouraged to explore the problem areas and to consider ways of changing; the student’s attempts to change then become the focus of subsequent sessions. The therapist helps the student remain focused in session by ensuring that the subject matter is relevant and by providing clarification when needed. For example, one student described helping her father remodel his house. This was relevant, since their relationship was one of the agreed-upon problem areas. However, she then went on to discuss the minute details of the remodeling; the therapist had to intervene at this point, since the interpersonal focus had been lost. The
therapist should be sure to intervene in a sensitive manner that does not appear dismissive of the patient’s experiences. For example, the therapist might say: “This is interesting, but I want to make sure we stay focused on your relationships, since I think that will be most helpful to our work.”

Clarification takes the form of pointing out patterns and inconsistencies, highlighting points that the student might miss. For example, another student recounted three interactions that appeared quite distinct. The therapist made an important clarifying intervention by pointing out that one factor contributed to each problematic interaction: the student's desire to avoid conflict at all cost. Clarification does not extend to making "interpretations," in which reference is made to a theoretical view on the disorder and its treatment. Throughout brief IPT-ED, the focus remains on the present, and the therapist should ensure that the student remains aware of the task at hand. At the end of each session, the therapist should summarize what has been covered. In addition, at intervals during the Intermediate Phase, the therapist reviews progress by considering the problem area and each of the treatment goals and assessing what has been achieved and what remains to be done.

**Implement the IPT strategies.** During the Intermediate Phase of brief IPT-ED, the therapist implements treatment strategies specific to the identified problem area as specified by Weissman et al., (2000). For an in-depth discussion of the IPT goals and strategies, (see Table 1), the therapist is encouraged to read Weissman et al (2000). Briefly, the four problem areas, goals, and strategies include:

A. **Interpersonal Deficits.** Interpersonal deficits include individuals who are socially isolated or who are in chronically unfulfilling relationships. They were present in 60.5% of the patients of the Wilfley et al. (2000) trial. The goal is to reduce the student's social isolation by helping enhance the quality of existing relationships and encouraging the formation of new relationships. To help these students, it is necessary to determine why they have this difficulty in forming or maintaining relationships. Thus, it may be appropriate to examine the nature of the student-therapist relationship, since, in this instance, this may be the student's only close relationship, and the therapist can easily observe it.

B. **Interpersonal Disputes.** Interpersonal disputes are conflicts with a significant other (e.g., a partner, other family member, coworker, or close friend) which emerge from differences in expectations about the relationship. These disputes were present in 29.6% of the patients in the Wilfley et al. (2000) trial. The therapist helps the student identify the nature of the dispute and generate options to resolve it. If resolution is impossible, the therapist assists the student in dissolving the relationship and in mourning its loss. Since the brief IPT-ED is conducted on a one-to-one basis, the other party in any dispute is not directly involved. In most cases, this seems fine and the results are good; however, in the case of marital disputes, we have encountered a few instances in which it might have been preferable to involve a student's spouse/partner. For example, it may be worth arranging supplementary conjoint
sessions in those cases in which a marital dispute is the primary problem and progress is limited. Weissman and colleagues (2000) have described an adaptation of IPT specifically for patients with marital disputes.

C. **Grief.** Grief is identified as the problem area when the onset of the student’s symptoms is associated with the death of a loved one, either recent or past. Grief was present in 6.2% of the patients in the Wilfley et al. (2000) trial. As mentioned earlier, interpersonal problems with grief can often be resolved comparatively quickly, and it is therefore worth addressing them first if more than one problem area is identified. The goals for treating complicated bereavement include facilitating mourning and helping the student to find new activities and relationships to substitute for the loss. Facing the loss requires the student to think in detail about the events surrounding the loss and express his or her feelings about it. Students with this problem area need to be educated about the grieving process and variations on it. Profound feelings of sadness are common, but so are feelings of anger and guilt. Reconstructing the relationship—both its positive and its negative aspects—is central to the assessment of exactly what has been lost and is needed in order to counter the idealization that so commonly occurs. As these students become less focused on the past, the therapist should assist them in thinking about the future and the establishment of new interests and relationships.

D. **Role Transitions.** Role transition includes any difficulties resulting from a change in life status (e.g., divorce, retirement or change in one’s work role, moving, leaving home, diagnosis of medical illness). Although role transitions were judged to be present as the primary problem in only 3.7% of the patients in the Wilfley et al. (2000) trial, this problem area may occur more often in student populations given the transitions involved in starting college or graduate training. The therapist helps the student deal with the change or transition by recognizing positive and negative aspects of the new role they are assuming, as well as pros and cons of the old role this replaces.

**Facilitate the student’s work on their identified goals.** In brief IPT-ED, therapy goals are used to directly address the identified problem area(s), which are linked to the ongoing problems with eating and shape and weight concerns. In the Intermediate Phase, the therapist will need to maintain a focus with the student each week on how they are applying their goals between sessions. As these goals are addressed, the therapist and student can begin working toward making the necessary changes. In the following vignette, notice how the therapist initiates the discussion of the goals and helps a student with interpersonal deficits to work on her goals:

**Therapist:** Samantha, now that we have started this middle phase, I wanted to check in with you to see how you are progressing on working towards achieving your goals. Specifically, you mentioned last week that you wanted to work on being more aware of what goes on in and around the times that you binge eat.
Samantha: I did start working on my goals, especially the one you mentioned, but it is a little overwhelming. I am beginning to identify more of what goes on for me around the times when I binge, but I don’t know what to do with it.

Therapist: All right, that’s a great start. What are you aware of?

Samantha: Sometimes, I’m afraid, like, "so and so won’t like this or me" and "this and this will happen", or I feel angry. And so I don’t know what to do, so I eat.

Therapist: This is really important work Samantha. Now that you have a clearer understanding of the circumstances around your binge eating, we can work together to help you find more effective ways to manage your feelings and relationships.

Samantha: I really want to.

Assist students in recognizing connections between eating disorder symptoms and interpersonal events during the week. A critical component in the Intermediate Phase is to facilitate and help strengthen the students’ connections between problems with eating and shape and weight concerns, and the difficulties they have in their interpersonal lives. As the student continues making these connections and developing strategies to alter the interpersonal context in which the eating disorder symptoms occur, the student will disrupt the binge eating cycle. In the following vignette, the therapist facilitates a student with Interpersonal Role Disputes to talk about the connections he has made between his binge eating and the difficulties he has with his professor:

Therapist: How has it gone for you this week with your goals Mark?

Mark: What I’ve realized is that I get a negative feeling when I have had a tough exchange with my physics professor. I get to a point where I ‘shift’ into automatic pilot, and my car will drive right into Jack-in-the-Box. And I know that I’m shut down. I have to deal with it on a different level other than eating. Because that’s what I do, I eat to numb myself as you said. And whatever makes me get that way, I have to look at that.

Therapist: This is great work Mark! One of the things that we discussed as a goal was to be thoughtful about what you are doing during the day and when you are binge eating -- being aware of when you find yourself “shifting”. It’s good that you are making that connection between your negative feelings and your binge eating. Now that you have made that connection, how would you like to start working on your interactions with your professor?

Work with the student to identify and manage negative and/or painful affects associated with their interpersonal problem area. Encouragement of affect involves a number of therapeutic techniques, which are intended to help the student express, understand, and manage affect. Depending on the nature of the affect and the student, the brief IPT-ED therapist may use two general strategies to help the student: (1) acknowledge and accept painful affects and (2) use his/her affective experience to bring about desired interpersonal changes.
A. **Encourage acceptance of painful affects.** Individuals with eating disorders often use food to cope with negative affect. Brief IPT-ED provides an arena to experience and express these feelings versus using food to cope with these feelings. As the feelings are expressed, it is important for the therapist to validate and help the student accept these feelings.

B. **Teach the student how to use affect in interpersonal relationships.** While the expression of strong feelings in the session is seen as an important starting point for therapeutic work, the expression of feelings outside the session is not a goal in and of itself. The goal is to help the student act more constructively in interpersonal relationships (e.g. not engage in eating disorder behaviors), and this may involve either expressing or suppressing affects, depending on the circumstances. A goal for the student in brief IPT-ED is to learn when her/his needs are met by expressing affect and when they are better met by suppressing affect. However, a primary goal is helping students to identify, understand, and acknowledge their feelings whether or not they choose to verbalize them to others.

The following is an example: The therapist immediately noticed that Sara was silent and withdrawn at the beginning of the session. Initially, she denied any relationship between her nonverbal behavior and the therapist’s observation. The therapist was persistent and she eventually acknowledged that she was feeling hurt because her father had not acknowledged her birthday. She spent some time clarifying and expressing her feelings of anger and rejection with regard to her relationship with her father. The issue that emerged in the session was "when do you stop wanting something from a parent that you can never get from them?" Even though she became aware of and expressed many painful feelings regarding her relationship with her father, Sara’s goal was not to go out and express these feelings to her father directly at this time. Instead, Sara and her therapist began to discuss how she can find herself more fulfilled and satisfied by working to make other choices in terms of who to turn to for support and care instead of binge eating.

**Help the student experience suppressed affects.** Many who struggle with eating disorders are emotionally constricted in situations where strong emotions are normally felt. An example may be the student who is unassertive and does not feel anger when his/her rights are violated. On the other hand, the student may feel anger but may lack the courage to express it in an assertive manner. Sometimes students will deny being upset, when it is clear that an upsetting interaction has just occurred. The therapist might say, "Although you said you were not upset, it appears to me that you have shut down since you talked about the situation with your boyfriend." In this way, the therapist will attempt to draw out affect when it is suppressed.

Some additional therapist techniques used in the middle phase of brief IPT-ED:

A. **Exploratory.** In order to facilitate a relatively free discussion of material, general, open-ended questions should be used, especially in the initial phases of a session. For
example, "Tell me about your relationship with your roommate", would be followed by progressively more specific questioning.

B. Clarification. The short term goal of this technique is to make the student more aware of what she/he has actually communicated. In order to clarify what the student has said, the therapist may call attention to contradictions in the presentation of material. Contradictions may be noted between the student’s affect expression and her/his verbal discussion. Discrepancies in experiences or perceptions can also be noted when the same material is discussed in a manner that contradicts earlier material that was presented. The therapist may ask a student to repeat or rephrase what has been said. This is particularly useful if the student has said something in an unusual way or contradicted previous statements. For example, "Mary, please help me understand that you said . . . when previously you had said . . ."

C. Communication analysis. This technique is used to identify communication difficulties and to help the student learn to communicate more effectively. It is important to note that these difficulties can be both verbal and non-verbal. In other words, it is not only important to consider what is said but also how it is said. The therapist asks a student to recall (in great detail) a recent interaction or argument he/she had with a significant other. Difficulties in communication can be identified, and the brief IPT-ED therapist can assist the student in finding more effective communication strategies.

D. Use of the therapeutic relationship. In this technique, the student’s thoughts, feelings, expectations, and behavior in the therapeutic relationship are examined insofar as they represent a model of the student’s characteristic way of feeling and/or behaving in other relationships. The premise behind this technique is that people have characteristic ways of interacting with others. This technique is especially helpful for individuals with eating disorders since treatment is often focused on interpersonal deficits (the student develops a relationship with the therapist as a model for other relationships) and interpersonal role disputes (the student receives feedback on how he/she comes across and thereby has the opportunity to understand the nature of his/her difficulties in relating with others).

Redirect issues about eating, weight, or shape to the interpersonal context. During this middle phase, students may bring up content-related topics about their eating disorder behaviors, or disturbed attitudes about eating, shape, and weight, that are not relevant to the work on their goals. When this happens, they need to be gently redirected back to their goals. Following the students into these ‘content’ areas detracts from the session focus and ultimately takes away from the work on their interpersonal problem area(s). The following is an example of how a therapist can gently, but firmly, redirect a student to focus on the work on his goals. In doing so, the therapist is able to engage the student in a more meaningful discussion about his relationship with his girlfriend.

Therapist: What did you want to work on today Robert?
Robert: Well, last week I spent a lot of hours on homework, which was really tough for me, so I didn’t have a whole lot of hours to eat, which was good. I had an episode Sunday, though. When I finished my homework at the library, I went back to my dorm room and started eating, and I didn’t stop until I got a phone call. Thank goodness my friend called me last night because I would’ve eaten all the way through till this morning.

Therapist: It seemed like one of the things you shared with me last week was that eating was a way for you to unwind, you know, de-stress. Instead of sharing your school stressors with your girlfriend, you’ll turn to food.

Robert: Boy, did I unwind, I ate this whole.......  

Therapist: Let me refocus you for a moment back to your goals. How is it coming with sharing more with your girlfriend?

Robert: Good, really good, my girlfriend and I are actually talking quite a bit more about what’s going on for me. She’s not used to that, so she’s kind of wondering what’s up with me. But then she knows why I’m asking questions and then talking to her more, because of therapy and my goals. She’s pretty private herself and doesn’t talk a lot, either. So it’s weird for us to do that.

Therapist: Sounds like it does feel weird, but as we discussed during the beginning of treatment, the more you are able to share your stressors with your girlfriend, the less you will be turning to food when you are stressed. Also, as you share with each other more, it will feel a lot less ‘weird’ to you and your girlfriend.

Robert: I do think that we are getting a little closer.

Mark the End of the Intermediate Phase. Primary goals for the therapist during this middle phase are to identify, challenge, and encourage students to alter maladaptive interpersonal relationships in their outside social lives. By the end of this phase, the therapist may formally bring this phase to an end by saying something like the following:

“You have made a lot of improvement in your relationships and you are having fewer problems with food and your body image. Part of what we need to do today is to reflect on what you have done as far as your goals and to talk about wrapping up our work together. So we’ll spend some time today talking about what is left to do on your goals and about any feelings you might have about ending our work.”
The Termination Phase

In the Termination Phase (the last one or two sessions in brief IPT-ED), the therapist assists the student in acknowledging the feelings associated with termination, evaluating and consolidating gains, detailing plans for maintaining improvements in the identified interpersonal problem area(s), and outlining remaining work. Students are also encouraged to identify early warning signs (e.g., overeating, negative mood) and to identify plans of action. The goals of the Termination Phase are outlined below:

1. Discuss termination explicitly
2. Educate the student about the end of treatment as a time for grieving; encourage him or her to identify associated affects
3. Encourage the student to reflect on the progress that she/he has made, especially, improved relationships/socialization outside of therapy
4. Outline goals for remaining work; identify areas and warning signs of anticipated future difficulty
5. Formulate plans for continued work after the treatment itself has ended

**Discuss Termination Explicitly.** The therapist systematically raises the issue of reactions to impending termination in the last session or two. Introducing the idea that termination is an explicit stage will plant the seed that it is an important topic to discuss. Therapists should always ask students how they feel about the ending of treatment— not least because this provides an opportunity to emphasize what has been achieved and to stress the student's probable competence at dealing with future areas of difficulty. The termination phase can be introduced in the following manner:

“This session and the next mark the last phase of our work together. We’ll be taking time to consolidate our work together and point out changes that you have made. We can reflect on what has been done and talk about what is left to do. I’m sure that these counseling sessions have been important to you. Therefore, it is important to talk about what it’s like to see the end of treatment in sight. You may experience feelings of sadness, apprehension, and even anger as we wrap things up. It is important that you talk about these feelings. What have you been thinking about or feeling in terms of our work ending?”

**Discuss termination as a potential time of grief.** Student reactions to the conclusion of treatments are often varied. As therapy nears completion, and sometimes well before that, students may develop anxiety about saying goodbye and going it alone. Since termination marks the end of a connection to the therapist, it has a theme of loss, an analogue of grief. It is important to state this possibility explicitly as unacknowledged sad feelings may lead to fears of relapse and an increase in symptoms. It is common for people with psychological difficulties to be particularly sensitive to perceived loss. Indeed, some students with issues of abandonment
or feelings of isolation will have voiced fears about the treatment ending early on, in the initial or middle phases of treatment. Even though the therapist reiterates the short-term nature of IPT, and helps the student to recognize progress in each session, many individuals fear that once they leave the therapeutic environment, their symptoms will return and/or they will not be able to retain the gains they have made. The therapist must recognize that working through each of these concerns is the task of the termination phase.

**Review progress.** An important aspect of the Termination Phase is encouraging students to talk about the progress they have made and for the therapist to give feedback about the changes they have seen.

"As you know, we only have one more session to go. What do you envisage happening regarding _____ over the coming months? How can you make sure that you build upon what you have achieved so far?"

This review helps to consolidate the work that has been done. It is not uncommon for individuals with eating disorder symptoms to attribute changes in treatment to the therapist rather than their own hard work. Misplaced credit may erode the student's confidence in their ability for continued success and improvement without treatment. Therefore, the therapist needs to emphasize how the student has begun to successfully manage their outside relationships and their affect. The basic message is the importance of the student assuming responsibility for monitoring his or her own life, relationships, and involvement in social activities.

**Encourage maintenance of therapeutic gains.** In this Termination Phase, the student is encouraged to identify areas that will need further attention. There are always goals that are not accomplished within the time frame of brief IPT-ED. Future difficulties (including self-criticism, negative mood, and overeating) can be expected and the therapist needs to cultivate a discussion of how to handle them. By discussing these issues openly, the student will receive the message that continued change and progress will require effort similar to the work they have already been doing. Predicting that setbacks will occur helps students to be realistic about change. It also underlines the fact that continuing to benefit from therapy will involve accepting personal responsibility for application. This is an important theme that works against passivity and undue reliance on others—be they therapists or family and friends.

Students should also be encouraged to view their eating disorder symptoms as vulnerability or an "Achilles heel", in the sense that it may recur at future times of difficulty. We encourage students to view any deterioration as a useful "early warning signal." It is an indication that they need to review what is happening in their lives and perhaps take some action. Guiding the student in a discussion of contingencies for handling future problems will bolster feelings of competence. It is vital to assist students in thinking about warning signs and symptoms that suggest a need for intervention. The therapist may suggest that they discuss these indicators with significant others as they can be helpful in noticing changes in much the same way as occurred in therapy.
**Bring treatment to a close.** The therapist needs to maintain a calm firmness about the ending of treatment and the importance of talking about it. It is useful to introduce some structure to the final meeting just as it was in the beginning sessions. In the last session, the student should be asked to think about what they would like to say, and how they would like to say goodbye. It is best for the therapist to take the lead here by formally saying goodbye while acknowledging the value of working with the student over the previous number of sessions. The therapist may bring the end of treatment to a close in the following way:

“Well Carol, I have really been struck by the level of your commitment and the risks you took in making so many important changes during treatment. It has been this risk-taking and commitment to change that has led you to break the grip of your eating disorder. I really want to encourage you to keep working on the goals that you have set for yourself. In many respects the real work begins today. It has been a pleasure to have been a part of this process with you.”
References


<table>
<thead>
<tr>
<th>Table 1: Phases of IPT</th>
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</thead>
<tbody>
<tr>
<td><strong>Initial Phase: Sessions 1-2</strong></td>
</tr>
<tr>
<td>• Give the syndrome a name; provide information about prevalence and characteristics of the disorder</td>
</tr>
<tr>
<td>• Describe the rationale and nature of IPT</td>
</tr>
<tr>
<td>• Conduct the interpersonal inventory to identify the current interpersonal problem area(s) associated with the onset and/or maintenance of the eating disorder symptoms</td>
</tr>
<tr>
<td>• Review significant relationships, past and present</td>
</tr>
<tr>
<td>• Identify interpersonal precipitants of episodes of binge eating, extreme dietary restraint, etc.</td>
</tr>
<tr>
<td>• Select and reach consensus about the IPT problem area(s) and treatment plan with patient</td>
</tr>
</tbody>
</table>
Table 2: Example of a “Life Chart” Completed by a Patient with BED

<table>
<thead>
<tr>
<th>AGE</th>
<th>PROBLEMS</th>
<th>RELATIONSHIPS</th>
<th>EVENTS/CIRCUMSTANCES</th>
<th>MOODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Normal weight</td>
<td></td>
<td>Tonsils are removed</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Begins gaining weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Concerns about weight; first binge; prescribed amphetamines to lose weight</td>
<td></td>
<td>Grandfather died</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td>Sister gets married, borrows money from parents, &amp; files for bankruptcy with her husband</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Less concern about weight because “boyfriend’s ex was a lot heavier than me” but began binge eating</td>
<td>Meets boyfriend, 23, who works at a gas station</td>
<td>Does not tell parents about boyfriend given father’s high profile job and position in the community</td>
<td>fearful of disappointing parents; worries about their finding out</td>
</tr>
<tr>
<td>17</td>
<td>Binge eating when alone; weight gain</td>
<td>Breaks up with boyfriend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Loses weight</td>
<td>Meets new friends</td>
<td>Graduates from high school; goes to college</td>
<td>Feels guilty not hanging out with friends but enjoys hanging out with her boyfriend</td>
</tr>
<tr>
<td>19</td>
<td>Binge eating when alone (“food was my only friend”); never binged when with him.</td>
<td>Boyfriend breaks up with her</td>
<td>throws herself into school work</td>
<td>Secrecy (wanting to be “perfect &amp; not disappoint my parents”); homesick; lonely</td>
</tr>
</tbody>
</table>

Begins Psychotherapy
<table>
<thead>
<tr>
<th>Interpersonal Problem Area</th>
<th>Description</th>
<th>Goals</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Grief                     | Complicated bereavement following the death of a loved one | • Facilitate the mourning process  
• Help patient re-establish interest in new activities and relationships to substitute for what has been lost | • Reconstruct the patient’s relationship with the deceased  
• Explore associated feelings (negative and positive)  
• Consider ways of becoming re-involved with others |
| Interpersonal deficits    | A history of social impoverishment, inadequate, or unsustaining interpersonal relationships | • Reduce patient’s social isolation  
• Enhance quality of any existing relationships  
• Encourage the formation of new relationships | • Review past significant relationships including negative and positive aspects  
• Explore repetitive patterns in relationships  
• Note problematic interpersonal patterns in the session and relate them to similar patterns in the patient’s life |
| Interpersonal role disputes | Conflicts with a significant other: a partner, other family member, coworker, or close friend | • Identify the nature of the dispute  
• Explore options to resolve the dispute  
• Modify expectations and faulty communication to bring about a satisfactory resolution  
• If modification is unworkable, encourage patient to reassess the expectations for the relationship and to generate options to either resolve it or to dissolve it and mourn its loss | • Determine the stage of the dispute: renegotiation (calm down participants to facilitate resolution); impasse (increase disharmony in order to reopen negotiation); dissolution (assist mourning and adaptation)  
• Understand how non-reciprocal role expectations relate to the dispute  
• Identify available resources to bring about change in the relationship |
| Role transitions          | Economic or family change: the beginning or end of a relationship or career, a move, promotion, retirement, graduation, diagnosis of a medical illness | • Mourn and accept the loss of the old role  
• Recognize the positive and negative aspects of the new role, and assets and liabilities of the old role  
• Restore self-esteem by developing a sense of mastery regarding the demands of the new role | • Review positive and negative aspects of old and new roles  
• Explore feelings about what is lost  
• Encourage development of social support system and new skills called for in new role |
Table 4: Case Example: Patient Goals (Interpersonal Deficits)

1. During our meeting you talked about having a difficult time identifying your thoughts and feelings, especially times when you binge eat. We know that many individuals who struggle with binge eating also have problems identifying just what is going on inside. This makes it hard to address the important interpersonal issues. Over the years, your binge eating has been one way that you have tried to take care of yourself. Unfortunately, this strategy has not been very successful and has led to just the opposite - your continuing to feel out-of-control and demoralized. The more aware you can be about your thoughts and feelings, the less likely you will need to use food as a way to manage them.

**GOAL:** When you begin to binge eat or feel out-of-control with your eating, stop and check in with yourself by asking “What’s going on? What’s the interpersonal issue that triggered this? How has it made me feel? What can I do to address the situation?” This may be difficult at first, so both inside and outside of the therapy try to be mindful of upset states and address the underlying issues and feelings as they come up - in the moment. As you are able to do this, you will be less likely to use food to blanket your distress.

2. During the interview you shared that over the years you have kept many secrets and, in the process, have kept your thoughts and feelings hidden inside. You mentioned that you have done this to protect people you care about (for example, your father and your son) and to protect yourself from having conflict with others. Your difficulty in communicating effectively and directly has made it difficult for you to manage conflict. From the time since this began, binge eating has been one way for you to manage the pressure of keeping so many things inside.

**GOAL:** In order for you to recover from your binge eating, it will be very important for you to begin to share your thoughts and feelings (both good and bad) with the important people in your life, such as your son and your boyfriend. This will ultimately bring you closer, though the others will have to get used to dealing with a new ‘you’. Use the therapy as a place to practice talking about your life and the issues you are trying to deal with. As you become more comfortable doing this, you will be less likely to use food as a way to keep your feelings inside.

3. You also mentioned that you have spent a good part of your life caring for and taking care of others (your son, your relationships, your organizations, your customers). Your overall competence has led people to come to you for support or to take on extra tasks that add to your already busy schedule.

**GOAL:** In order to recover from your binge eating it will be important for you to use therapy to develop techniques for saying ‘no’. This means that you will need to challenge the guilt you experience if you don’t immediately accept more responsibilities and your fears that others will not like you if you refuse. This cycle of self-denial and excessive responsibility appears to have had a negative effect on your relationships. Addressing this pattern in treatment will free up time for yourself and doing nice things for yourself will be a good way to start. As you work to prioritize yourself, you will be less likely to need to use food to nurture yourself. Use the therapy to discuss ways of making changes on this goal and to review your progress.