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Interpersonal Psychotherapy for Eating Disorders: A Systematic and Practical Review

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Summary
Interpersonal psychotherapy (IPT), initially developed for the treatment of unipolar depression, was adapted for the treatment of various mental disorders including the eating disorders bulimia nervosa, binge eating disorder, and anorexia nervosa. This systematic and practical review compiles the current evidence on the efficacy and predictors of IPT for eating disorders. Several randomized clinical trials show that IPT has a moderate to good efficacy in the treatment of bulimia nervosa that is lower than that of cognitive-behavioral therapy (CBT) in the short term, but equal in the long term, using similar mechanisms of change. For binge eating disorder, IPT yielded substantial short-term and long-lasting therapeutic gains, as did CBT. First evidence suggests moderate efficacy of IPT in the treatment of anorexia nervosa when compared to a non-specific clinical management, although long-term improvements were found. Further development of concept, diagnosis, and implementation, and a larger outcome- and process-related evidence base could contribute to increased efficacy and help specify indication and mechanisms of change of IPT for diverse eating disorders.

Zusammenfassung
Die Interpersonelle Psychotherapie (IPT), ursprünglich zur Behandlung unipolarer depressiver Störungen entwickelt, wurde für die Behandlung verschiedener psychischer Störungen adaptiert, darunter die Essstörungen Bulimia nervosa, die Binge-Eating-Störung und die Anorexia nervosa. Die vorliegende systematische und praxisorientierte Übersicht stellt den aktuellen Forschungsstand zur IPT bei Essstörungen hinsichtlich der Wirksamkeit und Prädiktoren zusammen. Mehrere randomisierte klinische Studien legen nahe, dass die IPT bei der Bulimia nervosa zwar weniger schnell wirkt als die Kognitive Verhaltenstherapie (KVT), langfristig aber ebenso moderate bis gute Effekte mit ähnlicher Wirkungsweise erzielt. Für die Binge-Eating-Störung weist die IPT dieselbe gute kurz- und langfristige Wirksamkeit wie die KVT auf. Zur Behandlung der Anorexia nervosa legen Initialbefunde im Vergleich zu einem nicht spezifischen supportiven klinischen Management eine mäßige Wirksamkeit der IPT nahe, wobei langfristig Verbesserungen eintreten. Weiterentwicklungen in Konzept, Diagnostik und Vorgehen sowie eine größere wirksamkeits- und prozessbezogene Datenbasis können dazu beitragen, die Effektivität weiter zu optimieren sowie Indikation und Wirkungsweise der IPT für verschiedene Essstörungen zu spezifizieren.

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Introduction

Interpersonal psychotherapy (IPT), originally developed in 1984 by Klerman and Weissman for the treatment of unipolar depression, is increasingly being adapted for treatment of other mental disorders [Weissman et al., 2000, 2009; Schramm, 2010]. These include the eating disorders bulimia nervosa (BN), which is characterized by recurrent binge eating and inappropriate compensatory behavior for prevention of weight gain (such as purging), and anorexia nervosa (AN), the primary feature of which is self-induced underweight by dietary restriction. Binge eating disorder (BED) was first defined in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV-TR) [American Psychiatric Association, APA, 2000] as an Eating Disorder Not Otherwise Specified (EDNOS), whose main feature is recurrent binge eating without regular compensatory behavior. All of these eating disorders are characterized to varying degrees by interpersonal problems, providing the principal therapeutic starting point for IPT, and by negative affect [Fairburn et al., 2009]; yet the specific symptoms and perpetuating factors raise the question of IPT's differential efficacy for the various eating disorders.

Several narrative [e.g., Wilson et al., 2007] and systematic reviews [Brownley et al., 2007; Bulik et al., 2007; Shapiro et al., 2007], as well as meta-analyses [Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (Association of Scientific Medical Societies), AWMF, 2010; Hartmann et al., 2011; Hay et al., 2009; Vocks et al., 2010] have reported on IPT, although partially without especially identifying its effects. Furthermore, some review articles excluded uncontrolled studies, case series, or single case studies, or did not report completely on predictors. Therefore, the aim of this systematic and practical review was to summarize the current state of research on the efficacy of IPT for eating disorders and the predictors, moderators, and mediators, while describing this therapeutic approach.

IPT for Eating Disorders

The major modification of IPT, which was first adapted for treatment of BN [Fairburn et al., 1991] and then used with BED [Wilfley et al., 1993] and AN [McIntosh et al., 2005], is that the therapeutic focus is not symptoms of depression, but those of the eating disorder. As a short-term outpatient therapy, IPT aims, for all eating disorders, to resolve the interpersonal problems that occur in the context of the eating disorder. The assumed mediator is thus a reduction of interpersonal problems, while cognitive-behavioral therapy (CBT) is supposed to normalize eating behavior, and reduce dietary restraint and shape and weight concern [Murphy et al., 2009].

The initial phase of IPT consists of an interpersonal inventory and clarification of goals; in the middle phase, current disorder-related interpersonal problems are treated. IPT has identified 4 core areas: grief, in the sense of the more complex grief caused by the loss of a loved one; interpersonal role conflicts in a relationship arising from differing expectations; role transitions resulting from a change in life status; and interpersonal deficits that lead to social isolation or chronically unsatisfactory relationships. The final phase is designed to consolidate the progress achieved and to identify areas for future work. In all phases of IPT, therapeutic strategies are used such as exploration, clarification, promotion of emotional expression, communication analysis, and behavior modification; strategies for specific problem areas were worked out [Weissman et al., 2000, 2009]. The therapeutic relationship is collaborative and the therapist takes an appreciative and supportive attitude toward the patient.

Methods

In the present review article, we have included randomized-controlled, controlled, and uncontrolled trials that investigated evidence of IPT's efficacy or analyzed the predictors, moderators, and mediators; we have also used individual case studies. The patient populations were diagnosed with BN and AN or EDNOS including BED, according to DSM-III-R or -IV-TR. Studies were excluded that used no IPT or used IPT interventions to an unspecified degree; did not constitute original work; did not contain sufficient information to derive solid conclusions; or were conducted in a language other than English or German.

Electronic searches (January 2012) were performed in PubMed, PsycInfo, Current Contents, Cochrane Central Register of Controlled Trials, Medline, and EmBase, supplemented by manual searches. The search terms were ('interpersonal psycho*' OR 'interpersonal therap*') AND ('bulimia' OR 'anorexia' OR 'binge eating' OR 'eating disorder'). From a total of 143 studies generated by the search, 33 were included.

The outcomes were given as remission or improvement of eating disorder symptoms, drop-out or exclusion from treatment, changes in associated psychopathology, in interpersonal/social functioning or quality of life, and in body weight. Completer analyses were indicated separately.

Most clinical studies evaluated short-term treatment with ca. 20 sessions in an individual setting. Deviations from this procedure are described in the text.

Results and Conclusions

Bulimia Nervosa

In a randomized trial Fairburn et al. [1991, 1993] were the first to compare IPT with CBT and behavior therapy (BT) in the treatment of 75 female patients with BN. By the end of treat-

ment, CBT and BT led to greater abstinence from purging than did IPT, but not greater abstinence from binge eating. One year after the end of treatment there were no longer any differences in remission from binge eating and purging (i.e., compensatory vomiting, misuse of laxatives or diuretics) (IPT 44%, CBT 36%, BT 20%). While the CBT patients showed the least dietary restraint by the end of treatment, and the CBT and IPT patients showed the least shape and weight concern, IPT and CBT at 1-year follow-up showed equally significant improvement in binge eating and purging, in the specific eating disorder- and general psychopathology, including depressive symptoms, and in social functioning. Body mass index (BMI, kg/m^2) decreased slightly but significantly. Overall, 19% of the patients discontinued treatment prematurely or had to be excluded. For all treatments, a reduction of selective attention to shape, weight, and food, experimentally detected by the Stroop Test, was documented from baseline to end of treatment [Cooper and Fairburn, 1994].

The 6-year follow-up [Fairburn et al., 1995] showed higher long-term abstinence rates for binge eating and any kind of compensatory behavior in the IPT (52%) and CBT patients (50%) than in the BT patients (18%). The reduction of the specific eating disorder psychopathology compared to baseline was less pronounced in CBT patients than in IPT and BT patients at 6-year follow-up. All the treatments showed improved general psychopathology and a slight but significant weight gain. These results suggest – in a small sample – good overall long-term efficacy of IPT, which, however, was lower for some aspects of eating disorder psychopathology than was the case with CBT.

Jones et al. [1993] documented significant improvements in binge eating and purging for all 3 forms of treatment, especially during the first 4 weeks of treatment. In the later course of therapy, the CBT and BT patients showed further improvements and significantly lower binge eating than the IPT patients, while the specific eating disorder- and general psychopathology improved equally with all treatments. The lower efficacy of IPT by the end of treatment is thus due to less rapid improvement of symptoms than with CBT. It should be noted that the continuous outcomes in the studies by Fairburn et al. [1991, 1993, 1995] were examined with completer analyses.

In a 2-center, randomized trial, Agras et al. [2000] treated 220 female BN patients with IPT or CBT. The remission rates for binge eating and purging were significantly lower after IPT (6%) than after CBT (29%) (d = 1.80). The CBT patients who had completed treatment showed less binge eating, purging, and restrained eating immediately after treatment than did the IPT patients. The decreased dietary restraint after CBT was also reflected in a more regular meal structure associated with remission, as determined by interview [Shah et al., 2005]. 4 months after the end of treatment there were no recognizable differences between IPT and CBT. The remission rates at 1-year follow-up were 17% for IPT and 28% for CBT. No differences were found in weight, shape, and eating concern, general psychopathology, interpersonal problems, or level of social functioning. A total of 30% of patients discontinued treatment or were excluded. These results show a moderate efficacy as well as a substantial drop-out in IPT and CBT. Again, more rapid efficacy was documented for CBT.

A randomized follow-up trial by Walsh et al. [2000] showed that patients who persisted with binge eating and purging behavior after IPT or CBT benefited from antidepressant therapy with fluoxetine, compared with placebo, and displayed fewer eating disorder symptoms and psychopathology. Medication could therefore be considered as a secondary treatment.

Naatz [1998] compared IPT and CBT, as well as an untreated control group, and randomized 69 unemployed women with BN. While the completer analyses showed no distinction between IPT and CBT in employment rates at the end of therapy, significantly fewer IPT patients had jobs than CBT patients at 1-year follow-up. The employment rates after therapy were associated with treatment outcome. These results highlight a need to examine treatments such as IPT for their potential to solve social problems like unemployment.

In a case series by Arcelus et al. [2009], the efficacy of IPT was evaluated for 59 female patients with BN or EDNOS with bulimic symptoms; in contrast to previous studies [Fairburn et al., 1993; Agras et al., 2000], behavioral interventions were included (e.g., food diaries), since the IPT concept allows it. At the end of treatment, 27% of patients were abstinent from binge eating and purging; similar rates were found at 3-month follow-up. At the end of treatment, at 3-month follow-up, and even at mid-treatment, there was a significant improvement of binge eating and purging, associated eating disorder psychopathology, interpersonal problems, and depression. A total of 24% of patients discontinued treatment prematurely. The fact that the study by Agras et al. [2000] showed higher remission rates for IPT could indicate that combining IPT with behavioral interventions increases the efficacy of IPT.

Sequential and Combined Treatment

Several studies have examined IPT as a secondary treatment for patients who did not respond to treatment with CBT. Mitchell et al. [2002], in a multicenter randomized trial, used IPT or antidepressant therapy (fluoxetine, desipramine) as a secondary treatment for 62 female patients with BN who had not responded to CBT. After IPT, 16% of the patients were fully remitted, compared to 10% after drug therapy; these results remained stable after a 6-month follow-up. A total of 40% of patients discontinued treatment or were excluded. The authors concluded that a sequencing of separate treatments such as CBT and IPT after non-response to one of them has little clinical benefit.

Since IPT had been used exclusively individually in the studies described above, Nevonen and Broberg [2006], building on an uncontrolled pilot study [Nevonen et al., 1999], con-

ducted a randomized comparison of the efficacy of a combined CBT-IPT treatment of 86 female patients with BN, in individual versus group format. The combination treatment consisted of 10 sessions of CBT followed by 13 sessions of IPT. The 2 formats were equally effective in the remission of binge eating and purging at the end of treatment and 2.5 years later (individual format: 31%, 38%; group format: 41%, 27%). Binge eating and purging, the specific eating disorder- and general psychopathology, depression, and interpersonal relationships generally showed medium-size improvement at 1-year follow-up ($0.37 \leq d \leq 1.63$), with a tendency for larger effects in the individual than in the group format. A total of 21% of patients ended the treatment prematurely or did not attend regularly.

The study by Nevonen and Broberg [2006], following the same design in N = 35 female patients with subclinical BN (EDNOS), showed equivalent remission rates after treatment in an individual format (6%) and a group format (17%), as well as at 2.5-year follow-up (59%, 67%). Individual therapy, however, resulted in a smaller improvement in general psychopathology than did group therapy. The 1-year effect sizes for the specific eating disorder and general psychopathology ranged from $0.08 \leq d \leq 2.83$. A total of 9% of patients discontinued treatment prematurely. Whether patients with full-blown BN should be offered individual therapy, while group therapy might suffice for those with subclinical BN, cannot be definitely determined given the exploratory nature of these studies. However, the feasibility and acceptance of the combination treatment and at least moderate long-term efficacy for female patients with clinical or subclinical BN has unequivocally been documented.

This was also illustrated in a case study by Hendricks and Thompson [2005], in which a female patient with BN, a depressive episode, and alcohol abuse was successfully treated with a combination of CBT and IPT. In the initial phase of treatment, CBT was used for treatment of binge eating, negative body image, and alcohol abuse. Then IPT was used for treatment of interpersonal problems that further perpetuated the purging behavior.

Predictors, Moderators, and Mediators

For the study by Agras et al. [2000], Wilson et al. [2002] documented during the course of therapy a faster effect of CBT compared with IPT on binge eating and purging, but not on shape and weight concern or interpersonal problems. Treatment-specific mediators did not emerge: In IPT and CBT, a reduction of dietary restraint in the first 4 weeks of treatment predicted less binge eating and purging by the end of treatment. Self-efficacy was also predictive of eating behavior, negative affect, shape, and weight at mid-treatment. At 1-year follow-up, however, an early reduction of dietary restraint was the only predictor still in effect. Reduction of interpersonal problems or the quality of the therapeutic alliance did not predict or mediate treatment outcome.

Fairburn et al. [2004] also showed that in IPT and CBT, remission from binge eating and purging as of the 8-month follow-up was best predicted by less purging or a greater reduction of purging in the fourth week of treatment. The patients who were remitted at the end of treatment, had a significantly higher BMI at baseline, less purging, and lower general psychopathology. These results confirm that CBT is a faster approach to the treatment of BN than is IPT. The effects of both treatment approaches could be optimized by early improvement of purging, dietary restraint, and self-efficacy, which might be more difficult to achieve with more severe symptomatology.

Further predictor analyses of the same study showed that a good therapeutic relationship and adherence to the manual were present in both IPT and CBT therapists, as was determined by audio recordings of the therapeutic sessions; however, adherence turned out to be greater in the more formalized CBT [Loeb et al., 2005]. Adherence was also positively associated with the therapeutic alliance. Treatment by CBT and – to a lesser extent – a better therapeutic alliance in the first weeks of treatment predicted a better outcome by the end of treatment. Also in the patients' estimation, CBT resulted in a more positive therapeutic alliance in the first weeks of treatment than IPT, predicting better treatment outcome after CBT [Constantino et al., 2005], probably because of a greater plausibility of the therapeutic approach. In IPT the therapeutic alliance was better, the fewer interpersonal problems there were at baseline; in CBT the relationship was better, the lower the symptom severity. Depending on the therapeutic approach, the patients' difficulties seem to have affected the quality of the relationship differently. Treatment expectation is also important: Patients who expected that the treatment would help them were more appreciative of the therapeutic relationship in CBT and IPT. These results suggest that it is indicated to strengthen treatment expectation early in therapy.

Compared to CBT, IPT was also associated with less initial motivation to change, with less remission by the end of treatment [Wolk and Devlin, 2001], such that in the less symptom-oriented approach of IPT the initial motivation for therapy could come to assume a greater role. In an analysis of interpersonal profiles, female patients who at baseline felt less interpersonally affiliated and less interpersonally rigid reported a better therapeutic alliance during therapy when treated with CBT than with IPT [Constantino and Smith-Hansen, 2008]. Interpersonal rigidity could interfere with the structured approach of CBT, while IPT offers greater control to the patients. However, problems with interpersonal affiliation could lead to a more positive therapeutic alliance in CBT, because the approach is not directly interpersonal.

Finally, the study by Agras et al. [2000] provided evidence of a greater reduction of binge eating among African American patients in IPT, while for other ethnic groups CBT was more effective [Chui et al., 2007]. However, interpretation of this finding is limited by a small cell occupation for ethnic mi-

norities. In the study by Fairburn et al. [1995], obesity of the father or premorbid obesity were treatment-unspecific negative prognostic indicators.

Binge Eating Disorder

In the first randomized trial conducted before BED was defined in DSM-IV (1994) Wilfley et al. [1993] assigned 56 mostly overweight and obese female patients with BN and without purging (DSM-III-R) to IPT or CBT in group format or to a waiting list control group (WL). Four months after treatment, the IPT and the CBT patients showed greater remission from binge eating than the control group (IPT 44%, CBT 28%, WL 0%) and a greater reduction of eating disorder psychopathology, depression, and interpersonal problems. Despite significant tendencies of relapse 6 and 12 months after the end of treatment, the reduction of binge eating episodes was stable compared to baseline. Body weight decreased slightly but significantly after IPT and CBT. Of the 36 patients in IPT and CBT, 22% discontinued treatment prematurely.

In a 2-center randomized trial, Wilfley et al. [2002] compared IPT and CBT in a group format in 162 women and men with BED (DSM-IV). More than 70% of the patients achieved abstinence from binge eating after the end of treatment (IPT 82%, CBT 74%) and 1 year later (IPT 72%, CBT 70%). Binge eating, the specific eating disorder- and general psychopathology, including depression, interpersonal problems, and social functioning showed stable improvement. CBT provided greater reduction of dietary restraint after the end of treatment than IPT; however, both approaches were efficacious on these parameters at 1-year follow-up. The BMI remained stable during treatment and during the follow-up period. Patients who were abstinent from binge eating achieved a slight but significant reduction in BMI at the end of treatment and at 1-year follow-up. A total of 16 patients (10%) discontinued treatment prematurely.

The long-term follow-up to this study by Hilbert et al. [2012] in a subsample of 70 patients after 46 months, showed a substantial persistence of abstinence rates (IPT 77%, CBT 52%). While there were no differences between the approaches at any time-point of assessment, abstinence rates and most indicators of eating disorder psychopathology were worse among CBT patients between 1-year and long-term follow-up, whereas they were stable or improved among IPT patients. In both treatment conditions, the number of binge eating episodes, the specific eating disorder- and general psychopathology, and depression were improved significantly compared to baseline, although binge eating episodes showed relapse tendencies. The BMI was stable. This differential time course is similar to the 'catching up' of IPT after treatment of BN, although the processes of change in both forms of treatment remain to be clarified.

Wilson et al. [2010] studied the efficacy of IPT in 205 women and men with BED, compared to book-based guided self-help (GSH) using CBT principles and behavioral weight loss treatment (BWL). The latter is not aimed at the treatment of binge eating, but rather at weight reduction. While there were no differences between treatment conditions in remission from binge eating by the end of treatment (IPT 64%, GSH 58%, BWL 55%), IPT and GSH achieved higher remission rates compared to BWL 2 years after the end of treatment (IPT 67%, GSH 65%, BWL 47%). BWL was more efficacious in the reduction of BMI and an increase of dietary restraint compared to the other 2 approaches after the end of treatment, but not after 2-year follow-up. Regardless of the treatment approach, patients who were abstinent from binge eating during the follow-up period were more likely to have clinically significant weight loss than patients who reported binge eating at all time-points of assessment. IPT patients discontinued treatment significantly less frequently than GSH and BWL patients (IPT 7%, GSH 28%, and BWL 30%). These results suggest that GSH for BED is an efficacious treatment option, comparable overall to IPT, while BWL is inferior to specialized treatment approaches for longer-term reduction of binge eating symptomatology. In addition, benefits of BWL related to weight management cannot be maintained in the long term.

Sequential and Combined Treatment

Agras et al. [1995] studied IPT as a secondary treatment after unsuccessful CBT, and BWL after successful CBT, compared with no treatment, in 50 women and men with BED. IPT achieved no further improvements with respect to binge eating, associated psychopathology, and body weight in patients who had been unsuccessfully treated with CBT. Despite the small sample size, the results raise the question of whether IPT achieved no improvement upon the results of CBT for the reason that it works by similar mechanisms of action. With BN also, separate treatment with IPT after unsuccessful CBT proved unsuccessful, although promising results have been achieved by combined treatment with CBT and IPT.

Predictors, Moderators, and Mediators

For the study by Wilfley et al. [2002], Hilbert et al. [2007] identified interpersonal problems at baseline or at mid-treatment as negative prognostic indicators for IPT and CBT, both at the end of treatment and at 1-year follow-up. This result is consistent with the predictive effect of Cluster B personality disorders on more frequent binge eating at 1-year follow-up, as identified by Wilfley et al. [2000]. If there were no interpersonal problems, increased shape and weight concern at baseline and mid-treatment were predictive of lower treatment outcome. There were no indications of treatment-specific moderators or mediators.

Wilson et al. [2010] reported that patients with more severe binge eating symptoms at the end of treatment were less often

in remission if they had been treated with GSH or BWL than with IPT. At 2-year follow-up, BWL patients had lower remission rates if they had greater eating disorder psychopathology than if their eating disorder psychopathology was less pronounced. Furthermore, patients with lower self-esteem and greater eating disorder psychopathology responded less well to BWL and GSH, while the treatment outcome of IPT was independent of these characteristics. In addition to these treatment-specific moderators, a history of depression and a lower educational level were non-specific negative prognostic indicators. It should be noted also that in case of strong negative affect, more BWL patients discontinued treatment than GSH patients, whereas in case of less negative affect, the reverse was true. These results suggest that IPT is particularly suitable for severe psychopathology, whereas GSH may be sufficient for less severe psychopathology. They also underscore BWL's low suitability for treatment of BED.

Sysko et al. [2010] demonstrated, on the basis of the same study, that patients who presented at baseline with highly pronounced binge eating, compensatory behaviors, shape and weight concern, and negative affect showed greater likelihood of remission from binge eating by the end of treatment if they had received IPT. On the other hand, patients with equally strong eating disorder symptoms but fewer compensatory behaviors were most likely to be abstinent if they had been treated with GSH. GSH provides a more direct focus on the treatment of eating disorder behavior than does IPT or BWL.

Further unspecific predictors of a less favorable response included stronger negative affect [Dounchis, 2001], greater binge eating symptoms, and earlier onset of binge eating [Agras et al., 1995].

Anorexia Nervosa

In the only randomized trial for AN, McIntosh et al. [2005] compared IPT, CBT, and non-specific supportive clinical management (CM) in 56 female patients with AN (by modified DSM-IV criteria). CM led more often than IPT to a good overall clinical outcome (i.e., few eating disorder characteristics); CBT was in-between (CM 75%, CBT 33%, IPT 15%). While there were no differences between treatments with regard to weight, BMI, and body fat, CM and CBT were superior to IPT in the reduction of dietary restraint, and CM led to better overall functioning (completer analyses). There were no other changes in eating disorder psychopathology and depression. A total of 38% of patients discontinued treatment prematurely.

The 6.7-year follow-up to this study by Carter et al. [2011] showed no differences in efficacy among the 3 treatments. While long-term CM resulted in a decline in remission rates (42%), IPT resulted in an improvement (64%; CBT remained unchanged at 41%). Restrained eating increased over the long term following CM, while after IPT or CBT there was a stable reduction. For all conditions, an increase in body weight and improvements in the specific eating disorder and general psychopathology were documented over the follow-up period. These results suggest that the less symptom-oriented focus of IPT and/or interpersonal or emotional avoidance tendencies of the patients might have reduced its efficacy. In the long term, however, IPT appears to catch up, possibly due to greater generalization of the strategies learned in therapy.

Discussion

This systematic review suggests a differential indication of IPT for various eating disorders. For BN, a moderate to good long-term efficacy of IPT has been documented, with possible improvement if IPT is combined with behavioral interventions. In comparison with CBT, the efficacy of IPT was similar, but not as fast. Current evidence-based guidelines therefore recommend IPT as an alternative treatment to CBT if the latter is not effective, not available or not desirable [AWMF, 2010; APA, 2006; National Institute for Health and Clinical Excellence, NICE, 2004]. Despite the lack of behavioral interventions, IPT worked in BN through CBT-specific, but not through IPT-specific mechanisms. The therapeutic alliance made a small contribution to the treatment outcome, but it was less positively perceived by IPT patients than by CBT patients. This less positive perception of the therapeutic alliance could be related to a less pronounced symptom orientation or less plausibility of treatment associated with the truncation of IPT for methodological reasons. This and the negative effect of low motivation to change in IPT indicate the need to render especially the early phase of therapy motivationally beneficial, which could also improve the substantial drop-out rates. For this, empirically supported models of the disorders [Ansell et al., 2012; Elliott et al., 2010; McIntosh et al., 2000; Rieger et al., 2010], a standardized assessment of interpersonal problems, and a more symptom-oriented approach could be used. Further clarification is also needed to determine for which patients IPT is particularly well-suited.

Compared to BN, just as good long-term efficacy of IPT as of CBT has been documented for BED. Guidelines recommend IPT as an alternative treatment to CBT [AWMF, 2010; APA, 2006; NICE, 2004]. In addition, a small but significant weight loss was shown for patients who achieved abstinence from binge eating. Given the substantial weight gain of BED patients before starting an eating disorder treatment [Barnes et al., 2011], a long-term stabilization of body weight can be considered as treatment success. Nevertheless, the question is how to achieve further optimization, for example, by regular physical activity. The lower discontinuation rates in BED than in BN are a positive outcome. Compared to other approaches such as guided cognitive-behavioral self-help, IPT was especially suitable for more severe eating disorder psychopathol-

ogy and greater negative affect. In the case of BED too, more research is needed to further elucidate the processes of change.

With regard to AN, for which no outpatient therapy with adequate efficacy is so far available, initial evidence suggests slight short-term efficacy of IPT in comparison to a flexibly designed, supportive clinical management. But over the long term, IPT caught up, as it did with BN, possibly because of a greater generalization of the strategies learned in therapy that are applicable to different types of interpersonal stressors. An interpersonal treatment focus is certainly indicated, as interpersonal problems are highly relevant to AN [McIntosh et al., 2000]. For the treatment of AN, however, it seems essential to have a strongly symptom-oriented approach at the beginning of therapy. In light of the findings on secondary treatment by IPT in BN and BED, this symptom-oriented approach could be combined with interpersonal interventions.

IPT interventions are increasingly being manualized within CBT [e.g., Fairburn, 2008; Hilbert et al., 2010], and, for various eating disorders and settings, the feasibility of combined approaches has been demonstrated, such as outpatient individual [Fairburn et al., 2009; Kong, 2005] or group therapy [Crafti, 2002; Friedrich et al., 2007] as well as inpatient therapy [Durand and King, 2003]. Fairburn et al. [2009] showed that a more broadly designed CBT with IPT interventions is better suited for more complex symptomatology than is CBT focused solely on specific eating disorder symptoms. Despite a growing evidence base of IPT, however, its use is not widespread. In Germany, it is not a 'guidelines psychotherapy' (meaning it is not covered by state health insurance), but in other countries such as the United States and Canada it is also rarely used [Mussel et al., 2000; Simmons et al., 2008]. IPT continuing education programs, e.g., within CBT curricula, thus appear to be vital to the dissemination of this therapeutic approach.

Overall, IPT is an evidence-based alternative to CBT for eating disorders, with a high degree of flexibility allowing integration with diverse therapeutic approaches. Applications for related disorders are in progress [e.g., Tanofsky-Kraff et al., 2010]. Further development of the concept, assessment, and procedures, as well as a larger database, could continue to help specifying IPT's indications and mechanisms of change for various eating disorders.

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