Interpersonal Psychotherapy for Binge Eating Disorder (BED)

Therapist’s Manual

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**Interpersonal Psychotherapy for Binge Eating Disorder (BED)**

In its goals, strategies and structure, IPT for BED closely resembles IPT for depression (Weissman et al., 2000). The IPT protocol for BED described here is an individual adaptation of Interpersonal Psychotherapy for Group (IPT-G) for BED as described by Wilfley and colleagues (1993; 1998; 2000). 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 PIs of this proposal have received Dr. Fairburn's permission to use portions of his treatment manual in the current treatment protocol. All therapists trained in this approach will necessarily have studied 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).

**Treatment Protocol**

IPT is a noninterpretive, 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. IPT assumes that the development of binge eating occurs in a social and interpersonal context and that the onset, response to treatment, and outcomes are influenced by the interpersonal relations between the patient and significant others. IPT moves through three defined phases, each of which is associated with specific strategies and tasks for the therapist and patient (Weissman et al., 2000). 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 advocates for the patient rather than remaining neutral.

In the study proposed here IPT will comprise 20 sessions, which last 50 minutes each, implemented over the course of 6 months. The first four sessions are carried out over a two-week period, followed by 12 sessions at weekly intervals. Sessions 17 and 18 will be bi-weekly and sessions 19 and 20 will occur every third week.

**The Initial Phase**

The Initial Phase of IPT usually occupies the first three to four sessions. The goals of the Initial Phase are outlined below:

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

It is explained that to help people break out of a self-perpetuating problem such as BED, it is necessary to find out what is keeping it going and then address the maintaining factors in treatment. It is explained that interpersonal difficulties are common in BED although many patients have limited awareness of them because of the distracting influence of their preoccupation with thoughts about eating, shape, and weight. The interpersonal difficulties play an important role in maintaining the eating disorder 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:

“Men and women with binge eating disorder often describe themselves as ‘stress eaters’. Indeed, according to reports by persons with binge eating disorder, negative feelings are the most frequent trigger for binge eating. 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 BED 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 IPT there is less emphasis on the patient's eating problem as such, except during the interpersonal inventory. Instead, the focus is on the patient's interpersonal difficulties. This is because focusing solely on the eating disorder would tend to distract the patient and therapist from dealing with the interpersonal difficulties that perpetuate the binge eating.

Patients are also told that IPT has three distinct phases, which are quite different in character (see Table 1). In the first, which occupies the first three or four sessions, the goal is to help the patient identify those interpersonal difficulties that are involved in the onset and/or maintenance of their binge eating 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 will be to help you make connections between your binge eating and the way in which you have coped or managed with difficult interpersonal situations. This initial phase will end with our agreeing upon the problem or problems and establishing some goals that will be the focus of treatment. Thereafter, our sessions will change in style. The
second phase, sessions five through sixteen, will be the time when you are going to be actively working on your interpersonal goals. During that phase, you’re going to notice changes in your binge eating, in your outside social life, and how you’re relating with 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 and ways of changing them. Your role will be not only to explore these difficulties in our treatment sessions but you must also experiment with ways of changing. Doing so will shed further light on the nature of your problems, and it may lead to change. In the final phase of treatment, sessions seventeen through twenty, 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 here to stress the time-limited nature of the treatment. IPT has a fixed number of sessions (20 in the proposed study), and these are held at weekly intervals until near the end of treatment, when they are held every 2 weeks (and then every 3 weeks). Therefore, even at the outset, it is possible to give the patient a good idea of when treatment is likely to end. The fact that the treatment has a fixed number of sessions helps the therapist stress the importance of working hard at treatment:

"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 also need to be explained (e.g., that sessions will always end on time, and that it is the responsibility of both the therapist and patient to ensure that they start promptly).

2. **Identify Current Interpersonal Problems**

Three sources of information are used to identify current interpersonal problems.

a. 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 patient see the relevance of this form of treatment.

Four separate histories are taken. The first is a history of the eating problem and how it has evolved. Key events and dates are recorded - for example, the ages at which the patient first began to diet and binge. The timing of major changes in weight is noted, as is prior experience of treatment. The second history is of the patient's interpersonal functioning prior to and since the development of the eating problem. Relationships with family and peers are especially relevant here. The third history is of significant life events, many of which will already have been identified. The fourth history is of
problems with self-esteem and depression. The history taking should culminate in the creation of a "life chart" in which separate columns are allocated to each domain. A typical life chart is shown in Table 2.

The patient should be encouraged to play an active role in the history-taking and the creation of the life chart. The whole process usually takes two to three 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 marital 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.

b. An assessment is made of the quality of the patient's current interpersonal functioning. This involves asking about the patient's social network. Inquiries should be made about family members, the patient's spouse or partner, confidants, work contacts, and friends and acquaintances. The topics to be addressed include frequency of contact, positive and negative aspects of each relationship, mutual expectations, intimacy, and reciprocity.

c. The precipitants of binge episodes are identified. In each of the assessment sessions, the therapist asks whether there have been any binges, and, if so, inquires about the circumstances preceding them. Since it is common for binge eating episodes to be precipitated by interpersonal events, they serve as "markers" of current interpersonal problems. Symptom relief starts with helping the patient understand that the binge eating symptoms are a part of a known syndrome, which responds to several treatments and has good prognosis.

3. Establish the relevant problem area(s)

By the third or fourth session, the nature of the patient'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 soluble 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 most soluble problem first also has the advantage that progress on one front often leads to progress on others. Not only are the patient'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.

4. Collaboratively develop interpersonal target goals

After the major interpersonal problem area(s) associated with the onset and/or maintenance of
BED is identified, the therapist makes a specific treatment plan with the patient 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 patient as possible. Following identification of a goal, the therapist will want to match concrete ideas for change, collaboratively identifying the specific steps the patient will take to improve relationships and socialization. Prior to the end of the Initial Phase, each patient will 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 patient with BED can be found in Table 4.

Toward the end of the Initial Phase, the therapist reminds the patient 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 identified and consider them in depth and from all possible angles. In this way, you will come to a better understanding of them. A key part of this process is thinking 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 principle 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 Intermediate Phase (sessions 5-16) of treatment begins after the patient and therapist have clearly defined the patient’s problem area(s) and established their treatment goals in sessions 1-4. 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 patient achieve their goals. The strategies can be introduced in the context of the ongoing therapy discussions as appropriate, but they should be specifically addressed. The goals of the Intermediate Phase are outlined below:

1. Implement the IPT strategies as outlined by Weissman et al., 2000
2. Facilitate the patient’s work on their identified goals
3. Assist patient in recognizing connections between binge eating symptoms and interpersonal events during the week
4. Work with the patient 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

In structuring the Intermediate Phase the IPT therapist takes a moderate position between the extremes of being highly active and merely reactive to the patient's concerns. In keeping with the goals of IPT, the therapist is somewhat active in helping the patient focus on bringing about improvement in current interpersonal problem areas. The therapist actively guides the patient to cover material that is relevant to the treatment goals. If the patient 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 patient’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 provide a more directed focus for the patient and focuses the patient on recent interpersonal events and binge eating symptoms, which the therapist attempts to link.

The patient is encouraged to explore the problem areas and to consider ways of changing; the attempts to change then become the focus of subsequent sessions. The therapist helps the patient remain focused by ensuring that the subject matter is relevant and by providing clarification when needed. For example, one patient described helping her father adapt his house. This was relevant, since their relationship was one of the agreed-upon problem areas. However, she then went on to discuss the nature of the adaptation; the therapist had to intervene at this point, since the interpersonal focus had been lost. Clarification takes the form of pointing out themes and inconsistencies, highlighting points that the patient might miss. For example, another patient had three problem areas that appeared quite distinct. The therapist made an important clarifying intervention by pointing out that a factor contributing to each problem was the patient's desire to avoid conflict at all cost. Clarification does not extend to malting "interpretations," in which reference is made to a theoretical view on the disorder and its treatment. Throughout, the focus remains on the present.

The therapist should ensure that the patient remains aware of the task at hand. At the end of each session, the therapist should summarizes what has been covered. In addition, at intervals during the Intermediate Phase, the therapist reviews progress by considering each of the problem areas and assessing what has been achieved and what remains to be done.

1. Implement the IPT strategies

During the Intermediate Phase of treatment, the therapist implements treatment strategies that are
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 patients 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 patient’s social isolation by helping enhance the quality of existing relationships and encouraging the formation of new relationships. To help these patients, 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 patient-therapist relationship, since this may be such a patient's only close relationship and it is present to be observed.

b. **Interpersonal Role Disputes.** Interpersonal role disputes were present in 29.6% of the patients in the Wilfley et al. (2000) trial. Such 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. The therapist assists the patient to identify the nature of the dispute and generate options to resolve it. If resolution is impossible, the therapist assists the patient in dissolving the relationship and in mourning its loss. Since the standard form of IPT 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 patient'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 was present in 6.2% of the patients in the Wilfley et al. (2000) trial. As mentioned earlier, they can often be resolved comparatively quickly, and it is therefore worth addressing them first. Grief is identified as the problem area when the onset of the patient’s symptoms are associated with the death of a loved one, either recent or past. The goals for treating complicated bereavement include facilitating mourning and helping the patient to find new activities and relationships to substitute for the loss. Facing the loss requires them to think in detail about the events surrounding the loss and express their feelings about it. Patients need to be educated about the grief 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 to counter the idealization that so commonly occurs. As patients become less focused on the past, they should be helped to think 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, often this problem area is a secondary one. The patient is helped to deal with the change by recognizing positive and negative aspects of the new role they are assuming, and pros and cons of the old role this replaces. Problems with role transitions are not confined to the difficulties of early adulthood. They include problems coping with other life changes, such as retiring, becoming a parent’s caregiver.

2. **Facilitate the patient’s work on their identified goals**

In IPT for BED, patient goals are used to directly address the identified problem area(s) which are linked to the ongoing problems with binge eating. In the Intermediate Phase, the therapist will need to maintain a focus with the patient each week on how they are applying their goals between sessions. As these goals are addressed, the therapist and patient 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 patient 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 your work is coming on 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 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 too.

3. **Assist patients in recognizing connections between binge eating symptoms and interpersonal events during the week**

A critical component in the Intermediate Phase is to facilitate and help strengthen the patients’ connections between their problems with binge eating and the difficulties they have in their interpersonal lives. As the patients’ continue making these connections and developing strategies to alter the interpersonal context in which the binge eating occurs, the patient will
disrupt the binge eating cycle. In the following vignette, the therapist facilitates a patient with Interpersonal Role Disputes to talk about the connections he has made between his binge eating and the difficulties he has with his boss:

**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 boss. 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 it. Because that’s what I do, I eat it, 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 boss?

4. Work with the patient to identify and manage negative and/or painful affects associated with their interpersonal problem area

**Encouragement of Affect.** Encouragement of affect involves a number of therapeutic techniques, which are intended to help the patient express, understand, and manage affect. Depending on the nature of the affect and the patient, the IPT therapist may use two general strategies to help the patient: (1) acknowledge and accept painful affects and (2) use her affective experience to bring about desired interpersonal changes.

a. **Encourage acceptance of painful affects.** Individuals with BED often use food to cope with negative affect. Therapy 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 IPT therapist to validate and help the patient accept them.

b. **Teach the patient how to use affect in interpersonal relationships.** While the expression of strong feelings in the session is seen as an important starting point for much therapeutic work, the expression of feelings outside the session is not a goal in and of itself. The goal is to help the patient act more constructively (e.g. not binge eating) in interpersonal relationships, and this may involve either expressing or suppressing affects, depending on the circumstances. A goal for the patient in IPT 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 patients 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 he was feeling hurt because her father had not acknowledged her son's first birthday. She spent some time clarifying and expressing her feelings of anger and rejection with regard to her own 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.

c. **Help the patient experience suppressed affects.** Many who struggle with BED are emotionally constricted in situations where strong emotions are normally felt. An example may be the patient who is unassertive and does not feel anger when their rights are violated. On the other hand, they may feel anger but may lack the courage to express it in an assertive manner. Sometimes patients will deny being upset, when it is clear that an upsetting interaction has just occurred. The therapists 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 husband." In this way, the therapist will attempt to draw out affect when it is suppressed.

Some additional therapist techniques:

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 husband", would be followed by progressively more specific questioning.

b. **Clarification.** The short term goal of this technique is to make the patient more aware of what she/he has actually communicated. Some examples of clarification techniques:

1) asking a patient to repeat or rephrase what has been said. This is particularly useful if the patient has said something in an unusual way or contradicted previous statements.

2) calling attention to contradictions in the presentation of material. Contradictions may be noted between the patient’s affect expression and her/his verbal discussion. Discrepancies can also be noted when the same material is discussed in a manner that contradicts earlier material that was presented. 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 patient learn to communicate more effectively. The therapists asks a patient to recall (in great detail) a recent interaction or argument they had with a significant other. Difficulties in communication can be identified and the IPT therapists can assist the patient in finding more effective communication strategies.

d. **Use of therapeutic relationship.** In this technique the patient’s thoughts, feelings, expectations, and behavior in the therapeutic relationship are examined insofar as they represent a model of the patient'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 people. This technique is especially helpful for patients with BED since treatment is often focused on interpersonal deficits (the patient develops a relationship with the therapist as a model for other relationships) and interpersonal role disputes (the patient receives feedback on how she comes across and thereby, has the opportunity to understand the nature of her difficulties in relating with others).

5. **Redirect issues about eating, weight, or shape to the interpersonal context**

During this phase, patients may bring up content-related topics about their binge episodes, 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. To follow the patient into these ‘content’ areas detracts from the session focus and ultimately away from the work on their problem area(s). The following is an example of how a therapist can gently, but firmly, help a patient get back on track to the work on his goals. In doing so, the therapist is able to engage the patient in a more meaningful discussion about his relationship with his wife.

**Therapist:** What did you want to work on today Robert?

**Robert:** Well, last week I spent a lot of hours at work, 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 work, I went in and started cooking, 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 work stressors with your wife, you’ll turn to food.

**Robert:** Boy, did I unwind, right on the refrigerator, 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 wife? 

**Robert:** Good, really good, my wife and I are actually talking quite a bit more. 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 wife, 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 wife.

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

6. Mark the End of the Intermediate Phase

Primary goals for the therapist during this phase are to identify, challenge, and encourage patients to alter maladaptive interpersonal relationships in their outside social lives. By the end of this phase, patients are acutely aware that treatment will soon be ending. This knowledge may bring up much anxiety. The therapist may formally bring this phase to an end by saying something like the following:

“Our session today marks the end of the intermediate phase of treatment. 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 the feelings you have about the end of this stage. We still have time to work on your goals, so we can spend some time today talking about what is left to do”.

The Termination Phase

In the Termination Phase (sessions 17-20), the therapist assists the patient 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. Patients 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 patient about the end of treatment as a time for grieving; encourage patient to identify associated affects
3. Encourage the patient 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

1. Discuss Termination Explicitly

The therapist systematically raises the issue of reactions to impending termination in each of the last several sessions. 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 patients 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 patient's probable competence at dealing with future areas of difficulty. The termination phase can be introduced in the following manner:

“The next four sessions mark the last phase of IPT. 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 therapy has 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 prepare to wrap things up. It is important that you talk about these feelings. What have you been thinking about or feeling in terms of treatment ending?”

2. **Discuss termination as a potential time of grief**

Patient reactions to the conclusion of treatments are often varied. As therapy nears completion, and sometimes well before that, patients 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 patients with issues of abandonment or feelings of isolation will have voiced fears about the treatments’s 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 patient to recognize progress in each session, many patients 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.

3. **Review progress**

An important aspect of the Termination Phase is encouraging patients 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 three more sessions 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 BED to attribute changes in treatment to the therapist rather than their own hard work. Misplaced credit may erode the patient’s confidence in the ability for continued success and improvement without treatment. Therefore the therapists needs to emphasize how the patient has begun to successfully manage their outside relationships and their affect. The basic message is the importance of the patients assuming responsibility for monitoring their own lives, their
relationships, and their involvement in social activities.

4. **Encourage maintenance of therapeutic gains**

In this Termination Phase, the patient is encouraged to identify areas that will need further attention. There are always goals that are not accomplished within the time frame of IPT. 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 patient will receive the message that continued change and progress will require effort similar to work they have already been doing. Predicting that setbacks will occur helps patients to be realistic about change. It also underlines that continuing benefits 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.

Patients should also be encouraged to view their eating disorder symptoms as a vulnerability or an “Achilles heel”, in the sense that it may recur at future times of difficulty. We encourage patients to view any deterioration as a useful "early warning signal." It is a sign that they need to review what is happening in their lives and perhaps take some action. Guiding the patient in a discussion of contingencies for handling future problems will bolster feelings of competence. It is vital to assist patients 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.

5. **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 patient 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 patient over the previous 19 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 risk 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 1: Phases of IPT

<table>
<thead>
<tr>
<th>Phase</th>
<th>Initial Phase: Sessions 1-4</th>
<th>Intermediate Phase: Sessions 5-16</th>
<th>Termination Phase: Session 17-20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Give the syndrome a name; provide information about prevalence and characteristics of the disorder</td>
<td>• Implement strategies specific to the identified problem area(s)</td>
<td>• Discuss termination explicitly</td>
</tr>
<tr>
<td></td>
<td>• Describe the rationale and nature of IPT</td>
<td>• Encourage and review work on goals specific to the problem area</td>
<td>• Educate patient about the end of treatment as a potential time for grieving; encourage patient to identify associated emotions</td>
</tr>
<tr>
<td></td>
<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>
<td>• Illuminate connections between symptoms and interpersonal events during the week</td>
<td>• Review progress to foster feelings of accomplishment and competence</td>
</tr>
<tr>
<td></td>
<td>o Review significant relationships, past and present</td>
<td>• Work with the patient to identify and manage negative and/or painful affects associated with their interpersonal problem area</td>
<td>• Outline goals for remaining work; identify areas and warning signs of anticipated future difficulty</td>
</tr>
<tr>
<td></td>
<td>o Identify interpersonal precipitants of episodes of binge eating, extreme dietary restraint, etc.</td>
<td>• Relate issues about eating, weight, or shape to the interpersonal problem area</td>
<td>• Formulate specific plans for continued work after termination of treatment</td>
</tr>
<tr>
<td></td>
<td>• Select and reach consensus about the IPT problem area(s) and treatment plan with patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 2: Example of a Personal Historical Timeline Table 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>Perceives parents as being extremely disappointed in sister</td>
</tr>
<tr>
<td>16</td>
<td>Less concern about weight because “boy friend's ex-wife was a lot heavier than me” but began binge eating</td>
<td>Meets boy friend, 23, who works at a gas station</td>
<td>Does not tell parents about boy friend given father’s high profile job and position in the community</td>
<td>Fearful of parents’ disappointment; worries about their finding out</td>
</tr>
<tr>
<td>18</td>
<td>Binge eating when alone</td>
<td>Becomes engaged</td>
<td>Graduates from high school; goes to technical school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loses weight</td>
<td>Tells sisters, not parents</td>
<td>Abortion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paul breaks off the engagement</td>
<td>Boy friend “steals” back the ring (seen on his new girlfriend); throws herself into work as a secretary; is promoted repeatedly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More comfortable about weight (“boy friend's wife was a lot heavier than me”); Binge eating when alone (“food was my only friend when he was away”); never ate when with him.</td>
<td>Meets new boy friend, who works as a salesman; he says he is separated from his wife who is pregnant</td>
<td>Boy friend's wife pickets her parents’ house; parents do not make mention of this</td>
<td>Does not feel guilty about the relationship</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lies to family and friends, telling them that they got married</td>
<td>Moves to Minnesota with boy friend</td>
<td>Secrecy (wanting to be “perfect &amp; not disappoint my parents”); homesick</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spouse of coworker tells her he is cheating on her</td>
<td>Throws boy friend out of the house; on his way out he takes her ring from her jewelry box</td>
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</tr>
<tr>
<td>27</td>
<td>Binge eating as an outlet</td>
<td>Gets pregnant, marries the father, an alcoholic, who is “cruel and verbally abusive”</td>
<td>Lies to mother that she got pregnant after the wedding; birth of first child</td>
<td>Compliant, scared</td>
</tr>
<tr>
<td>28</td>
<td></td>
<td>Bob occasionally shoves her</td>
<td>“I channeled my energy into my son”</td>
<td>Hateful</td>
</tr>
<tr>
<td>32</td>
<td>“Eating a lot”</td>
<td>Husband hits her; she stands up to husband only once, to ask him to choose between her and alcohol</td>
<td>Does not tell anyone (“Nobody had a clue that we didn’t have a wonderful marriage”)</td>
<td>Scared</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bob no longer drinks but continues being verbally abusive</td>
<td>Continuing Den Mother activities; very active in church</td>
<td>Emotionally distant (“I made it happy for me”)</td>
</tr>
<tr>
<td>39</td>
<td></td>
<td>Has sex with husband approximately 2 times a year</td>
<td>Husband invests $20,000 of their joint money in real estate - all money lost; patient begins saving “every penny,” sending $5,000 to her sister to open a savings account; became a workaholic</td>
<td>Fearful husband will hit her; obedient; proud at holding onto her feelings; derives esteem from keeping her trouble from her children and others</td>
</tr>
<tr>
<td>41</td>
<td>Eating as a way to “hold everything together”</td>
<td>Sexual relationship with husband ends; although she does not express anger, he yells at her, saying he can do whatever he wants with his money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td></td>
<td>260 lb., highest weight ever; blood pressure increasing with increasing weight</td>
<td>Marital therapy with clergy for 3 months</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td></td>
<td>Loses 60 lbs.</td>
<td>Patient files for divorce</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
<td>Regains 30 lbs.</td>
<td>Meets current boyfriend</td>
<td>Mother dies</td>
</tr>
<tr>
<td>51</td>
<td></td>
<td>Binge eating at night on objectively large amounts of food at least 3 times per week.</td>
<td>Moves in with current boyfriend</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td></td>
<td>Does not tell family members she is seeking psychological help</td>
<td>Works 14+ hour days, not pausing to eat or rest during the day</td>
<td>Feels satisfied with their relationship</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Table 3. Interpersonal Problem Areas: Description, Goals, and Strategies (Klerman et al., 1984; Weissman et al., 2000)

<table>
<thead>
<tr>
<th>Interpersonal Problem Area</th>
<th>Description</th>
<th>Goals</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grief</strong></td>
<td>Complicated bereavement following the death of a loved one</td>
<td>• Facilitate the mourning process</td>
<td>• Reconstruct the patient’s relationship with the deceased</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Help patient re-establish interest in new activities and relationships to substitute for what has been lost</td>
<td>• Explore associated feelings (negative and positive)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Help patient re-establish interest in new activities and relationships to substitute for what has been lost</td>
<td>• Consider ways of becoming re-involved with others</td>
</tr>
<tr>
<td><strong>Interpersonal deficits</strong></td>
<td>A history of social impoverishment, inadequate, or unsustaining interpersonal relationships</td>
<td>• Reduce patient’s social isolation</td>
<td>• Review past significant relationships including negative and positive aspects</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enhance quality of any existing relationships</td>
<td>• Explore repetitive patterns in relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Encourage the formation of new relationships</td>
<td>• Note problematic interpersonal patterns in the session and relate them to similar patterns in the patient’s life</td>
</tr>
<tr>
<td><strong>Interpersonal role disputes</strong></td>
<td>Conflicts with a significant other: a partner, other family member, coworker, or close friend</td>
<td>• Identify the nature of the dispute</td>
<td>• 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)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Explore options to resolve the dispute</td>
<td>• Understand how non-reciprocal role expectations relate to the dispute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Modify expectations and faulty communication to bring about a satisfactory resolution</td>
<td>• Identify available resources to bring about change in the relationship</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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</td>
<td>• Review positive and negative aspects of old and new roles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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)</td>
<td>• Explore feelings about what is lost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Understand how non-reciprocal role expectations relate to the dispute</td>
<td>• Encourage development of social support system and new skills called for in new role</td>
</tr>
<tr>
<td><strong>Role transitions</strong></td>
<td>Economic or family change: the beginning or end of a relationship or career, a move, promotion, retirement, graduation, diagnosis of a medical illness</td>
<td>• Mourn and accept the loss of the old role</td>
<td>• Review positive and negative aspects of old and new roles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognize the positive and negative aspects of the new role, and assets and liabilities of the old role</td>
<td>• Explore feelings about what is lost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Restore self-esteem by developing a sense of mastery regarding the demands of the new role</td>
<td>• Encourage development of social support system and new skills called for in new role</td>
</tr>
</tbody>
</table>
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.
An Illustrative Case History: Interpersonal Deficits

Barb, a 53-year-old cosmetologist, presented for treatment for binge eating disorder. At the time of the initial intake she was having three binge episodes a week during which she consumed an unambiguously large amount of food (typically 3-4 fast food sandwiches within a half-hour) and felt a loss of control. She reported being most likely to binge eat when feeling uneasy, and shared that her overeating caused her marked distress. Barb’s binge eating began at age 15 and had been followed by years of dieting and weight fluctuations. At 231 pounds, Barb was severely overweight and above the 95th percentile of weight for her age. An investigator-based assessment indicated that she had significant eating psychopathology which included an extreme fear of weight gain and great discomfort in allowing herself or others to see her body. Barb had no other Axis I psychopathology but met criteria for obsessive-compulsive personality disorder with a subthreshold diagnosis of self-defeating personality disorder. Barb had never been in therapy before.

The Initial Phase

Barb met with her therapist to begin the interpersonal inventory and identify her current interpersonal problems. During this initial meeting the therapist talked with Barb about her diagnosis and instructed her about how taking an interpersonal approach would lead to the amelioration of her binge eating. She was also educated about binge eating disorder and reassured that her eating disorder was driving her incremental weight gain and out-of-control eating rather than these being due to a lack of motivation on her part. After learning about her current symptoms by discussing a recent episode, Ms. K’s therapist skipped back to her very first time binge eating, using this as a frame through which to move forward chronologically in time. In doing so, together she and her therapist began to construct a ‘life chart’ of relationship difficulties that were involved in the onset and maintenance of her binge eating problems (see Table 2). Barb had a history of conflict avoidance and a fear of criticism. At the age of 15, she began a series of failed relationships which she had attempted to hide or glorify (by saying she was married when she wasn’t) in order to appear as the “perfect” daughter and to not disappoint her parents. Accordingly, she binged when she was alone and used food to “numb out” in order to manage the feelings that she kept private. Her attempts at secrecy and use of food to disconnect from her feelings continued throughout Barb’s subsequent marriage. Although her husband had been cruel and verbally abusive, Barb worked hard to “fool everyone for 18 years” into believing that she had a fulfilling relationship because she didn’t want anyone to think that she had failed in her marriage. Since her divorce, Barb had been in a live-in relationship but remained emotionally disconnected from her boyfriend. In the same way, she concealed her eating disorder from him, ate very little when they were together, and continued to binge eat when alone. At work, Barb shared that she put in 14-hour days because she felt uncomfortable “saying no” to her customers’ requests to see her before and after their business hours. Given the long periods of time she spent on her feet without breaks to eat or rest, Barb clearly disregarded
her needs to an extreme degree. Consequently, she found herself binge eating at night (such on her way home from work) to avoid the conflictual feelings she had about experiencing resentment and frustration regarding her workload. Together, Barb and her therapist examined the link between her binge eating and use of food as a primary coping strategy to manage her negative affect states and avoidance of conflict. Given her history of unfulfilling relationships and an inability to effectively manage her interpersonal relationships, the therapist identified interpersonal deficits as her primary problem area.

Toward the end of the third session, Barb and her therapist began to collaboratively identify treatment goals that would assist her in working on her interpersonal deficits. Three goals were identified that related to both her binge eating and her work resolving problems with interpersonal deficits. As her first goal, Barb was directed to become more aware of and to learn to identify her feelings when she began to binge eat or feel out-of-control with her eating. She was told that many people who struggle with binge eating have difficulty identifying and labeling their affective states. Learning to do this would provide her an extremely useful tool with which to begin to eliminate her binge episodes and, in a preliminary way, to help increase her connections with others. As another goal, Barb was encouraged to begin sharing her feelings with others (especially her boyfriend with whom she lived) rather than trying to avoid potential conflict. The therapist discussed with her that years of lying to important people in her life and self-deceit to maintain an image of perfection had led to her inability to communicate effectively or manage conflict. Given her history of failing to convey her feelings, wishes, and needs to others, beginning to share a full range of feelings with her boyfriend, son, and coworkers would be especially important for her work on her interpersonal problem area. As a final goal, Barb was instructed to find ways to nurture herself rather than spending all of her energy caring for others. Consistent with her problem area, Barb had established a pattern (common among binge eaters) of excessively caretaking for others in her relationships. Barb was encouraged to take better care of herself in order to break the vicious cycle of self-denial that she has established in her significant relationships. In addition, focusing on herself in relationships would also teach Barb about more effectively negotiating her interactions. Given the inextricable link between her problem area and binge eating, Barb’s therapists explained that the exclusive focus on these goals would lead to the elimination of her binge eating. Prior to the beginning of the Intermediate Phase, Barb began doing important work on her goal of taking care of herself and sharing more with her boyfriend. She also began thinking about ways that she might be able to reduce her workload. As a result, Barb shared with her therapist that she was feeling better about herself. Barb’s therapist marked with her the end of the Initial Phase, and indicated that the structure of the sessions would change (i.e., she would take on more responsibility to talk about her progress on her goals).

**The Intermediate Phase**

During the second phase of treatment, Barb continued sharing the work she had been doing on her goals in her outside life. Her therapist encouraged her to notice her style of glossing over
problems, and Barb continued to receive helpful feedback, both in and out of sessions, about minimizing her feelings. As Barb spoke about her unhappiness during her first marriage, she began to understand that maintaining the facade of a perfect life prevented her from turning to others for assistance. In fact, discounting her own feelings in general prevented her from experiencing her emotions or dealing with her feelings in more adaptive ways. As treatment progressed, Barb had several opportunities at work where she found herself in conflict with others. In session, the therapist used the IPT techniques of clarification, communication analysis, and encouragement of affect to assist Barb in finding ways of negotiating the conflict. After several attempts, Barb was finally able to experience that conflict could be worked through effectively. In addition, Barb began to share more with sisters, communicate more effectively with coworkers, and set limits with customers by refusing some of their requests. Toward the end of the Intermediate Phase, Barb was aware of the enormous energy she had spent trying to conceal her problems and was sharing more with her friends and family. As a result, she reported her relationships were more satisfying, and in fact she and her boyfriend had become engaged.

**The Termination Phase**

At the beginning of this Termination Phase, the therapist spoke with Barb about the subtle shift in treatment focus for the remaining sessions. Specifically, the therapist told Barb that the session marked the beginning of the final or Termination Phase of treatment. Even though Barb would still be encouraged to push her work forward on her treatment goals, the therapist told her that they would be spending some of the remaining session time reviewing and consolidating her progress, formally saying goodbye to one another, and discussing how she can use what she has learned in treatment to manage future interpersonal challenges. Barb used the remaining time during the termination phase to continue taking better care of herself by decreasing her work hours. By the end of treatment, Barb had also begun to have frank discussions with her son about his unresolved feelings about his father. In reviewing her progress, Barb was able to acknowledge that over the course of treatment she was able to recognize her feelings and take care of her needs by making more time for herself. Barb also noted that she was able to attend to negative feelings “without feeling as if the world was coming to an end.” She shared that as she began to accomplish these goals, her relationships with others began to get better.

At the end of treatment, Barb had stopped binge eating. At a 1-year follow-up visit, Barb had lost 70 pounds from her initial assessment weight and continued to be binge-free.