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Interpersonal Psychotherapy for the Prevention of Excess Weight Gain and Eating Disorders: A Brief Case Study

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Interpersonal psychotherapy (IPT) is a brief, time-limited therapy that focuses upon improving interpersonal functioning and, in turn, psychiatric symptoms (Freeman & Gil, 2004; Klerman, Weissman, Rounsaville, & Chevron, 1984). IPT's central mechanism involves relating psychiatric symptoms to interpersonal problem areas and developing strategies for dealing with these problems. IPT was developed for the treatment of unipolar depression, and is grounded in the hallmark interpersonal theories underscoring interpersonal functioning as a critical component of psychological adjustment and well-being (Klerman et al., 1984). In the IPT model, interpersonal experiences are theorized to precipitate psychopathology, and conversely, psychopathology may result in impairments in one's ability to interact effectively with others (Klerman et al., 1984). IPT makes no assumptions about the causes of psychiatric problems, but assumes that the development, maintenance, and treatment of psychiatric symptoms occur within influential social and interpersonal contexts.¹

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¹For a more detailed presentation of this case, see the *Casebook of Evidence-Based Therapy for Eating Disorders*, Thompson-Brenner (Ed.), 2015. The relevant chapter is presented more briefly in this special section, with a particular focus on aspects of relational functioning. Extensive information on IPT for depressive disorders, detailing empirical background, theoretical foundation, and strategies and techniques, are fully described in a comprehensive book (see Weissman, Markowitz, & Klerman, 2000).

A strong body of research evidence links difficulties in interpersonal functioning with eating disorder (ED) symptoms (Wilfley, Wilson, & Agras, 2003). The interpersonal model of binge eating (BE) posits that social problems are a key trigger of binge episodes; problematic interpersonal interactions generate negative feelings, which in turn precipitate out-of-control eating as a coping mechanism to temporarily reduce negative affect (Rieger et al., 2010). Ultimately, BE worsens negative mood and is frequently accompanied by feelings of guilt, shame, and disgust (Haedt-Matt & Keel, 2011). As a result, BE increases social isolation and exacerbates difficulties in interpersonal relationships, which in turn exacerbate ED symptoms (Rieger et al., 2010). IPT promotes awareness and expression of painful affect and assists patients to develop effective strategies for managing negative feelings, including healthy interpersonal skills.

A substantial evidence-base supports the efficacy of IPT with adults with bulimia nervosa (BN) and binge eating disorder (BED; e.g., Wilson, Wilfley, Agras, & Bryson, 2010). The use of a Group IPT format offers multiple therapeutic strategies for addressing interpersonal problems (Wilfley et al., 1993; Wilfley, MacKenzie, Welch, Ayres, & Weissman, 2000). The group is viewed as a “live” social network, designed to decrease social isolation and promote the formation of new relationships (Wilfley, Frank, Welch, Spurrell, & Rounsaville, 1998). These tasks may be particularly difficult for individuals with BED, who commonly experience shame and self-stigmatization with respect to BE and excess body weight.

Although most existing research on IPT for EDs has been conducted with adults, IPT appears to also benefit overweight adolescents who experience ED symptoms and are at elevated risk for a full-syndrome ED (Tanofsky-Kraff et al., 2015). Children and teens with excess body weight experience frequent teasing, social isolation, stigmatization, and social rejection (Hayden-Wade et al., 2005; Pearce, Boergers, & Prinstein, 2002; Strauss & Pollack, 2003). Not surprisingly, overweight youth experience poorer social functioning and negative feelings about themselves regarding their body shape and weight than youth who are not overweight (Fallon et al., 2005; Schwimmer, Burwinkle, & Varni, 2003; Striegel-Moore, Silberstein, & Rodin, 1986).

The most prevalent ED symptom among overweight youth is “loss of control” (LOC) over eating, the primary criterion for binge eating. LOC eating is the experience of being unable to stop or control eating, regardless of the amount being consumed. The feeling of losing control is subjective, but distinctive to those who experience it, and it distinguishes binge eating from other experiences such as overeating. Overweight youth who report even infrequent LOC eating (e.g., one episode per month) manifest more psychosocial difficulties than overweight youth without LOC (Tanofsky-Kraff, 2008). Youth with LOC are at greater risk for developing partial- or full-syndrome BED (Tanofsky-Kraff et al., 2011), excessive body weight (Tanofsky-Kraff et al., 2006, 2009), and risk factors for cardio-metabolic disease (Tanofsky-Kraff et al., 2012).

IPT for the prevention of excess weight gain (IPT-WG) is a group program designed to reduce LOC eating in adolescents. IPT-WG was adapted from two previously established IPT manuals: (a) IPT-Adolescent Skills Training for the prevention of depression (Young & Mufson, 2003) and (b) group IPT for binge-eating disorder (Wilfley et al., 2000). By

improving interpersonal issues among girls with LOC, IPT-WG seeks to reduce the negative emotions that facilitate LOC eating and ultimately decrease or eliminate LOC episodes, thereby averting likely future excess weight gain. Two randomized controlled trials have demonstrated that IPT-WG is well received by adolescent girls with LOC eating at-risk for adult obesity, and that IPT-WG is superior to health education in preventing long-term binge eating (Tanofsky-Kraff et al., 2010, 2014).

Case Example

Method

“Jane Doe” was a 13-year-old, non-Hispanic White girl² participating in a clinical research trial of IPT-WG. Girls at-risk for adult obesity and BED were randomly assigned to take part in 12 weeks of preventative group treatment. Participants were 12–17 years old with a body mass index (BMI; kg/m²) between the 75th and 97th percentiles for their age, in good physical health reporting at least one recent episode of LOC eating. BMI provides a measure of weight standardized for height. According to Centers for Disease Control (CDC) standards, a BMI between 18.5 kg/m² and 24 kg/m² is in the normal range. Although many girls in the study had subthreshold psychiatric symptoms and endorsed concerns about their body shape and weight, individuals with full-syndrome psychiatric disorders were excluded and referred for treatment elsewhere.

At an initial screening, Jane was interviewed about her eating, body shape and weight concerns, and other potential emotional problems. Her eating behaviors and body shape concerns were assessed via the Eating Disorder Examination (Fairburn & Cooper, 1993). Her weight and height were measured. Jane described her depressive symptoms on the Beck Depression Inventory II (BDII; Beck, Steer, & Brown, 1996) and the presence or absence of Axis I disorders was assessed via the Schedule for Affective Disorders and Schizophrenia for School-Age Children (Kaufman et al., 1997).

Treatment involves three individual and 12 group sessions. At the initial individual session, prior to group, the rationale for the program is reviewed, rapport is built, and an “interpersonal inventory” is conducted with the client to learn about her social network and difficulties in important relationships, particularly difficulties that are linked to problems with negative mood and LOC eating. The adolescent’s interpersonal problems are conceptualized in three problem areas: (a) interpersonal deficits, applying to those individuals who are socially isolated or have chronically unfulfilling relationships (frequently the result of poor social skills); (b) interpersonal role disputes, referring to conflicts with a significant other such as a parent, sibling, or peer, frequently emerging from differences in expectations about the relationship; (c) role transitions, or difficulties associated with life adjustments such as a change in schools, graduation, moving, or parental divorce.³ Goals are set in these problem areas, and subsequently addressed in therapy. Two brief 15-min individual sessions occur halfway through therapy and prior to termination, to

²Prior to the start of therapy, the patient’s parent/guardian provided written informed consent to participate in the study, including consent for the recording of therapy sessions and publishing of unidentifiable data. The patient’s name and identifying information have been thoroughly disguised to protect confidentiality.

reinforce work on goals. Throughout the intervention participants are encouraged to examine links between their relationships, mood, and eating patterns.

Jane's IPT-WG group included five other early adolescent girls (mostly aged 12–13) at risk for adult obesity and BED. The group was facilitated by a psychologist with a doctorate in child clinical psychology and a doctoral student in clinical psychology. Both leaders had considerable experience running groups and working with adolescents with eating and weight problems.

Results

Baseline individual assessment.—At baseline, Jane endorsed LOC eating and had a BMI at the 97th percentile. Jane also endorsed elevated depressive symptoms, score of 24 on the Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996); 25 is the clinical cutoff for major depressive disorder, but she denied major depressive disorder or any psychiatric disorder currently or in the past. She had no prior experience with therapy or psychotropic medication. Jane's mother's report of Jane's symptoms fell within normal ranges.

Jane's primary presenting problems centered upon LOC eating episodes and concerns about her weight. She reported experiencing her first LOC episode at age 7, at the same time that she remembered becoming overweight. Over the past 1–2 years as she entered early adolescence and transitioned to middle school she reported experiencing LOC episodes with increasing frequency, and distress. Jane reported she often snacked or ate too much in response to feeling depressed. On the Eating Disorder Examination (Fairburn & Cooper, 1993), she described significant body weight and body shape dissatisfaction, endorsing feelings of shame and embarrassment when wearing clothes that showed her shape, and considerable distress when she became aware of her body, such as when viewing her image in a mirror, showering, weighing herself, or shopping for clothes: *Shopping is always so depressing. My mom and I went to the mall on Saturday so that I could get some new bras, and it was just so awful. I didn't want to try anything on, and my mom got so annoyed. I mean, she was annoying me! Nothing was going to fit me right, so I didn't even see the point.* Jane was not currently dieting but had made several brief, unsuccessful dieting attempts over the past 1–2 years by *counting calories, eating diet foods, and eating frozen meals.* She denied current or past attempts to control her weight with extreme weight control behaviors.

Interpersonal inventory.—At a pregroup individual meeting, Jane presented as friendly and engaged. She was talkative and eager to describe her relationships, mood, and eating. Jane lived with both biological parents and younger sister. She described a conflictual relationship with her mother, with frequent arguments. Her mother, who herself was obese and described her own difficulties with binge eating at the assessment, reportedly worked long hours and was often tired and stressed. Most arguments with her mother involved conflicts over Jane wanting to do things with peers: *I just like to get out of the house. I get*

³In contrast to adult IPT programs, adolescent programs infrequently encounter youth with “grief” as their IPT problem area (one of the four primary problem areas in adult IPT). As these youth have substantively different experiences than other adolescent group members, they are referred to alternative therapies.

down when I sit around the house and my mom won't take me anywhere. Jane wished her parents would let her spend more time with friends.

Jane listed three friends in her social network, including two from elementary school who did not attend her middle school. In Jane's second year of middle school, her family relocated to a different neighborhood. She did not know many people at her new school, and she reported difficulty making new friends. Jane said she had one friend at school *who I can kind of talk to*, but she did not see this friend outside of school often. She did not see her friends from elementary school often, and wished she could see them more frequently: *My mom NEVER wants to take me anywhere. She says she's too tired and stuff. And I'm not allowed to go places on my own.* Jane enjoyed going to her local swimming pool, walking around the mall, or going to the movies, but she rarely was able to do these activities because of difficulties arranging for a parent to take her. Jane also described some teasing and bullying at school.

At the initial pregroup individual meeting with Jane, the therapists introduced the IPT model: *Many kids that we work with tell us that they have a bad interaction with someone—like a fight with their mom or someone at school giving them a hard time about their weight—and they feel really badly about that, and then find themselves—at some point, it could be right away or later in the day—eating a lot of food, especially foods that aren't so healthy, and feeling like they can't control their eating. Is that something that you've ever experienced?*

Jane *Definitely. Like, this week my mom and I were arguing [tearful] and I found myself in the kitchen eating.*

Therapist It sounds like you know exactly what we're talking about. On that particular day, what time of day was it? What were you arguing about?

Jane It was around 6 o'clock and my mom had just gotten home from work. I was asking her if I could get a ride to go to the mall with Mary and Jenny, and she like blew up at me.

Therapist What did she say?

Jane She was all like "I'm tired, Jane, and I'm not going to talk with you about this right now." She never lets me go anywhere!

Therapist What happened next? You said you found yourself in the kitchen.

Jane *[Crying.]I was like, "WHATEVER," and went to the kitchen and ate some chips. I had like the entire bag.*

Therapist What else?

Jane I also had a granola bar and some cookies.

Therapist How were you feeling after the fight with your mom, before you started eating?

Jane I was really angry.

Therapist Any other feelings?

Jane I also was a little depressed.

Therapist I can see how that must have felt really bad. How about after you were done eating?

Jane I don't know. I wasn't really paying attention.

Therapist Sometimes kids tell us that they “zone out” when they're eating.

Jane Yeah.

Therapist One thing we're going work on in the group is to encourage you to pay attention to how you're feeling, especially when you notice that your eating feels out of control or when you have a fight with someone, like your mom. What happened after you were done eating? Did you and your mom ever talk again about going to the mall or about the fight?

Jane No. That's usually what happens. We just go our separate ways. I just went to my room and listened to music, did my homework.

Therapist It sounds like you and your mom had this fight about the mall, you felt angry and depressed, and then you found yourself eating a lot in a way that felt out of control. That's exactly the kind of thing we're going to be working on in the group.

Although Jane's interpersonal problems could be conceptualized as falling into several interpersonal problem areas, the therapists viewed her primary interpersonal problem area as a “role dispute” given the emphasis on the conflicts with her mother. However, the group leaders were cognizant that she was also struggling with a role transition because of the recent change to a new school and increasing isolation from peers and due to conflict with parents around transitional issues—namely, independence. Jane and her mother were having difficulties communicating around conflicts concerning Jane's new role as a teenager. Jane desperately wanted to have more friends and to be able to spend time with peers outside of school, and her interactions with her parents were not effectively supporting this developmental transition. It was notable that although Jane experienced LOC eating as a child, it was not until conflicts with her mother escalated during early adolescence that the LOC became more frequent and severe, and accompanied by negative affect and marked dissatisfaction with her appearance.

The therapists asked Jane what she thought of the following goals:

It sounds like working out a better way to deal with conflicts with your mom would really help you to feel better and in turn, to decrease the times that your eating feels out of control. Is this something that you'd be willing to work on in the group? Do you think that that goal would be helpful?

It also sounds as though you would like to work on your friendships. Specifically, increasing the amount of time you spend with friends outside of school and also, forming some new friendships at school. The hope is that this would help you to get the support you need from people your own age, we expect that this would help to improve your mood and also lessen your loss of control eating. What do you think of that goal?

Jane was enthusiastic about both goals. However, she was skeptical that her mom would allow her to spend more time with friends. The therapists encouraged her to keep an open mind.

Initial phase of group intervention (Session 1–3).—In the initial sessions, introductions were made and guidelines for the group were established, such as confidentiality and its limitations, speaking to others respectfully, commitment to attendance and participation, and arriving on time. The girls were very talkative and eager to get to know each other. The therapists worked to encourage rapport while simultaneously keeping them focused on the treatment material.

The therapists' observations of Jane in a group setting with other girls her age was clinically informative and revealed information that was not apparent in the pregroup individual meeting. Although Jane appeared highly motivated to connect to the other girls in the group, she demonstrated some social deficits with her peers. For instance, she was so eager to participate that she frequently interrupted others to talk about herself. Her speech and laughter were occasionally louder than that of other group members. It became clear that Jane would benefit from learning more effective communication skills and ways of relating to others her age.

In these initial sessions, several semistructured activities were conducted to provide psychoeducation on risk factors for excessive weight gain, to review the interpersonal model connecting relationships, feelings, and LOC eating, to set the groundwork for communication analysis, and to learn key communication skills. Communication analysis is the process of analyzing the “he said, she said” of an interpersonal exchange. Girls were taught that what they say (i.e., the content of their speech) and how they say it (e.g., their tone of voice) affects how the other person will respond and the course of the interpersonal interaction. Specific communication skills were explained as tools for altering the course of interactions to get what they desire from a particular interaction. Example communication skills include using “I” statements to express feelings (e.g., *I feel really disappointed that you can't drive me to the mall* vs. *You never drive me to the mall. I hate you!*), choosing the right timing to have a conversation (i.e., when people have had time to calm down and think through thoughts and feelings vs. in the heat of the moment), and putting yourself in the other person's shoes (i.e., understanding and communicating the other person's perspective in a conflict). In the initial phase these concepts were taught generically, and in the subsequent phases the girls were encouraged to apply these skills to their individualized goals. Jane participated actively in these activities and readily grasped the material.

Middle phase of group intervention (Sessions 4–9).—In this phase the therapists assisted group members in sharing recent interpersonal interactions from the past week relevant to their goals, including the effect on their mood and changes in their eating patterns. Role-plays were used to review the interpersonal interactions and to plan for future, more effective interaction.

Jane made progress on both of her goals. With respect to improving communication skills with her mother, Jane made a number of important changes. Foremost, choosing the right time to approach her mother was central to a successful interaction. With the feedback of other group members, Jane realized that talking to her mother right after she came home from work—when her mother was very tired out from the day—was unlikely to be effective. Instead, she attempted to talk to her mother on the weekend, to schedule a time to talk to her mother, and to give her mother advance notice if she hoped her mother would take her somewhere. Jane also learned to pick a time to have a conversation when she could prepare herself to stay calm as opposed to getting very upset and worked up. Role-playing the conversation in the supportive context of the group helped Jane to feel prepared and less anxious in approaching her mother to ask for assistance with transportation or other things that she wanted. By using these skills, Jane reportedly succeeded in obtaining her mother's help to drive her places and therefore was able to spend more time with friends as well.

Through the course of the middle phase of therapy, Jane disclosed to the group that her mother would sometimes make very painful comments to Jane about her appearance. In one poignant session, she shared with the other girls: *Last week, my mom was yelling at me in the morning because I was late for the bus and she had to drive me to school. As I was getting out of the car she said, "Jane, you are an ugly person" [crying].*

Another group member That is so mean.

Therapist How did that make you feel, Jane, when your mom said that to you?

Jane I felt really, really sad.

Therapist Do you think your mom knows how much that hurt your feelings?

Jane *No. She was so mad that she had to drive me to school and that I made her late to work.*

Therapist Let's do a "communication analysis" - a play-by-play - of exactly what happened. You were running late getting out of bed and getting ready for school, why don't we start there.

Jane I hit snooze on my alarm—I have trouble getting up in the morning—and next thing I know I was going to miss the bus. I asked my mom if she could drive me to school.

Therapist What did you say exactly? Let's act it out so we can really get a picture of what happened.

Jane Mom, you need to drive me. I missed the bus [complaining, demanding tone]. And my mom said, “Jane, this is ridiculous. I’m going to be late for work.” But she drove me anyways.

Therapist What was your mood like in the car? Your mom’s mood? What was said next?

Jane Well, I was pretty grumpy. I’m not the nicest person in the morning. My mom was like, “You could at least be pleasant if I have to drive you to school.” And then I said, “It’s not my fault—I hate the morning!” I was pretty much pouting. I also didn’t have any time to get ready so I looked and felt awful. When my mom went to drop me off and I got out of the car that’s when she said I was a bad person.

Therapist I can understand how that would be a very hurtful comment. Do you think she meant that you were acting in a bad way—not really that you were a bad person?

Jane Yeah, probably.

Therapist How do you think she would respond if you were to tell her how much that hurt your feelings?

Jane I don’t know.

In the remainder of this session with Jane, the therapists—utilizing input from the other group members—worked to help Jane appreciate her own contribution to the negative interpersonal exchange and to see the value in having a follow up conversation with her mom about this event. Since Jane’s conflicts with her mother frequently involved one or both of them saying hurtful things in the heat of the moment, with no follow-up, the therapists encouraged Jane to share her feelings with her mother in a way in which her mother was likely to be receptive. Using communication skills such as putting herself in the other person’s shoes (e.g., *I’m sorry, mom, about the other morning. I should have gotten up when my alarm went off, and I know you must have been feeling really stressed about getting to work.*), the group helped Jane to generate a script for talking to her mom, and the therapists asked Jane to try it out as “work at home.” Jane was anxious about talking to her mother and put off the conversation for several weeks. The individual midgroup meeting provided an opportunity for the therapists to encourage her to try this conversation with her mother.

In the final session of the middle phase, Jane reported that she had spoken to her mother. They had a very positive conversation in which Jane told her mother that the specific comment her mother had made that morning really hurt her feelings. Her mother responded positively, telling Jane that she didn’t really mean what she had said and that she wanted to work with Jane on fighting less often. Her mother didn’t enjoy their fights and felt badly when things were said that neither of them really meant. Jane felt anxious before the interaction, but she felt very positive after the conversation. In contrast to times of conflict with her mother, Jane had no episodes of LOC eating after the exchange. The therapists praised Jane for the excellent work she had done in trying out a new way of communicating,

and pointed out to Jane and the other group members that by communicating with her mother more positively, she felt better and more in control over her eating.

Jane's second goal was to spend more time with friends outside of school and to develop new friendships. The group setting was an excellent environment for Jane to practice more effective ways not only of seeking support from others but also in providing support to others her age—important interpersonal skills for developing the more intimate friendships that characterize adolescence. Jane's interpersonal skills within the group context became increasingly effective during the middle phase of group. For example, the therapists were able to redirect Jane to provide supportive feedback to others, drawing on how she could connect from her own experiences, as opposed to turning the conversation exclusively to focus on herself.

Another group member, "Alexis": ... *so, I really want to visit my dad's house this weekend, but I also want to spend time with my friends. Stephanie invited me to spend the night at her house and we really want to go see that new Robert Pattinson movie together. My dad doesn't understand. He's going to get really, really mad if I tell him that I don't want to come over ...*

Jane [Interrupting ...] *I want to see that movie! I liked the last one that he was in. Aaah ... he is so cute.*

Therapist Jane, you've also had some difficulties talking to your parents about wanting to do things with a friend, rather than staying at home with the family. Putting yourself in Alexis's shoes, how do you imagine that she is feeling?

Jane Stressed. You really want to go to the movie, but you're also worried that you're going to let your dad down.

Alexis Exactly. I am really stressed.

Throughout the middle phase, Jane became better at commenting on others' experiences in the group in a way that offered emotional support and fostered connecting with girls her age. The therapists pointed this out to the group: *Part of becoming a teenager involves becoming closer to your friends. As a group you all have really become closer in here with each other and done a great job at sharing personal things with each other, as well as supporting each other. These are important skills that you can apply outside of the group to form closer friendships.*

Regarding her second goal, the therapists and the group encouraged Jane both to make specific plans with her friends from elementary school who she rarely saw, and also to work on becoming closer to friends at her new middle school. In Group Jane role-played reaching out to a newer friend to make plans outside of school. Jane reported success at both "assignments." She went to the pool with one of her longtime friends, and she went to see a movie with a newer friend.

Termination phase of group intervention (Sessions 10–12).—The termination phase reinforces middle phase progress and prepares girls to continue work on their goals after the program ends.⁴ Jane self-reported her progress in her post-termination individual appointment as follows:

Therapist How have the changes you’ve made in your relationships affected your eating?

Jane I think I eat more normally.

Therapist What do you mean?

Jane Well, since I’ve been feeling better—you know, less depressed, and also less mad—I don’t eat because I feel those ways.

Response to termination can be variable, with some youth looking forward to having the weekly time back and other groups feeling sad or anxious about losing the support of the group. Therapists acknowledge all types of reactions and emphasize that no one in particular is right or wrong. With regard to the latter reaction, girls are reminded that they have done the work and now own the skills to handle interpersonal stressors in the future.

Termination and Follow-up Assessments

Immediately following the 12-week group program, Jane reported a similar frequency of LOC eating episodes—approximately 2 per month over the past 3 months—relative to her baseline assessment. Yet, she no longer endorsed associated distress about these episodes. By 6 months after the intervention, her LOC episodes had decreased to only 1 in the previous 3 months. This low frequency of LOC eating and absence of associated distress about such eating episodes persisted at the 1-year and 3-year follow-up assessments. Jane reported she no longer felt distressed about her eating and no longer ate in response to depressive symptoms or stress. In contrast to her elevated depressive symptoms at intake, she reported no depressive symptoms at subsequent assessments through 3-year follow-up (BDI total score of 3 or 4, indicative of no depression, at each follow-up).

After the intervention, Jane’s body weight gain trajectory was less than expected. She started with a BMI at the 97th percentile for her age. When her weight gain stabilized, she dropped to the 94th percentile, and remained at the 94th percentile through the 3-year follow-up. Although Jane remained overweight, she was no longer in the obese category and the intervention achieved the intended goal of preventing excessive weight gain, as adolescents at the 97th percentile will typically increase in BMI percentile over time. Also, quite notably, with this weight stabilization, Jane’s body image improved dramatically. As described earlier, she started with high concerns about body shape and weight. Following the intervention and through 3 years follow-up, she no longer reported body dissatisfaction: *I feel pretty good about myself. I’m happy with how I look.*

⁴Jane’s significant progress on other goals—with her father, and with a boy who was teasing her at school—are described in detail in Tanofsky-Kraff et al., 2015, as are more detailed descriptions of the therapists’ efforts to underscore the relationship between relationships, mood, and eating.

Conclusion

The case of Jane illustrates a successful example of IPT-WG for the prevention of excessive weight gain and for the prevention of BED. Prior to the intervention, Jane's characteristics put her at high risk for continuing to gain excessive weight with growth and for developing BED. She was obese, she reported frequent LOC eating episodes, she experienced elevated depressive symptoms, and showed binge eating (Spoor et al., 2006). Jane also described interpersonal patterns that often characterize obese adults with BED. She had high levels of conflict with a parent, which frequently triggered depressed mood states, and in turn, LOC eating episodes. She also socially isolated and had some difficulties maintaining and developing friendships. It is easy to imagine a scenario in which these symptoms persisted, LOC episodes increased in their frequency, and Jane continued to gain excess weight as she entered adolescence. In such a scenario, body dissatisfaction would increase, and Jane would be at-risk for developing exacerbated problems with her mood and depressive symptoms. From the framework of an interpersonal theoretical account of LOC eating, interpersonal problems, negative emotions, LOC eating, and the accompanying shame and low self-worth that accompany it would create a very problematic cycle. We believe that intervening with teenagers such as Jane provides an optimal window for prevention of excessive weight gain and BED. Preliminary evidence supports the efficacy of IPT-WG to decrease LOC episodes and prevent excessive weight gain (Tanofsky-Kraff et al., 2010), and reduce binge eating and BED (Tanofsky-Kraff et al., 2014).

References

- Beck AT, Steer RE, & Brown GK (1996). Manual for the Beck Depression Inventory-II. San Antonio, TX: Psychological Corporation.
- Fairburn CG, & Cooper Z (Eds). (1993). The eating disorder examination Binge eating, nature, assessment and treatment (12th ed, pp. 317–360). New York, NY: Guilford Press.
- Fallon EM, Tanofsky-Kraff M, Norman AC, McDuffie JR, Taylor ED, Cohen ML, ... Yanovski JA (2005). Health-related quality of life in overweight and nonoverweight black and white adolescents. *The Journal of Pediatrics*, 147, 443–450. 10.1016/j.jpeds.2005.05.039 [PubMed: 16227028]
- Freeman LMY, & Gil KM (2004). Daily stress, coping, and dietary restraint in binge eating. *International Journal of Eating Disorders*, 36, 204–212. 10.1002/eat.20012 [PubMed: 15282690]
- Haedt-Matt AA, & Keel PK (2011). Revisiting the affect regulation model of binge eating: A meta-analysis of studies using ecological momentary assessment. *Psychological Bulletin*, 137, 660–681. 10.1037/a0023660 [PubMed: 21574678]
- Hayden-Wade HA, Stein RI, Ghaderi A, Saelens BE, Zabinski MF, & Wilfley DE (2005). Prevalence, characteristics, and correlates of teasing experiences among overweight children vs. nonoverweight peers. *Obesity Research*, 13, 1381–1392. 10.1038/oby.2005.167 [PubMed: 16129720]
- Kaufman J, Birmaher B, Brent D, Rao U, Flynn C, Moreci P, ... Ryan N (1997). Schedule for affective disorders and schizophrenia for school-age children-present and lifetime version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 980–988. 10.1097/00004583-199707000-00021 [PubMed: 9204677]
- Klerman GL, Weissman MM, Rounsaville BJ, & Chevron ES (1984). Interpersonal psychotherapy of depression. New York, NY: Basic Books.
- Pearce MJ, Boergers J, & Prinstein MJ (2002). Adolescent obesity, overt and relational peer victimization, and romantic relationships. *Obesity Research*, 10, 386–393. 10.1038/oby.2002.53 [PubMed: 12006638]
- Rieger E, Van Buren DJ, Bishop M, Tanofsky-Kraff M, Welch R, & Wilfley DE (2010). An eating disorder-specific model of interpersonal psychotherapy (IPT-ED): Causal pathways and treatment

implications. *Clinical Psychology Review*, 30, 400–410. 10.1016/j.cpr.2010.02.001 [PubMed: 20227151]

Schwimmer JB, Burwinkle TM, & Varni JW (2003). Health-related quality of life of severely obese children and adolescents. *JAMA: Journal of the American Medical Association*, 289, 1813–1819. 10.1001/jama.289.14.1813 [PubMed: 12684360]

Spoor ST, Stice E, Bekker MH, Van Strien T, Croon MA, & Van Heck GL (2006). Relations between dietary restraint, depressive symptoms, and binge eating: A longitudinal study. *International Journal of Eating Disorders*, 39, 700–707. 10.1002/eat.20283 [PubMed: 16941629]

Strauss RS, & Pollack HA (2003). Social marginalization of overweight children. *Archives of Pediatrics and Adolescent Medicine*, 157, 746–752. 10.1001/archpedi.157.8.746 [PubMed: 12912779]

Striegel-Moore RH, Silberstein LR, & Rodin J (1986). Toward an understanding of risk factors for bulimia. *American Psychologist*, 41, 246–263. 10.1037/0003-066X.41.3.246 [PubMed: 3457546]

Tanofsky-Kraff M (2008). Binge eating among children and adolescents In Jelalian E & Steele R (Eds.), *Handbook of child and adolescent obesity* (pp. 41–57). New York, NY: Springer.

Tanofsky-Kraff M, Cohen ML, Yanovski SZ, Cox C, Theim KR, Keil M, ... Yanovski JA (2006). A prospective study of psychological predictors of body fat gain among children at high risk for adult obesity. *Pediatrics*, 117, 1203–1209. 10.1542/peds.2005-1329 [PubMed: 16585316]

Tanofsky-Kraff M, Shomaker LB, Olsen C, Roza CA, Wolkoff LE, Columbo KM, ... Yanovski JA (2011). A prospective study of pediatric loss of control eating and psychological outcomes. *Journal of Abnormal Psychology*, 120, 108–118. 10.1037/a0021406 [PubMed: 21114355]

Tanofsky-Kraff M, Shomaker LB, Stern EA, Miller R, Sebring N, Dellavalle D, ... Yanovski JA (2012). Children's binge eating and development of metabolic syndrome. *International Journal of Obesity*, 36, 956–962. 10.1038/ijo.2011.259 [PubMed: 22234282]

Tanofsky-Kraff M, Shomaker LB, Wilfley DE, Young JF, Sbrocco T, Stephens M, ... Yanovski JA (2014). Targeted prevention of excess weight gain and eating disorders in high-risk adolescent girls: A randomized, controlled trial. *American Journal of Clinical Nutrition*, 100, 1010–1018. [PubMed: 25240070]

Tanofsky-Kraff M, Shomaker LB, Young JF, & Wilfley DE (2015). Interpersonal psychotherapy for the prevention of excess weight gain and eating disorders In Thompson-Brenner H (Ed.), *Casebook of evidence-based therapy for eating disorders* (pp. 195–219). New York, NY: Guilford Press.

Tanofsky-Kraff M, Wilfley DE, Young JF, Mufson L, Yanovski SZ, Glasofer DR, & Salaita CG (2007). Preventing excessive weight gain in adolescents: Interpersonal psychotherapy for binge eating. *Obesity*, 15, 1345–1355. 10.1038/oby.2007.162 [PubMed: 17557971]

Tanofsky-Kraff M, Wilfley DE, Young JF, Mufson L, Yanovski SZ, Glasofer DR, ... Schvey NA (2010). A pilot study of interpersonal psychotherapy for preventing excess weight gain in adolescent girls at-risk for obesity. *International Journal of Eating Disorders*, 43, 701–706. 10.1002/eat.20773 [PubMed: 19882739]

Tanofsky-Kraff M, Yanovski SZ, Schvey NA, Olsen CH, Gustafson J, & Yanovski JA (2009). A prospective study of loss of control eating for body weight gain in children at high risk for adult obesity. *International Journal of Eating Disorders*, 42, 26–30. 10.1002/eat.20580 [PubMed: 18720473]

Thompson-Brenner H (Ed.). (2015). *Casebook of evidence-based therapy for eating disorders*. New York, NY: Guilford Press.

Weissman MM, Markowitz J, & Klerman GL (2000). *Comprehensive guide to interpersonal psychotherapy*. New York, NY: Basic Behavioral Science Books.

Wilfley DE, Agras WS, Telch CF, Rossiter EM, Schneider JA, Cole AG, ... Raeburn SD (1993). Group cognitive-behavioral therapy and group interpersonal psychotherapy for the nonpurging bulimic individual: A controlled comparison. *Journal of Consulting and Clinical Psychology*, 61, 296–305. 10.1037/0022-006X.61.2.296 [PubMed: 8473584]

Wilfley DE, Frank MA, Welch RR, Spurrell EB, & Rounsaville BJ (1998). Adapting interpersonal psychotherapy to a group format (IPT-G) for binge eating disorder: Toward a model for adapting

empirically supported treatments. *Psychotherapy Research*, 8, 379–391.
10.1080/10503309812331332477

Wilfley DE, MacKenzie KR, Welch RR, Ayres VE, & Weissman MM (2000). *Interpersonal psychotherapy for group*. New York, NY: Basic Books.

Wilfley DE, Wilson GT, & Agras WS (2003). The clinical significance of binge eating disorder. *International Journal of Eating Disorders*, 34, S96–S106. 10.1002/eat.10209 [PubMed: 12900990]

Wilson GT, Wilfley DE, Agras WS, Bryson SW (2010). Psychological treatments of binge eating disorder. *Archives of General Psychiatry*, 67, 94–101. [PubMed: 20048227]

Young JF, & Mufson L (2003). *Manual for Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST)*. Unpublished manual.