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ScienceDirect

Comprehensive Psychiatry 55 (2014) 170–178

COMPREHENSIVE PSYCHIATRY

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Interpersonal problem areas and alexithymia in adolescent girls with loss of control eating

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Abstract

This study investigated the links among interpersonal problem areas, depression, and alexithymia in adolescent girls at high risk for excessive weight gain and binge eating disorder. Participants were 56 girls (M_{age} = 14.30, SD = 1.56; 53% non-Hispanic White) with a body mass index (BMI, kg/m^2) between the 75th and 97th percentiles ($M_{BMI\ z}$ = 1.57, SD = 0.32). By design, all participants reported loss of control eating patterns in the past month. Adolescents were individually interviewed prior to participating in a group interpersonal psychotherapy obesity and eating disorder prevention program, termed IPT for the prevention of excessive weight gain (IPT-WG). Participants' interpersonal problem areas were coded by trained raters. Participants also completed questionnaires assessing depression and alexithymia. Primary interpersonal problem areas were categorized as interpersonal deficits [as defined in the eating disorders (ED) literature] (n = 29), role disputes (n = 22), or role transitions (n = 5). Girls with interpersonal deficits–ED had greater depressive symptoms and alexithymia than girls with role disputes (p's ≤ 0.01). However, girls with role transitions did not differ from girls with interpersonal deficits–ED or role disputes. Interpersonal problem area had an indirect association with depression via alexithymia; interpersonal deficits–ED were related to greater alexithymia, which in turn, was related to greater depressive symptoms (p = 0.01). Among girls at risk for excess weight gain and eating disorders, those with interpersonal deficits–ED appear to have greater distress as compared to girls with role disputes or role transitions. Future research is required to elucidate the impact of interpersonal problem areas on psychotherapy outcomes.

Binge eating, characterized by episodes of overeating accompanied by a lack of control over eating, is the hallmark behavior of binge eating disorder (BED) [1]. BED is associated with a range of psychological problems including distress about shape and weight, poor social functioning, low self-esteem, mood and anxiety disorders [2], as well as poor physical health [3].

Although full-syndrome BED is rarely observed in children and adolescents, reports of infrequent (≥1 episodes in the past month) loss of control eating (LOC eating) are common. LOC eating is defined as the experience of being unable to control what or how much is being consumed, regardless of the amount of food reportedly eaten [4]. Prevalence rates of LOC eating range from 4% to 45%, with higher estimates among overweight (versus non-overweight) youth, adolescents (versus pre-adolescents), and girls (versus boys). Youth with reported LOC eating are more likely to be heavier and to have greater fat mass than their peers without LOC eating episodes [4]. Paralleling adult BED, pediatric

This research was supported by NIDDK grant 1R01DK080906-01A1 and USUHS grant R072IC (to M. Tanofsky-Kraff) and NIH, NICHD Intramural Research Program ZIA-HD-00641 (to J. Yanovski). Disclaimer: The opinions and assertions expressed herein are those of the authors and are not to be construed as reflecting the views of USUHS or the US Department of Defense.

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0010-440X/$ – see front matter © 2014 Elsevier Inc. All rights reserved.
http://dx.doi.org/10.1016/j.comppsych.2013.08.005

LOC eating is associated with increased eating-related psychopathology, symptoms of depression and anxiety, and dysfunctional emotional regulation strategies [4–6]. Notably, LOC eating in middle childhood is predictive of excess weight gain [7], the development of partial and full-syndrome BED, and worsening symptoms of depression [8].

Despite the adverse associations and consequences of LOC eating, not all youth reporting the behavior continue to experience episodes over time. In one naturalistic study, about half of children who endorsed LOC eating during childhood continued to report LOC eating 4 years later, and only youth with persistent LOC eating experienced the greatest increases in psychological distress [8]. Therefore, identifying those youth who are at greatest risk for persistent LOC eating may elucidate those in greatest need of prevention and/or early intervention.

1. Interpersonal psychotherapy model as applied to binge eating disorder/loss of control eating

Group Interpersonal Psychotherapy for Eating Disorders (IPT-ED) was developed specifically for the treatment of adults with BED; the intervention targets improvements in interpersonal problem areas that purportedly lead to reductions in binge eating [9]. The interpersonal model also has been applied to intervening with LOC eating in youth with a group program termed IPT for the Prevention of Excess Weight Gain (IPT-WG) [10]. As with IPT-ED, IPT-WG focuses on improving interpersonal problems that precipitate or maintain LOC eating. Reductions in LOC eating are anticipated to prevent the excessive weight gain linked to adolescents' LOC episodes and to prevent the development of BED [10]. Unlike IPT-ED, which was developed as a treatment for adults with BED and often co-morbid clinical depression, IPT-WG was designed as a selective, preventive intervention for adolescents at risk for excessive weight gain and BED [10]. The IPT-WG approach shares a number of features with IPT-Adolescent Skills Training (IPT-AST) [11]. Like IPT-AST, IPT-WG is geared for adolescents in content and structure. Primary components of the IPT-WG include psycho-education about the interpersonal model of LOC eating, discussion of normative social developmental changes of adolescence—particularly as they pertain to eating- and weight-related issues—and interpersonal social skill building through communication skills training and role playing. Role plays are tailored to assist group members in working on personalized, interpersonal goals. The group facilitators formulate one to three specific goals with each adolescent during an interpersonal inventory conducted at a pre-group, individual session.

The manifestation of adolescents' LOC eating symptoms can be conceptualized as falling within one of four primary interpersonal problem areas: a) interpersonal deficits, b) interpersonal role disputes, c) role transitions, and d) grief. IPT programs developed for BED treatment or prevention (i.e., IPT-ED or IPT-WG) conceptualize problem areas somewhat distinctly as compared to traditional IPT [9,12,13]. From an eating disorder-specific approach, *interpersonal deficits* are used to designate individuals with either poor social skills that drive social isolation, or individuals with repeatedly difficult or ineffective social interactions that yield chronically unsatisfying relationships [9]. The former (e.g., social isolation) *only* is considered the classic interpersonal deficit in IPT treatment for clinical depression when such problems occur in the absence of a significant life transition [14]. The eating disorder-specific conceptualization of interpersonal deficits *also* encompasses individuals with many relationships that are superficial, unfulfilling, and/or characterized by ineffective communication or conflict. Conceptualized as such, interpersonal deficits affect a majority (>60%) of adults presenting for IPT-ED treatment for BED [9]. *Interpersonal role disputes* refer to conflicts with one or two significant others (e.g., a parent, other family member, or peer) that emerge from differences in expectations about the relationship. *Role transitions* are a significant change in life status such as, for adolescents, a change in schools, graduation, moving, parental divorce, or having difficulty with the transition from pre-adolescent to adolescent types of relationships and the accompanying expectations and requirements of a different skill set. The problem area of *grief* is identified when the onset of the individual's symptoms is associated with either the recent or past loss of a close person. In IPT-WG, multiple interpersonal problem areas may apply. IPT-WG focuses on identifying and changing the maladaptive interpersonal context in which the LOC eating symptoms developed and have been maintained [10].

1.1. Link between interpersonal problem area, depression, and binge eating disorder/loss of control eating

To date, no study has examined whether problem area designation differentiates youth with LOC eating. In theory, individuals with LOC or binge eating who present with interpersonal deficits may constitute a vulnerable subset of individuals due to pervasive deficits in social functioning across multiple relationships and social domains. In contrast to other problem areas, a classification of interpersonal deficits in IPT-ED or IPT-WG may denote difficulties that impede an individual's ability to establish and maintain healthy relationships with others. Among adults, interpersonal deficits are highly correlated with depression [15]. In obese adult women, those with social skills reflective of interpersonal deficits, such as low assertiveness, poor capacity to interact with strangers, and high distress in social situations, were more likely to have BED compared to obese women without such interpersonal characteristics [16]. Although no study has examined adolescents, it has been hypothesized that those with the type of interpersonal deficits that parallel adult women with BED may be more vulnerable to depressive symptoms compared to youth with