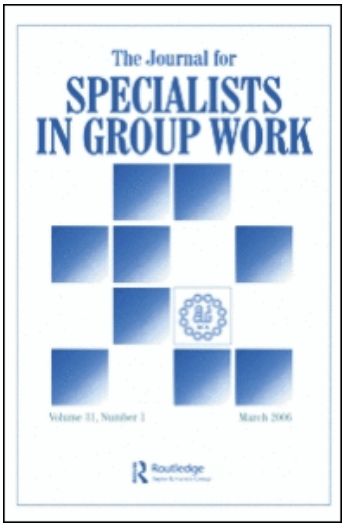

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Interpersonal Group Therapy for Women Experiencing Bulimia

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PRACTICE

Interpersonal Group Therapy for Women Experiencing Bulimia

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Bulimia Nervosa (BN) is a chronic disorder that results in a high degree of psychological impairment for many women. This article presents a description of Interpersonal Therapy for Group (IPT–G), an evidence-based approach for the treatment of BN. The author presents a rationale for the use of IPT–G, an outline of the group model, and provides considerations for using IPT–G in clinical practice.

Keywords: *bulimia; group treatment for bulimia; interpersonal therapy*

Bulimia Nervosa (BN) is considered one of the leading causes of psychological impairment among women (Striegel-Moore & Bulik, 2007). Lifetime prevalence rates for Bulimia Nervosa (BN) range between 1–3% of women, although many more women experience sub-threshold bulimic symptoms that significantly impair their life functioning (American Psychiatric Association, 2006; Hoek & Van Hoeken, 2003). BN most often runs a chronic course, beginning in adolescence and persisting across the lifespan, with high rates of remission and relapse (Chavez & Insel, 2007; Wilson, Grilo, & Vitousek, 2007). Women may struggle with symptoms for many years before seeking help, making great efforts to conceal the disorder from others. Even when women do seek treatment, it is of concern that most mental health practitioners report a lack of training in evidence-based approaches for eating disorders (Mussell et al., 2000; Simmons, Milnes, & Anderson, 2008). Further, while cognitive behavioral therapy (CBT) is recommended as a first-line treatment for BN, it is effective for only between 30–50% of clients (Wilson et al., 2007).

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Because many women who receive treatment for BN do not respond well to CBT (Wilson et al., 2007), it is important for group counselors to be aware of effective alternatives. One lesser-known treatment that has also shown strong empirical support is Interpersonal Therapy (IPT) in both individual and group formats (American Psychiatric Association, 2006; Mitchell, Agras, & Wonderlich, 2007; National Institute of Clinical Excellence [NICE], 2004; Wilson et al.). Best practices indicate that IPT for BN is particularly beneficial for those who have interpersonal or life transition problems or for clients reluctant to engage in CBT (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; American Psychiatric Association, 2006; Mitchell et al., 2007). IPT for group (IPT–G), with its focus on improving interpersonal relationships, is an ideal modality for helping members to increase their awareness of relational difficulties and to practice changing them within a group context (Weissman, Markowitz, & Klerman, 2000).

Because IPT-G is not well disseminated among practitioners (Simmons et al., 2008) and shows promise for treating BN, the purpose of this article is to describe IPT–G for women experiencing bulimia. It should be noted that many men also experience BN and related symptoms, but they are far outnumbered by women with these concerns (Hoek, 2006). For the purposes of this article, IPT treatment for women clients is provided. First a rationale for the use of IPT–G is described. Next an IPT group for women with BN is outlined in detail, including a description of the pre-group meeting and the three stages of the group. Finally, strengths and challenges of the IPT–G model in clinical practice are highlighted.

RATIONALE FOR INTERPERSONAL THERAPY-GROUP

Interpersonal Therapy (IPT) is a time-limited, semi-structured therapy originally designed for the treatment of depression (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman et al., 2000). Since then, it has been modified for use with a variety of disorders and was first adapted for BN by Fairburn and colleagues (Fairburn, Jones, Peveler, & Hope, 1993). It was published in manualized form for individual therapy in 1997 (Fairburn, 1997) and for group therapy in 2000 (Wilfley, Mackenzie, Welch, Ayres, & Weissman, 2000). Unlike the better-known CBT model for treating eating disorders (which focuses on changing behaviors and thoughts related to disordered eating), IPT does not address eating symptoms directly. Instead, it focuses almost exclusively on identifying and modifying current interpersonal difficulties and life stressors (Weissman et al., 2000).

The IPT focus on interpersonal concerns is highly relevant for women with BN, as they typically exhibit a number of peer, family, or marital relational problems, including conflict avoidance, perfectionism, difficulties with role expectations, fear of rejection, deficits in social problem solving, and lack of perceived social support (Apple, 1999; Wilson et al., 2007). Women with BN often have problems in directly communicating their needs in relationships as they tend to prioritize others' needs above their own (Kalodner & DeLucia-Waack, 2003; Tantillo, 2000). The premise of IPT–G is that over time, women learn to use binges, purges, or other bulimic behavior as ways to cope with these types of relational problems (Weissman et al., 2000) or to avoid negative feelings (Fairburn, 1997). In group, members can learn to identify their particular relational concerns, recognize the connection between their symptoms and these interpersonal problems, and then develop better coping skills and communication strategies to improve their relationships (Weissman et al., 2000). IPT–G assumes that as members learn to cope directly with their problems, their symptoms will subside (Agras et al., 2000; Weissman et al., 2000).

IPT is currently the only psychological treatment with demonstrated outcomes comparable with CBT for eating disorders (Wilson & Fairburn, 2007). In one major multisite study comparing CBT and IPT for clients with bulimia, Agras and colleagues found that more clients with CBT were abstinent or in recovery immediately following treatment, but found no differences between treatments at 1-year follow-up (Agras et al., 2000). Based upon these and other studies, the American Psychiatric Association Best Practice Guidelines and the National Institute of Clinical Excellence recommend IPT as an effective treatment for BN that is particularly appropriate for individuals with interpersonal problems or who are reluctant to engage in CBT (Agras et al., 2000; Mitchell et al., 2007).

Studies in general indicate that there is efficacy for group therapy for clients with bulimia (Baumann, 2006; Crafti, 2002; Levine & Mischna, 2007) with comparable outcomes found between individual and group therapy (Nevonen & Broberg, 2006; Tasca & Bone, 2007). Wilfley and her colleagues first demonstrated the effectiveness of IPT–G for bulimia (Wilfley et al., 1993). When group CBT was compared with group IPT for women with nonpurging bulimia, clients who received CBT and IPT both showed significant improvement in reducing their binge eating compared with those assigned to a waitlist condition (Wilfley et al., 1993). In a later study, Wilfley and colleagues also found that clients randomly assigned to group IPT or group CBT recovered at equivalent rates, both at post-treatment and at 1-year follow up (Wilfley et al., 2002). Both studies demonstrate IPT–G as a viable treatment model for counseling women with BN.

IPT–G MODEL FOR THE TREATMENT OF BN

According to Wilfley's IPT–G manual, groups are designed to be closed, with eight to ten members per group and two co-leaders. The group generally lasts 20 sessions, divided into three stages, beginning with an initial screening and pre-group meeting (Wilfley et al., 2000). A distinctive feature of IPT–G is that leaders provide information to group members in writing throughout the group process. Wilfley and colleagues suggest that the case formulation, target goals, and treatment plan be provided in writing to the group members following the pre-group meeting. In addition, they suggest that a summary of each member's progress towards her identified goals be provided in writing during the week following each session (either through mail or an agreed-upon form of electronic communication; Wilfley et al., 2000).

Initial Screening

Prior to the individual group meeting, the group leaders conduct a screening to determine the potential member's diagnosis and her appropriateness for the group. Prescreening members for potential fit with the group is an important factor in group cohesion and potential success (Wanlass, Moreno, & Thomson, 2005). First, only women are included in this particular IPT–G approach. While men also experience BN, women are far more at risk for the disorder (Striegel-Moore & Bulik, 2007), and female members will share common gender role socialization experiences (Maine, Davis, & Shure, 2008). Second, it is also important that members meet *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision [*DSM–IV–TR*]; (American Psychiatric Association, 2000) criteria for BN or Eating Disorder, Not Otherwise Specified with bulimia-related symptoms. These criteria include binge episodes (e.g., periods of uncontrolled eating in which large amounts of food are consumed) and/or maladaptive compensatory behaviors to purge the body of unwanted calories (e.g., vomiting, misuse of laxatives, diuretics, or over-exercise; Wilson et al., 2007). Wilfley and colleagues (2000) recommend that individuals who meet criteria for anorexia nervosa (or those whose focus is primarily on food restriction) be excluded from an IPT–G group for BN. These individuals generally have a distorted body image, are medically underweight and malnourished, are in denial about their problem and have no desire to change it, and are socially withdrawn (Reiss & Dockray-Miller, 2002). In contrast, women with BN are more likely to be distressed by their symptoms and to want to change them (Reiss & Dockray-Miller, 2002; Wilfley et al., 2000).

Additional exclusion criteria include those individuals whose immediate needs are stability and safety, such as those who have severe personality or psychotic disorders, those who are suicidal, or those experiencing acute life stressors for which they are not able to cope adequately. These women should be referred to individual counseling or to a longer-term group model where they can address these more pressing needs prior to engaging in group treatment for an eating disorder. Further, clients who are actively abusing substances should also be excluded from group so that they can be referred to substance abuse treatment before attempting to address BN (Reiss & Dockray-Miller, 2002; Wifley et al., 2000).

Pre-group Meeting

Once group membership is determined, members are invited to attend a 90-minute individual meeting with the group counselors. During this session, it is important for the counselors to first address motivational concerns (Vitousek, Watson, & Wilson, 1998). Clients are likely to be discouraged and may have sought help from multiple counselors before joining the group (Peck & Lightsey, 2008). They are also likely to be fearful that the leaders' ultimate goal is to make them gain weight (American Psychiatric Association, 2006). To reduce member resistance, it is important to validate these fears openly and to provide warmth, empathy, and understanding in order to build rapport (Stuart & Robertson, 2003). Clients can be reassured that the IPT–G approach has demonstrated effectiveness in significantly reducing disordered eating symptoms (Fairburn, 1997; Wilfley et al., 2000). Instillation of hope is important, because research indicates that when clients with eating disorders have high expectations for change and success, there is a stronger therapeutic alliance and more positive treatment outcome (Constantino, Arnow, Blasey, & Agras, 2005; Wolk & Devlin, 2001).

To prepare each member for the group, leaders can provide initial education about the IPT–G structure. Leaders can highlight the potential benefits of the group, emphasizing the opportunity to learn from other members in addition to the group leaders. The member can also be introduced to the idea of the group as interpersonal laboratory in which she can receive immediate feedback from others, identify communication problems, and practice new skills that will transfer to relationships outside of the group. In addition, leaders can discuss risks associated with group membership, including limits of confidentiality and the discomfort she may experience when she expresses her feelings directly (Wilfley et al., 2000).

A final and critical aspect of the pre-group individual meeting is for the leaders to conduct a comprehensive interpersonal inventory

(Wilfley et al., 2000). This is done by asking the member to review her life history in four areas: (a) What is the history of the eating disorder? What were early precipitants of your initial binge/purge cycles? What were the circumstances surrounding the time of your first binges or purges? (b) What is your interpersonal history like before and since the development of your bulimic symptoms? For example, have you had recent losses? Problematic relationships? Changes in social support network? What are your important relationships like? What are positive and negative aspects of each important relationship? Are your expectations met? What are the current communication problems? How do you resolve interpersonal problems? How well do you engage with social support? (c) What are some significant life events you have experienced, and when did they occur? (d) What are some problems with self-esteem and depression you have experienced, and when did these occur? (Fairburn, 1997; Weissman et al., 2000).

The group leader and client can then create a life chart comprised of these four columns (Fairburn, 1997). By reviewing these inventories, the counselors and client begin to conceptualize her concerns in one of four IPT problem areas: role transitions, role disputes, grief, or interpersonal deficits (Klerman et al., 1984). As the leaders identify the members' specific interpersonal problem area, they can assist her in understanding how her eating disorder might have developed as a way to cope with these difficulties (Weissman, Markowitz, & Klerman, 2007). A treatment plan can then be developed based upon this formulation, including specific target goals and steps the member can make to improve her relationships.

Initial Stage (Sessions 1–5)

A primary task during the first five sessions is for the leaders to facilitate a safe and trusting environment in which members are able to share their thoughts and feelings openly. This will be difficult at first, as many clients with bulimia have long experienced a sense of alienation, self-stigmatization, and shame related to their eating disorder, spending much of their energy attempting to hide their feelings and bulimic behaviors from others. Group leaders can spend time normalizing members' discomfort and anxiety, reassuring them that the group will provide a unique opportunity to experience universality with other women who have common problems, thereby decreasing their shame and isolation. It is also important for group leaders to provide some structure and information to help in the creation of group norms that lead to cohesion and trust (Wanlass et al., 2005). For example, in the first session of a group for women experiencing BN, the members were initially reluctant to talk. After leaders prompted

them to share why they wanted to participate in the group, they began to discuss their current diets, how they avoided food in order to prevent binges, and how they feared entering into any treatment that might cause them to gain weight. At this point the co-leaders reminded members of the group emphasis on current interpersonal relationships and feelings, not on binge prevention strategies. They reminded the members about the importance of making the most of every session in a time-limited group, and the need for members to share directly with one another rather than simply responding to leaders' prompts (Fairburn, 1997; Wilfley et al., 2000). As members realized that the group would be a chance to take the focus off of weight, shape, and dieting and to talk about problems in their most important relationships, they began to feel more comfortable sharing their experiences.

In addition to creating a therapeutic environment, a second major task in the initial stage is to assist each member in explicitly linking her bulimic symptoms with her current interpersonal problems. Women who are caught in a cycle of binges and purges may not be able to objectively evaluate the function that these behaviors serve in their lives. As they interact in the group, they recognize how others have also learned to use their disordered eating as a mechanism for coping with difficulties. For example, leaders in a group can point out commonalities among members who may not have learned to express their needs directly in relationships: "Kayla, I notice that you and several other members have shared that you have difficulty speaking up and telling your friends and family what you really want. It seems like all four of you tend to hold in your anger, but then turn to binges to help you numb these negative feelings." Members can then learn to recognize the ways they use bulimic symptoms to avoid conflicts or regulate negative emotions they experience in response to unmet needs in their relationships (Maine, 2009; Tantillo & Kreipe, 2006).

During sessions four and five, leaders can begin prepare members for the working stage by encouraging continued member-to-member feedback and by guiding them to consider working on their specific individual goals.

Working Stage (Sessions 6–15)

A primary task of the working stage is to assist members as they make progress on their interpersonal treatment plans. As they focus on their individual goals, all members will also be working towards three broad group goals. First, members will be learning better socialization and communication skills that can be practiced first within the group and then generalized to relationships outside the group. Second, members will learn to recognize the importance of connections

with others and in giving themselves permission to ask for help or support when needed (Tantillo, 2000; Weissman et al., 2000). As members take risks in sharing their needs openly and receiving feedback from the group, they are better prepared to express their need for support with others (Kalodner & Delucia-Waack, 2003).

The third group goal is for members to express feelings openly and directly both in the group and in their daily lives (Wilfley et al., 2000). Members may need practice in first learning to become more aware of their feelings by uncovering, exploring, and accepting both the painful and positive aspects of significant relationships in their lives (Wilfley et al., 2000). For example, a member discusses her relationship with her father, and for the first time is able to acknowledge her disappointment over how the relationship did not meet her expectations for what she needed from her father. At the same time, she was also able to verbalize her feelings of love and concern for her father.

Once members gain awareness of their feelings, they can practice staying present with these emotions and can spend time examining the ways they tend to express their feelings within the context of relationships. The group is a place where members can begin to practice speaking their feelings directly and receiving feedback about how this is received by others. In the previous example, the member practiced in group what she might like to say to her father when she feels ready to communicate her authentic feelings to him. Members can also practice voicing their feelings towards one another, particularly as conflicts arise during the working stage of the group (Wilfley et al., 2000).

In addition to these general group goals, members will also be working on their specific treatment plan goals that are based upon identified IPT problem areas: Interpersonal Disputes, Role Transitions, Grief, and Interpersonal Deficits. These are described in detail in the IPT manuals (Fairburn, 1997; Klerman et al., 1984; Weissman et al., 2000; Wilfley et al., 2000), and are summarized in the following paragraphs.

Interpersonal role disputes. Previous research indicates that interpersonal role disputes are the most common IPT problem area, occurring in the majority of clients with BN (Fairburn, 1997). The goal in this problem area is to assist the member in successfully resolving a conflict with significant others in her life. For example, many women with bulimia have experienced conflicts as a result of unmet expectations, mistreatment, and betrayals in their relationships with parents, friends, or significant others. To assess the history of the dispute, the leaders might ask such questions as: When did you first become aware of the dispute? What are your expectations of this person and how have they changed? What have you already tried to do to resolve the dispute? What prevented these attempts from working? How do you

communicate your needs? and How has your communication pattern changed during the dispute? (Fairburn, 1997; Weissman et al., 2000).

Next leaders can help the member determine the stage of the dispute: *negotiation* (ongoing attempts to improve the relationship), *impasse* (neither individual is attempting to change), or *dissolution* (the relationship is beyond repair). Each member's action plan will be dependent upon the stage of the dispute. For example, if a member is at the negotiation stage, she may spend time in the group closely examining her patterns of communication with the person with whom she has a conflict. She can receive feedback in the group about the ways she communicates her needs, how she expresses anger, and how she responds to others when they ask her for help (Weissman et al., 2000). Members can assist one another in problem-solving and in practicing new ways of communicating, or work to change their expectations of relationships if these have been unrealistic. They may also benefit from role playing with other members and to observe modeling of appropriate communication (Stuart & Robertson, 2003).

If the member is at the impasse stage in her relationship, she can brainstorm alternatives for making a decision to either move the relationship back towards negotiation or to facilitate its movement towards dissolution. To move towards negotiation, she might have to invest more energy in the relationship, take risks in sharing her feelings, and open up the conflict in order to resolve it. If she decides that dissolution is the best solution, the group can assist her in taking action to end the relationship. In this case, she may need to spend time mourning the loss of the relationship, incorporating aspects of grief work, and accepting the loss as a role transition (as described in the next section; Weissman et al., 2000).

A potential limitation with IPT's straightforward approach to improving relationship disputes is that it does not account for the larger sociocultural context that envelops women's lives. Because of socialization for women in current culture in which girls often learn that self-assertion is unfeminine or undesirable, women with BN have often learned to present an inauthentic self to others that is nonassertive, people-pleasing, and reluctant to voice an opinion in a direct or appropriate manner (Maine et al., 2008; Tantillo, 2000). Even while adopting this socially sanctioned role, they also feel resentful of continually being taken advantage of by others (Reiss & Dockray-Miller, 2002). Members may be fully aware of the role dispute and the need to resolve it, but feel powerless or confused by their perceived lack of options. In group, members can uncover the sociocultural experiences they share as women and why it is particularly difficult for many women to become more assertive out of fear that they may put their relationships in jeopardy. They can discuss how becoming more assertive will help

them become empowered to take control in their lives and to deal directly with conflicts rather than turning to food to numb their feelings or to avoid their problems.

The group can provide an ideal setting for learning unfamiliar but essential assertiveness skills, allowing members the opportunity to practice the differences between being passive, assertive, and aggressive. Members can also practice being assertive with other members and dealing directly with intragroup conflicts (Reiss & Dockray-Miller, 2002). Slowly they can learn that they do have the right to assert themselves, to ask for what they want in relationships, and to say no to requests, even when this feels risky (Mendelsohn, 2007).

Role transitions. Like role disputes, role transitions are common difficulties in women with bulimia (Fairburn, 1997). Role transitions include difficulties in releasing a previous life role and in embracing a new one, such as managing changes related to marriage, parenthood, graduation from high school or college, or career advancement. For a group member facing role transitions, the first step is to assist her in clearly identifying the nature of the actual transition. Once the roles are defined, she can focus first on her old role, fully exploring her feelings about it, and mourning the loss of a role that is comfortable and familiar. She can also explore how the loss affects her sense of identity and relationships with others.

The member can then begin to examine her feelings about the new role. For example, what is causing her to experience anxiety or ambivalence about her new role? What are the potential benefits and opportunities that the new role may yield? How does the new role fit with her overall life goals? It may be helpful to assist the member in creating a chart, comparing and exploring the pros and cons of both the old and new roles in an effort to create a balanced picture of the transition (Weissman et al., 2000). The next step will be for the member to examine the specific demands of her new role. What does it require? Are there things she needs to learn? How can she go about developing these skills? What are the strengths she already possesses that she can bring to the new role? Finally, she can examine her support system and the ways in which she may need to ask for help in transitioning to the new role.

As with the Interpersonal Disputes area, a limitation of the IPT approach to role transitions is that it does not specifically incorporate women's socialization experiences regarding gender roles. For some women, problems with role transitions might be exacerbated by contradictory gender role messages they have received (American Psychological Association, 2007). In adolescence, many girls become attuned to societal messages regarding the priority of caretaking in

relationships. Simultaneously they experience social pressures to be independent, self-reliant, assertive, and high achieving in academic and career pursuits, while also achieving cultural standards for attractiveness (Choate, 2008; Denmark, 1999). When girls attempt to meet these often incompatible expectations, it can result in a sense of inadequacy, confusion, and frustration. Women with BN have often used binges, purges, and a focus on their body weight and shape as a way to avoid or deal directly with these contradictory gender roles. In the group, leaders can facilitate a discussion around the pressures that women face in current culture and impossibility of trying to meet these demands simultaneously. They can also discuss how these pressures might be complicating a member's ability to transition to a new role in her life.

Grief. While not a common interpersonal area for clients with BN, grief issues can be resolved comparatively quickly so should be addressed first when this theme is present (Fairburn, 1997). The first step in IPT grief work is to assist the member in connecting the loss with the onset or increase of bulimic symptoms. Once this link is made, the member is encouraged to actively mourn the loss by thinking about and describing it in detail: What happened right before, during, and after the loss? How was your relationship with the person around the time of the loss? If the loss was a death, how did you find out about it? How did you react to it? What was the funeral like for you? How did you grieve during the funeral? Next, the member can explore her feelings about the relationship and the loss in the present. For example, what is she struggling with most now that the person is not present in her life anymore? It is especially helpful for her to create a realistic picture of the relationship, recalling both the good and bad qualities, because exploring a balanced view of a lost relationship helps to facilitate the mourning process (Weissman et al., 2000). During the recounting of past events and current feelings, members can assist in normalizing and validating the client's painful feelings. Finally, the member can examine the need for establishing a current social network that will provide support (Stuart & Robertson, 2003).

Interpersonal deficits. This problem area is identified when a client has longstanding difficulty in initiating or maintaining intimate relationships. As originally defined in the IPT manual, clients with interpersonal deficits may have few friends, limited contact with their families, or a history of repeated relationship failures. They may have sought jobs in which they can remain isolated, and prefer solitary activities. Further, their social skill deficits are likely to manifest in the relationship with the leaders or group members, making a

therapeutic alliance difficult to form. It should be noted that in Fairburn's research, this area was not common in women with BN, as he viewed it as more of a personality style than as a problem resulting from an acute social stressor (Fairburn, 1997). However, in the IPT–G manual by Wifley and colleagues (2000), the researchers broadened the problem area definition to encompass any social skills deficits that might interfere with members' relationships. To make improvements in this area, the leaders can assist the member in assessing her interpersonal problems by discussing her current relationships, past relationships, and relationships with leaders and group members. As part of this review, the members can provide the client with specific feedback about her communication style and how they think it might be improved. She may also benefit from basic social skills training exercises that can be practiced both within and outside of the group (Fairburn, 1997).

Termination Stage (Sessions 16–20)

During the final five sessions, group leaders can prepare group members for termination in several ways. First, members should be given adequate opportunities to process their feelings regarding the ending of the group, grieving any feelings of loss they may be experiencing, and exploring what it will be like when they can no longer rely on the group for support or feedback. Members may also need time to process any negative reactions regarding the group. For example, they may be resentful for not receiving enough attention from group leaders, or they may be frustrated if their disordered eating symptoms have not yet improved. Leaders can encourage members to explore these feelings openly and can reassure them that it often takes several months before the full benefits of IPT are experienced (Agras et al., 2000), as it takes time for relational patterns to change and for new relationships to be established.

A second task is to help members consolidate their learning from the group. Leaders should encourage each member to review the specific progress she has made towards her individual goals (Tantleff-Dunn, Gokee-LaRose, & Peterson, 2004). As members recognize progress towards their treatment goals, leaders can also reinforce any gains made in the three general group goal areas (e.g., use of better communication skills, development of strong social support systems, and open expression of feeling). Members should also identify areas where continued work is needed and develop a plan for action steps they will take once the group has ended. A third task is for leaders to successfully structure the final session. During this session leaders can offer members an opportunity to say goodbye by having them provide each

member with specific feedback about her contributions to the group. During the last session, leaders can also remind members that an individual follow-up session will be held approximately 4–5 months after the termination session in order to review continued progress and to develop additional interpersonal goals (Wilfley et al., 2000).

DISCUSSION AND FUTURE DIRECTIONS

The IPT–G treatment model presented in this article is a semi-structured group approach for women experiencing BN. Research demonstrates that IPT is a viable alternative to CBT for the treatment of BN (Agras et al., 2000; American Psychiatric Association, 2006; NICE, 2004). While CBT focuses specifically on changing a client's eating-related behaviors and on modifying maladaptive cognitions related to weight and shape, the IPT approach avoids these topics and instead focuses almost exclusively on resolving problems in interpersonal relationships (Apple, 1999). While no research to date has identified the specific properties of IPT or CBT that might enable a counselor to make decisions regarding those particular clients that might benefit from one treatment over the other, best practices do suggest that IPT should be recommended for clients with pressing interpersonal or life transition problems (American Psychiatric Association, 2006). Further, because IPT offers some containment and structure without providing strong behavioral directives for change (Apple), it may be beneficial for clients who do not prefer the highly structured, homework-driven CBT approach or who are resistant to changing their eating behaviors at the outset of therapy. It may also be particularly helpful for women who have difficulties in their relationships but who may not realize it because they have been so focused upon trying to control their weight and shape. By taking the emphasis off of diets, binges, and appearance, members are able to explore the underlying problems that are driving the disorder.

As with any approach, there are several limitations. The first is lack of specific attention to the broader sociocultural context of women's lives as noted previously. It will be important for leaders to understand women's unique socialization experiences and to assist members in deconstructing the messages they have received regarding the prioritization of appearance and relationships. A second limitation is related to time constraints. The recommended 20-session model might be unrealistic for group leaders depending upon their work setting. The model requires that leaders have time to schedule a screening meeting, pre-group meeting, and follow-up meeting with each member. The manuals also recommend that leaders provide members with

treatment plans and weekly written summaries, all which require an additional time commitment. Third, some members might be frustrated with the relatively slow rate of symptom improvement and the lack of direct focus on changing disordered eating behaviors. As stated previously, leaders need to provide education throughout the group regarding the IPT rationale and also reassure clients when improvements in symptoms occur more slowly than expected.

A final limitation with the approach is that few studies have examined IPT effectiveness for clients with BN at different stages of recovery. Future research can further specify particular client characteristics that might be best matched with the IPT model versus the CBT approach. There are also few studies conducted for IPT with members of ethnic minority groups who experience disordered eating. This is generally because the numbers of ethnic minority clients with eating disorders included in treatment studies are generally too small to make conclusions about the differential impact of treatment. In one study comparing IPT and CBT that did analyze treatment differences by group, researchers found that while CBT was most effective in the overall sample, Black clients who received the IPT treatment showed better reductions in binge eating compared to those who received CBT. Based on small sample size ($n = 8$) no conclusions can be drawn from these findings, but is noteworthy that IPT has been shown to be effective for diverse client groups in other treatment outcome studies for disorders including depression (Chui, Safer, Bryson, Agras, & Wilson, 2007). It is clear that while the IPT–G model described in this article shows support as an evidence-based approach for working with women experiencing BN, more research is needed to extend the studies of Fairburn, Wilfley, and others. Despite its demonstrated effectiveness in previous outcome studies, IPT is not well-disseminated among mental health professionals. It is hoped that this article is a step in providing group counselors with information that will enable them to plan and lead effective IPT–G groups for women experiencing BN.

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