An Integration of Cognitive-Behavioral Therapy and Interpersonal Psychotherapy for Bulimia Nervosa: A Case Study Using the Case Formulation Method

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ABSTRACT
Objective: The current study provides an illustration of an integration of cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT) for the treatment of bulimia nervosa (BN), based on the case formulation strategy.

Method: A 25-year-old Hispanic female referred herself for the treatment of eating difficulties and depressed mood. Diagnostic criteria were met for BN, major depressive episode, and alcohol abuse. Components of both CBT and IPT were utilized throughout the course of treatment.

Results: CBT techniques appeared to be most effective in eliminating binge eating and binge drinking behavior, whereas IPT techniques seemed to be most effective in reducing purging behavior. Results revealed that the client was no longer experiencing clinically significant symptoms of BN, depression, or alcohol abuse at end of treatment and follow-up (18 months after treatment onset).

Discussion: Findings support the integration of CBT and IPT for the treatment of BN and, potentially, other eating disorders. © 2005 by Wiley Periodicals, Inc.

Keywords: bulimia nervosa; cognitive-behavioral psychotherapy; interpersonal psychotherapy

Introduction
Numerous therapy modalities exist for the treatment of bulimia nervosa (BN; Thompson, 2004). Although cognitive-behavioral therapy (CBT) appears to be the treatment of choice for BN (Pike, Devlin, & Loeb, 2004; Wilson & Pike, 2001), considerable evidence suggests that interpersonal psychotherapy (IPT) represents a comparable alternative, particularly with regard to long-term outcome (Tantleff-Dunn, Gokee-LaRose, & Peterson, 2004). Although integrative approaches for eating disorders have long been advocated (Thompson & Williams, 1987), few examples of the combined use of CBT and IPT appear in the literature. The current report describes a case wherein specific CBT and IPT strategies were selected and implemented based on a formulation of the specific factors relevant to the perpetuation of the eating disturbance (Persons, 1991). The case formulation strategy predicates selection of treatment on an assessment of client-specific factors hypothesized to maintain the disturbance and is a strategy also advocated by Fairburn, Cooper, and Shafran (2003) in their new transdiagnostic model. In the case below, we detail why specific CBT and IPT methods were chosen, how they were implemented, and the resulting outcome on symptoms.

Case History
Rebecca, a 25-year-old Hispanic female, referred herself for treatment of eating difficulties and depressed mood. At intake, she was 6 ft tall and weighed 150 lb (body mass index [BMI] = 20.3). She reported binging and inducing vomiting approximately once per week, and dated the onset of this behavior at 3 months before coming to therapy. She recalled that she had never had any concerns about her physical appearance until the time of her first romantic relationship at age 21. Apparently, her first boyfriend criticized her 175-lb (BMI = 23.7) physique and pressured her to lose weight, substantially affecting the way she viewed her body. At the end of this relationship, Rebecca felt disgusted with her appearance and decided...
that the only way to ensure success in her future relationships was to lose weight. An additional precipitating factor for her eating disturbance appeared to be graduation from college at age 22. Feeling that she had little control over the direction of her life, Rebecca restricted her eating behavior in an attempt to “have control over something” in her life. At one point, her body weight dropped to 135 lb (BMI = 18.3). Alarmed at her behavior, Rebecca moved to her hometown to be closer to her family and friends. She slightly increased her food intake and gradually gained weight, however, she remained unhappy and was determined to restrict her diet and modify her appearance. According to her report, Rebecca began to binge and vomit as a way to cope with her depression. To further manage her negative affect, she began drinking to intoxication two to three times per week. These binge drinking episodes often coincided with her episodes of binging/purging.

Assessment

The following assessment measures were used: the Drive for Thinness (DT), Bulimia (B), and Body Dissatisfaction subscales of the Eating Disorders Inventory-2 (EDI-II; Garner, 1991); the Structured Clinical Interview for DSM-IV Axis I Disorders-Clinical Version (SCID-CV; First, Spitzer, Gibbon, & Williams, 1997); the Personality Assessment Inventory (PAI; Morey, 1991); and the Beck Depression Inventory-2 (BDI-II; Beck, 1996). Results of the EDI-II indicated the following scores: DT (23), B (6), and BD (23). These scores are indicative of a level of drive for thinness and body dissatisfaction above the averages reported by Garner for eating-disordered samples (DT = 14.5; BD= 16.6) and a score on the B subscale about midway between the eating-disordered norms (10.5) and controls (1.2).

These results, coupled with Rebecca’s self-reported binging and purging behavior, were sufficient to warrant a diagnosis of BN as described in the 4th ed. of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). In addition, Rebecca reported symptoms of depression and alcohol abuse on the SCID-CV sufficient to meet diagnostic criteria for major depressive episode and alcohol abuse. Results of the PAI further suggested that Rebecca was experiencing clinically significant levels of depression and alcohol abuse. Her BDI score of 26 indicated a moderate level of depression.

Treatment

Stage 1

Behavioral outcome measures throughout the course of treatment are presented in Figure 1. The initial stage of treatment focused on the reduction of restrictive eating behavior and binge drinking through CBT techniques. To address the belief that eating on a regular basis would result in rapid weight gain, cognitive restructuring was employed (e.g., Pike et al., 2004). Furthermore, to reduce the incidence of drinking to intoxication, stimulus control and response cost strategies were instituted. These interventions resulted in the immediate cessation of self-reported binge eating/purging and binge drinking.

Stage 2

The goal of the second stage of treatment was to address Rebecca’s negative thoughts regarding the shape and appearance of her body. Using the CBT techniques pioneered by Cash and Hrabosky (2004), psychoeducational and behavioral strategies were employed. The psychoeducational component involved a discussion of societal definitions of beauty. The purpose of this discussion was to challenge Rebecca’s dysfunctional attitudes about attractiveness. Then, a desensitization strategy was enacted that required Rebecca to focus on a particular body part in the mirror on a daily basis. She was instructed to start with features of her appearance that elicited only mild anxiety. Once comfortable focusing on these features, she would progress to those that elicited increased levels of negative affect. Eventually, Rebecca would allocate time to each body part until more comfortable with her appearance. Stage 2 interventions resulted in the continued abstinence from binge eating/purging and binge drinking and self-reported improvements in body image.

FIGURE 1. Self-reported incidence of binge eating (gray bars), vomiting (black bars), and binge drinking (open bars). Stage 1 = 0–1 months; Stage 2 = 1–2 months; Stage 3 = 2–5 months; Stage 4 = 5–18 months.
Stage 3

Two months into treatment, Rebecca experienced relapses to binge eating/vomiting and binge drinking behavior. Thus, the primary aim of the third stage of treatment was to prevent future relapses. In addition to the ongoing use of strategies employed during Stages 1 and 2, CBT-based relapse prevention strategies were developed. These interventions were met with limited success. Although Rebecca stopped binge eating, she continued to vomit.

Stage 4

Examination of Rebecca’s purging behavior revealed that all episodes were preceded by interpersonal crises (e.g., the end of a romantic relationship). IPT is based on the notion that mental illness is strongly associated with interpersonal difficulties (Frank & Spanier, 1995; Tantleff-Dunn et al., 2004). Consequently, the primary focus of the fourth stage of treatment was to reduce purging behavior through IPT components.

Rebecca identified a pattern in her relationships she had not previously considered. Specifically, Rebecca stated she worried excessively about the future of her relationships. This worry inhibited her ability to form close bonds. Moreover, she asserted that her happiness was largely dependent on the status of her romantic relationships.

A strategy was devised to modify the nature of Rebecca’s relationships and interpersonal behavior. Specifically, Rebecca would approach her romantic relationships in a more casual manner, conceptualizing each as an opportunity to develop her interpersonal skills. Moreover, she would communicate her feelings of insecurity with her romantic partners in an attempt to elicit their support. According to her report, Rebecca experienced a decrease in anxiety with regard to her romantic relationships. This intervention was met with a gradual decrease and eventual cessation of purging behavior.

Follow-up Assessment

One-Year Follow-Up

A complete assessment was conducted during Stage 4, approximately 12 months into treatment. On the EDI-II, her scores had decreased by 30% on the DT subscale (from 23 to 16), by 9% on the BD subscale (from 23 to 21), and by 33% on the B scale (from 6 to 4). These findings, in addition to her self-reported vomiting behavior, resulted in the diagnosis of eating disorder not otherwise specified (EDNOS). The SCID-IV indicated that Rebecca was no longer experiencing symptoms of depression, alcohol abuse, or any other Axis I disorders sufficient to meet DSM-IV diagnostic criteria. Results of the PAI revealed that although Rebecca was no longer experiencing significant levels of depression and alcohol abuse, she reported significant interpersonal difficulty (as evidenced by an elevated score on the Borderline subscale). Her BDI score of 5 indicated a dramatic decrease in her depression level, from a score of 26 indicative of moderate depression to a minimal level of depressive symptoms.

End of Treatment (18 months)

Before termination of treatment at Month 18, a final assessment was conducted. Results of the EDI-II revealed continuing improvement for Rebecca: Her DT score was 12 (below the eating-disordered norm of 14.5), her B score was 0 (putting her below the average for controls), and her BD score was 14 (indicating a score at the mid point between the eating-disordered norm (16.6) and controls (12.2)). Overall, her EDI-II subscale changes represented a substantial improvement from the initial intake. Indeed, because Rebecca reported abstaining from vomiting for 3 months, no eating disorder diagnoses were made. Findings of the SCID-CV indicated that she was not experiencing symptoms sufficient to warrant any DSM-IV Axis I diagnosis. The PAI further revealed no significant psychological difficulties. Rebecca’s BDI score of 10 was a nonsignificant increase from the 12-month follow-up, keeping her in the minimal level of depression range according to Beck norms (Beck, 1996).

Discussion

The current case study has three important implications. First, the results lend support to the use of the case formulation approach in treating subjects with BN and other eating disorders. Adjusting the focus of treatment according to the needs of the client may represent a more effective means of addressing maladaptive behaviors than a standard or manual-based treatment. Second, the results suggest that an integration of both CBT and IPT may represent an effective treatment for BN and other eating disorders. Indeed, initial evidence supports the effectiveness of such an integration (Crafti, 2002; Nevonen, Broberg, Lindstrom, & Levin, 1999). Third, the positive effects of including a focus on interpersonal difficulties during the latter stages of our case adds support to Fairburn et al.’s (2003)
view that interpersonal difficulties may be one of four factors that operate with the core eating disturbance pathology to prevent a full resolution of eating disturbances. Future research should continue to explore the efficacy of CBT, IPT, and integrative CBT-IPT treatments with large samples of individuals with BN and other eating disorders.

References