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An eating disorder-specific model of interpersonal psychotherapy (IPT-ED): Causal pathways and treatment implications

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ABSTRACT

Several studies support the efficacy of interpersonal psychotherapy (IPT) in the treatment of eating disorders. Treatment outcomes are likely to be augmented through a greater understanding, and hence treatment targeting, of the mechanisms whereby IPT induces therapeutic gains. To this end, the present paper seeks to develop a theoretical model of IPT in the context of eating disorders (IPT-ED). After providing a brief description of IPT, the IPT-ED model is presented and research supporting its theorized mechanisms is summarized. This model proposes that negative social evaluation plays a pivotal role as both a cause (via its detrimental impact on self evaluation and associated affect) and consequence of eating disorder symptoms. In the final section, key eating disorder constructs (namely, the developmental period of adolescence, clinical perfectionism, cognitive dysfunction, and affect regulation) are re-interpreted from the standpoint of negative social evaluation thereby further explicating IPT's efficacy as an intervention for individuals with an eating disorder.

Contents

1. Introduction . . . 400
2. Overview of IPT . . . 401
3. Theoretical model of IPT for eating disorders (IPT-ED) . . . 402
   3.1. Overview of the IPT-ED model . . . 402
   3.2. Negative social evaluation triggers low self-esteem and negative affect . . . 403
   3.3. Negative social evaluation triggers eating disorder symptoms . . . 403
   3.4. Eating disorder symptoms exacerbate negative social evaluation . . . 405
   3.5. Summary of the IPT-ED model . . . 405
4. The reconceptualization of eating disorder related constructs in social evaluative terms . . . 405
   4.1. Adolescence and early adulthood . . . 405
   4.2. Clinical perfectionism . . . 406
   4.3. Cognitive dysfunction . . . 406
   4.4. Affect regulation strategies . . . 407
5. Concluding comments . . . 407
References . . . 408

1. Introduction

Among psychiatric conditions, eating disorders are unique in that their core features—the control of body shape, weight, and eating—have immense social currency in cultural settings in which thinness

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and/or dietary restraint are highly valued. These varied settings include medieval female saints whose religious tradition venerated suffering and denigrated the flesh (Bell, 1985), Chinese Daoist practices that emphasize fasting as a means of attaining spiritual perfection (Eskildsen, 1998), or the "cult of thinness" of contemporary Western culture (Hesse-Biber, Leavy, Quinn, & Zoino, 2006, p. 208). The social status to be gained from bodily and dietary control can only be enhanced in societies where the majority of individuals struggle with problems of overweight or obesity (World Health Organization, 1998). That aspects of eating disorder symptomatology are socially prescribed, suggests a central role for interpersonal factors in the development and maintenance of these conditions.

Consistent with an interpersonal formulation of eating disorders, there is abundant evidence highlighting the existence of interpersonal dysfunction in the lives of individuals with an eating disorder (for a review, see Wilfley, Stein, & Welch, 2003). Moreover, there is support for the efficacy of interpersonal psychotherapy (IPT), an approach that targets interpersonal problems as a means of resolving psychological symptoms (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman, Markowitz, & Klerman, 2000), in the treatment of eating disorders (e.g., Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Wilfley et al., 1993; Wilfley et al., 2002).

Yet in stark contrast to cognitive behavior therapy (CBT), in which eating disorder-specific adaptations were originally formulated in the 1980s (e.g., Fairburn, 1985), there is no empirically supported theoretical model of IPT for eating disorders. The insufficient theoretical foundation of IPT is not unique to eating disorders and is partly the legacy of IPT having evolved in the context of treatment outcome evaluation such that questions as to *why* it is effective have lagged behind questions as to *whether* it is effective (Stuart & Robertson, 2003).

Nevertheless, both general (Stuart & Robertson, 2003) and disorder-specific models of IPT have been proposed, such as IPT for depression (Frank & Spanier, 1995), dysthymia (Markowitz, 2003), and borderline personality disorder (Markowitz, Skodol, & Bleiberg, 2006). Attachment theory (Bowlby, 1977) has been described as the theoretical foundation of IPT in that psychological problems are hypothesized to develop when an individual's needs for attachment (i.e., strong affectional bonds with preferred others) are not being met (Stuart & Robertson, 2003). These bonds "provide opportunities for intimacy, nurturance, validation of self worth, and a sense of connectedness with others" (Frank & Spanier, 1995, p. 353) and their disruption results in various forms of emotional distress such as anxiety, depression, and anger. However, these attachment-based approaches were not designed to account for the mechanisms by which attachment disturbances elicit eating disorder symptoms as opposed to other forms of psychopathology.

To initiate the process of theory-building in IPT for individuals with an eating disorder, the present paper proposes a theoretical model that seeks to explain IPT's efficacy and to guide its future implementations in this population. After providing a brief overview of IPT, the paper is divided into two sections. The first section presents our theoretical model of IPT for eating disorders (IPT-ED), beginning with an overview of the model followed by a review of the research supporting the theorized mechanisms by which specific interpersonal problems maintain, and are in turn maintained by, eating disorder symptoms. Emphasizing the validating aspects of attachment bonds, it will be argued that negative social evaluation plays a central role in triggering disturbances of the self and hence eating disorder symptoms. Given the primacy of negative social evaluation in our IPT-ED model, the second section provides a re-examination of several key eating disorder relevant constructs (including the developmental stage of adolescence as a risk period for the onset of eating disorders, clinical perfectionism, dysfunctional cognitive processes, and affect regulation strategies) from the perspective of negative social evaluation.

2. Overview of IPT

IPT originated as a standardized form of interpersonally-oriented psychotherapy for use in treatment outcome research on depression (Birchall, 1999; Swartz, 1999; Tantleff-Dunn, Gokee-LaRose, & Peterson, 2004; Weissman, 2007). As with CBT, IPT is typically implemented as a time-limited treatment, consisting of 12 to 20 sessions spanning four to six months (Birchall, 1999; Wilson, 2005). IPT is well tolerated by patients and is easily learned by competent therapists (Birchall, 1999; Crafti, 2002; Tantleff-Dunn et al., 2004). Although the therapist is less directive in IPT than in the behavioral therapies (Apple, 1999), IPT itself is a focused intervention (with a focus on the interrelatedness of interpersonal problems and psychological symptoms) and in this way has come to differentiate itself from traditional, supportive psychotherapy (Tantleff-Dunn et al., 2004). The hallmark of IPT is the completion of a chronological review of the individual's significant life events, fluctuations in mood and self-esteem, and interpersonal processes in order to identify areas of social functioning associated with the development and maintenance of psychological symptoms (Wilfley, MacKenzie, Welch, Ayres, & Weissman, 2000; Wilfley et al., 2003). Typically, the result of this collaborative formulation is the identification of problems in one or two of the following areas of interpersonal functioning: grief, role transitions, interpersonal role disputes, and interpersonal deficits.

In IPT for eating disorders (Jacobs, Welch, & Wilfley, 2004; Tanofsky-Kraff & Wilfley, in press), the problem area of grief is identified when eating disorder symptoms are associated with the loss of a person or a relationship. A role transition is identified as a focus of treatment when eating disorder symptoms are associated with a change in life status. Interpersonal role disputes are addressed in treatment when eating disorder symptoms are related to conflict between the person with the eating disorder and significant others as a result of different expectations about the relationship. The problem area of interpersonal deficits is applied when eating disorder symptoms are associated with poor social skills or repeatedly difficult interactions that yield chronically unsatisfying relationships.

Given its similarities with CBT (time-limited, structured, acceptable, and transferable), yet its distinctive focus on resolving interpersonal difficulties, IPT has served as a comparison treatment in research on bulimia nervosa, binge eating disorder, and anorexia nervosa. IPT has been found to yield comparable recovery rates to CBT in the long-term for bulimia nervosa (Agras et al., 2000; Fairburn et al., 1991) and in both the short- and long-term for binge eating disorder (Wilfley et al., 2002). Research has also demonstrated some advantages of IPT over other psychological treatments (e.g., greater effectiveness than behavioral weight loss treatment and CBT-based guided self-help for individuals with BED who have low self-esteem and high eating disorder psychopathology) (Wilson, Wilfley, Agras, & Bryson, 2010). However, research also indicates limitations in the use of IPT for the treatment of patients with an eating disorder. In addition to the delayed therapeutic effects of IPT relative to CBT in the treatment of bulimia nervosa (Agras et al., 2000), one study found that IPT yielded significantly poorer post-treatment recovery rates compared to specialist supportive clinical management in the treatment of patients with full or partial syndromes of anorexia nervosa, although there was no significant difference between CBT or IPT in this regard (McIntosh et al., 2005; McIntosh et al., 2006).

Previous research evaluating IPT in the context of eating disorders has typically entailed various limitations in its implementation that are likely to have diminished its therapeutic effects. Among these methodological limitations are the failure to discuss eating disorder symptoms (and hence their connection with interpersonal problems), a prolonged period of assessment in the IPT intervention with a consequently insufficient amount of time for working on change, and the exclusion of strategies that are common to both IPT and CBT from the IPT intervention (and thus its potential attenuation) so as to more