

Interpersonal Psychotherapy: *An overview*

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Despite inclusion in Federal Government funded Medicare programs such as *Better Outcomes* and *Better Access* the profile of Interpersonal Psychotherapy (IPT) in teaching programs across Australia is low, and psychotherapists often know little about IPT other than it is evidence-based. This paper provides an overview of the structure and process of Interpersonal Psychotherapy. While there are more authoritative reviews on IPT, on the whole these reviews and IPT in general have not pervaded the psyche or reading of the average Australian psychotherapy practitioner.

Interpersonal Psychotherapy (IPT) is a time-limited, interpersonally focused, psychodynamically informed psychotherapy that has the goals of symptom relief and improving interpersonal functioning. IPT is concerned with the ‘*interpersonal context*’—the relational factors that predispose, precipitate and perpetuate the patient’s distress. Within IPT interpersonal relationships are the focus of therapeutic attention as the means to bring about change, with the aim of helping patients to improve their interpersonal relationships or change their expectations about them. In addition, the treatment also aims to assist patients to improve their social support network so that they can better manage their current interpersonal distress (Stuart & Robertson, 2003).

The history and evolution of IPT

From the late 1970’s American psychiatry turned its focus to evidence-based medicine, in particular the randomised control trial. The traditional clinical view was that most interventions seemed to work for depression. With the advent of antidepressant medications, and their apparent effectiveness in treating depression, it was necessary to

compare these with the established psychological therapies. The timeframe for the therapy ‘control’ treatment was determined by the research design, rather than being drawn from any evidence base. As such, the traditional assumption that IPT was of 16 weeks duration was based upon academic considerations, not clinical ones.

In order to standardise what seemed to comprise the elements of good psychotherapy, researchers led by Gerald Klerman devised a treatment that integrated what was thought to be the essence of medical psychotherapy and constructed a treatment programme that would fit neatly within a treatment trial. Klerman and colleagues believed that, given depression invariably had an impact on communication and interpersonal interactions, as well as consequences for the patient’s marriage, family, work and community activities, this was a worthy focus for psychotherapeutic intervention. The development of IPT therefore did not follow the conventional path of a theory leading to practice. However, several theories are considered influential in the development of IPT including the attachment theory of Bowlby and his successors, and communication theory

(Stuart & Robertson, 2003). Whilst IPT made no assumptions about aetiology of depression, the social risk factors for depression as identified by Brown and Harris (1978), Paykel, Weissman & Prusoff (1978), and Henderson (1988) also influenced the development of the approach.

IPT first appeared as the control treatment for studies investigating the efficacy of antidepressant medications (Klerman, Weissman, Rounsaville & Chevron, 1984). Like many serendipitous findings in science, IPT was found to be of comparable efficacy to medication in these studies and earned itself a place alongside Aaron Beck’s Cognitive Behaviour Therapy (CBT) as a credible candidate for investigation as an active treatment.

For many years IPT remained little known outside academic circles in the USA and Europe, unlike CBT. In the late 1990’s, there was an increased interest in IPT amongst clinicians. This culminated in the formation of the *International Society for IPT* (ISIPT) in 2000. Since that time, dissemination of IPT has increased momentum within some mental health circles. The recent inclusion of IPT in the focused psychological strategies for the Medicare funded *Better Outcomes*

in *Mental Health and Better Access to Mental Health* programs has resulted in increased exposure for and interest in IPT across Australia.

The structure of IPT

There are five distinct phases in the IPT approach; assessment, the initial sessions, middle sessions,

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termination sessions or conclusion of acute treatment, and maintenance sessions. In the assessment phase, the therapist completes a standard clinical interview and determines the suitability of IPT for the patient. If the patient is suitable the therapist proceeds through the initial sessions of IPT including socialising the patient to IPT, which is referred to as '*creating the IPT focus*', completing an interpersonal inventory, developing an interpersonal formulation and contracting the patient to a specific number of sessions. In the middle sessions, the therapist and patient address the relevant problem areas (ideally one but can be more more) using key IPT techniques. During the termination phase, or what is often referred to as the *conclusion of acute treatment phase*, the therapist and patient review progress in the problem areas and plan for future problems. Maintenance sessions can be conducted to prevent relapse or to work through any remaining problems, but only after a new contract is negotiated. The focus should remain on interpersonal issues and the short to mid term nature of IPT should be kept in mind. Each of these stages is now explained in more detail.

a. The initial assessment for IPT suitability

The 'assessment phase' of IPT determines whether the patient is a suitable candidate for IPT. Non-specific issues are considered such as suitability for any psychological intervention, motivation for change, ego strength, adequacy on non-psychological treatments, and so forth.

Stuart and Robertson (2003) suggest that the following characteristics can increase the likelihood that patients will benefit from IPT:

- a relatively secure attachment style;
- the ability to relate a coherent narrative of their interpersonal network and specific interpersonal interactions;

- a specific interpersonal focus for distress;
 - a good social support system.
- Perhaps the most critical judgement is whether the IPT intervention

resonates with the patient's view of their psychological distress. The assessment phase ends with a treatment contract with the patient to proceed with a specific number of IPT sessions and to work on one or more specific interpersonal problems.

b. The initial sessions

The initial sessions of IPT include a number of specific tasks. The primary goals are to develop an interpersonal formulation, which is a detailed hypothesis about why the patient is having interpersonal difficulties, and to gauge the patient's social support in general. The interpersonal formulation is a modification of Engel's Biopsychosocial model, integrating the four IPT problem areas. Intrinsic to this process is the development of an *Interpersonal Inventory* (IPI).

The IPI functions as the main



Illustration: Savina Hopkins

structural component of this process with a specific focus of the patient and therapist on:

- 1) current relationships;
- 2) the history of the patient's current problems as applied to that relationship;
- 3) information that is relevant to the process of resolving the problem area, for example attachment style, communication style, and patterns of interaction;
- 4) setting appropriate treatment goals. (See Figure 1.)

With the completion of the interpersonal inventory, an interpersonal focus is formulated using the four IPT problem areas.

c. *The middle sessions*

In the middle sessions of IPT the therapist and patient address one or more of the four IPT problem areas using key IPT techniques. Whilst working on these issues the therapist is mindful of the patient's attachment style and communication style. In general, after identifying specific problems during the assessment and initial phases, the therapist gathers more information about the specific problem area(s). Both patient and therapist then work to develop solutions to the problem, such as improving the patient's communication skills or modifying his or her expectations about a dispute. A suitable solution is selected, and the patient attempts to implement it between sessions. In subsequent sessions the patient and therapist work to refine the solution(s) and implement these accordingly. The four problem areas and a number of key IPT techniques are outlined later.

d. *Concluding acute treatment and maintenance treatment*

Rather than using the traditional psychoanalytic model in which 'termination' is a severing of the therapeutic relationship, in IPT, the provision of acute treatment comes to an end as specified by the therapeutic contract. This does not necessarily signify the end of the therapeutic relationship. It is often agreed that the patient and therapist will have further therapeutic contacts via a new negotiated contract.

The specific goals at the conclusion

of treatment are to foster the patient's independent functioning and to enhance his or her sense of competence. Ideally, IPT teaches patients new communication skills, helps them to develop insight into how they communicate their needs, and helps them to establish more functional social support networks, all in the service of improving interpersonal functioning. The therapist should review the progress made in therapy, and give as much positive feedback to the patient as is genuinely possible. A review of the problems identified in the Interpersonal Inventory and progress in dealing with these, as well as reviewing associated symptomatic improvement should be conducted. A summary of the positive changes that the patient has made in improving his or her communication and in developing an improved social support network should also be undertaken. Credit for change should be ascribed primarily to the patient. Although the therapist has served as a 'coach,' the patient has done the difficult work and has implemented the changes discussed.

IPT should be conceptualised as a two-phase treatment, in which a more intense acute phase of treatment

focuses on resolution of immediate symptoms, and a subsequent maintenance phase follows with the goal of preventing relapse and maintaining productive interpersonal functioning. In addition to being supported by theory, research, and experience, this model also fits well with current clinical best practice.

In clinical practice, IPT can be seen to follow a family practice or general practitioner model of care, in which short-term treatment for an acute problem or stressor is provided until the problem is resolved. Once resolved the therapeutic relationship is not terminated. As with a general practitioner, the therapist makes him or herself available to the patient should another crisis occur, at which time another time-limited course of treatment is undertaken. In the interim, the therapist may want, in the same fashion as the general practitioner, to provide periodic maintenance sessions.

The conclusion of acute treatment is a mutually negotiated and agreed ending of intense intervention. This includes a review of the patient's progress in resolving the interpersonal problems first identified in the

Interpersonal Inventory

Bill (Husband)

- Married 6 years (together 9)
- Wanted a baby
- Used to communicate well
- Talked about it before she got preg.
- Seemed committed

PROBLEMS

- Won't talk
- Gets angry whe confronted
- (nb she reports very hostile interactions)
- Won't contribute
- Seems to hide in work

EXPECTATIONS

- Wants him to keep his word (To be a father)
- 'Equal Time'
- Less hostile in communicating

COMMUNICATION – seems not to communicate point clearly

PROB SOLVING – Previously present

Figure 1. The interpersonal inventory is a register of all key current relationships. It can be a semi-structured set of notes in a file, or a specific document, depending upon clinician preference

interpersonal inventory, planning for future problems that may arise in the problem area, and anticipating the emergence of new interpersonal problems. The patient's responses to the end of acute treatment should be discussed in order to prevent the potential of symptom intensification, and to emphasise to the patient that the therapeutic relationship has been a successful experience for the patient.

A new contract for maintenance sessions should be negotiated if indicated and if both parties are able to continue. When a patient's symptoms are recurrent or unresolved, maintenance sessions can be contracted, usually at a less frequent interval to monitor interpersonal problems and further develop interpersonal skills as required. This must be a structured and predetermined course of treatment, similar to how the initial phase of treatment was structured.

The IPT problem areas

Within the four problem areas, interpersonal processes are made more understandable for the patient. The four IPT problem areas are

- *grief*,
- *interpersonal disputes* (role disputes),
- *role transitions*,
- *interpersonal sensitivity* (interpersonal deficits).

Psychosocial stressors from any of the problem areas can lead to psychological distress or psychiatric syndromes, in particular when combined with an attachment disruption in the context of a poor social support network.

Interpersonal disputes

Interpersonal disputes (initially known as *role disputes*) should be selected as a problem area when overt or covert disputes are contributing to the patient's problems or illness. Disputes are often covert as patients fail to mention disputes that are too painful, or they think are unsolvable such as many disputes within families. As a consequence, these covert disputes may only become obvious during a thorough assessment. Examples of disputes according to Stuart and Robertson (2003) include the following:

- *overtly hostile conflict*, e.g., domestic violence, verbal abuse,
- *betrayals*, e.g., infidelity, impropriety, conflicting loyalties within a family,
- *disappointment*, e.g., unmet expectations at work or school,
- *inhibited conflicts*, e.g., anger at a partner's illness or disability (p.168).

Attachment theory speculates that disruptions in an individual's intimate attachments, such as those caused by interpersonal disputes, make vulnerable individuals more likely to suffer psychological distress. (Stuart & Robertson, 2003). Most minor disagreements are usually resolved

patient move on from the relationship, and undergo a role transition (Stuart & Robertson, 2003).

Intervention in interpersonal disputes in IPT involves enhancement of communication of attachment needs and problem solving styles, and modifying expectations on the part of the patient.

Role transitions

Adaptation to change is at the core of adaptation to life. All interpersonal relations occur in a complex psychosocial setting and individuals experience these relationships consistently within that

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by individuals over time and do not constitute significant stressors in their lives. Interpersonal disputes are of clinical significance when their resolution is beyond the patient.

Interpersonal disputes can present as acutely distressing, smouldering and persistent or as a relationship in dissolution. Ultimately, IPT intervenes in disputes by assisting the patient to revisit the process of resolving the dispute or helping the patient move towards an acceptable dissolution of the relationship.

In order for this process to occur, the therapist must understand the 'state of play' in the dispute. In IPT this is achieved by staging the dispute. Disputes are identified as one of three stages: *negotiation* where there are ongoing attempts by both parties to bring about change; *impasse* which implies that the attempts at resolving the dispute have stalled and communication efforts to resolve the dispute and associated affect are less likely to be occurring; and *dissolution* when the process is at such an advanced stage that the goal of interventions in IPT is to help the

setting. Though some transitions, such as loss of health may be seen as wholly negative by the patient, most change involves elements that are perceived as good and bad. In IPT, role transitions are assumed to be a focus of treatment when the patient develops psychological distress in the context of change. Invariably, the change is experienced as a loss.

Like interpersonal disputes, role transitions are varied in their nature. Examples according to Stuart and Robertson (2003: 184) include:

- *situational role transitions*, e.g., job loss, promotion, graduation, migration.
- *relationship role transitions*, e.g., marriage, divorce, step-parenthood.
- *illness related role transition*, e.g., diagnosis of chronic illness, adaptation to pain or physical limitations.
- *post-event role transition*, e.g., post-traumatic symptoms, refugee status.

Interventions in role transitions aspire to help the patient to:

- 1) define the old role and new role in a balanced and realistic way that is more acceptable to the patient.

- 2) accept the emotional component of the loss of the 'old role' and the perceived challenges of the 'new role'.
- 3) develop and implement skills and attitudes that overcome the perceived challenges of the 'new role'.

Grief

At some stage in the life cycle we all experience grief and loss. This process can be complicated by a variety of factors that necessitate grief-oriented therapy to navigate a path toward completion of the process. Many authors have theorised about the intrapsychic processes that mediate an individual's progress through grief and loss, and many share a view that the human being who suffers loss progresses through a myriad of emotional responses including sadness, despair, anger, and anxiety, and ultimately progresses to initiate new interests and relationships to replace the relationship that has been lost (Stuart & Robertson, 2003).

In IPT, grief is considered to be relevant as a complicated bereavement. The basic tasks of working with grief in IPT according to Stuart and Robertson (2003) are:

- 1) diagnosing grief as a problem area;
- 2) clarification of the circumstances of the loss;
- 3) linking the timing of the loss to the onset of symptoms;
- 4) helping the patient accept painful affect associated with the loss;
- 5) helping the patient communicate the loss to others;
- 6) recreating the relationship with the deceased;
- 7) helping the patient utilise existing social supports and develop new attachments.

Interpersonal deficits/sensitivity

The IPT problem area of interpersonal sensitivity relates to a difficulty in forming and maintaining relationships that often results in loneliness and social isolation. The consequent impoverished social support network leads to interpersonal problems, and often psychiatric problems such as depression due to attachment needs not being met. This is particularly likely if a social stressor occurs such as a transition or death.

Attempts at improving one's social supports are often frustrated by poor communication and relationship skills.

In the original descriptions of IPT, the term interpersonal 'deficits' was used (Klerman et al., 1984). Deficits can be seen as pejorative term and therefore the term 'sensitivity' has been suggested as an alternative by Stuart and Robertson (2003).

Interpersonal sensitivity is manifested in many ways. This includes patients who report having few friends, and repeated relationship failures or conflict with others. Patient behaviour during sessions is also a clinical marker of sensitivity including passivity and hostility toward the therapist. A difficulty in forming a relationship with the therapist may also indicate interpersonal sensitivity.

Whilst the true nature of interpersonal sensitivity is a pervasive process ingrained in the patient, IPT seeks to intervene by helping the patient resolve a current interpersonal stressor. The scope of possible intervention in a structured and focal treatment in the process is most effective if it is limited to an acute or current problem. By nature, the patient with interpersonal sensitivity will have known no different in their life experience. On this basis, attempts to elaborate and alter a complex problem in such a focus may serve to further reinforce the patient's pervasive sense of failure in relationships. A focus on the manifestations of interpersonal sensitivity in a current interpersonal problem in the 'here-and-now', will enable the patient and therapist to crystallise the patient's interpersonal difficulties in an accessible and meaningful way.

IPT helps reduce the patient's isolation and assist in their expansion of social repertoire via the following interventions according to Stuart and Robertson (2003: 216):

- 1) optimising the patient's current relationship functioning;
- 2) helping the patient establish new supportive relationships;
- 3) resolving the patient's acute interpersonal stressor.

The process involves the therapist in a review of old relationships, current relationships and the relationship with the therapist to obtain a better

understanding of relationship patterns that assist and impede the formation and maintenance of relationships. The therapist aims to optimise the functioning of current relationships through assisting the client to reconnect with old relationships and form new relationships. The therapy relationship can serve as a modelling experience for the patient who proceeds through the stages of forming and maintaining a relationship, and then managing the evolution and termination of the relationship with the therapist. At a fundamental level this relationship acts as a secure base for the patient to form and maintain other relationships.

IPT techniques

IPT therapists should be proficient in basic micro-counselling and psychotherapy skills. Additionally, there are a number of specific techniques that are central to the success of IPT, although not unique to IPT. This includes non-directive and directive exploration, clarification, encouragement of affect, communication analysis, role play, problem solving (or decision analysis), and the therapeutic relationship (Stuart & Robertson, 2003). Three key techniques are briefly outlined below.

The therapeutic relationship

In IPT the establishment of a productive therapeutic alliance is more important than any technique. A basic tenet of IPT is that all interventions should be therapeutic and should enhance the alliance. Of course, the IPT therapist needs to draw boundaries when necessary and to be active and directive as required, as it is a structured therapy. There is effectively a balance between activity and active listening (Weissman et al., 2007). Furthermore, the therapeutic relationship is not viewed in terms of transference in that difficulties within the therapeutic relationship are addressed in the here and now in terms of the clients' wider interpersonal network, rather than being about a past relationship. For example, if a client is angry about the therapist running late, the client is encouraged to express this in a way that enhances their existing interpersonal skills, and there is an exploration of how the anger and its

expression may affect relationships within their wider interpersonal network.

The therapeutic relationship can be used in IPT as a means to gather information, and as a means of attending to the patient's attachment needs and helping them to experience a successful relationship. The therapist can use the relationship indirectly as a means to bring about therapeutic change, for example modeling different communication patterns. Most importantly, the therapeutic relationship provides the safe background against which change may occur.

Encouragement of affect

This technique is used to help patients express, understand and manage affect (Weissman et al., 2007). According to Stuart and Robertson (2003, 125) there are several goals regarding the use of affect in IPT:

- 1) to assist the patient to recognise his or her immediate affect;
- 2) to assist the patient to communicate his or her affect more effectively to others;
- 3) to facilitate the patient's recognition of affect that may have been suppressed, or that the patient may find painful to acknowledge.

Of particular importance is the therapist's attention to and facilitation of *'process affect'*—affect displayed during the conduct of therapy—as opposed to *'content affect'*—affect about past events or interactions outside of the therapeutic relationship (Stuart & Robertson, 2003). This can serve to increase the patient's awareness of feelings they may be unaware of such as anger or guilt. The therapist also encourages patients to express a range of feelings during sessions and explores with them how these feelings can be expressed safely outside of sessions to resolve disputes and enhance their interpersonal network.

Communication analysis

Disordered communication is hypothesised to be a primary reason for interpersonal problems. In particular, the therapist is attuned to ambiguous and indirect verbal and non-verbal communication that could be changed to more direct, less ambiguous verbal communication (Weissman et al., 2007). Recent incidents and past

incidents of note are explored in some detail to detect these difficulties and to explore alternate and more effective ways of communicating. The detail is required to offset what are often biased accounts by patients who typically put the blame on the other party, or in more self-deprecating patients who put excessive blame on themselves. Sources of information also include in-session communication with the therapist and collateral information from other sources. Communication analysis often leads on to other techniques such as problem solving and role-play. In terms of change the therapist may also serve as a role model for communication.

The overall goals of communication analysis according to Stuart and Robertson (2003) are:

- identify communication patterns and responses elicited from others;
- identify the client's contribution to communication problems;
- motivate the client to communicate more effectively;
- learn new and more effective skills.

The case of Brendan

Brendan is a 22 year old referred by his GP for psychological therapy under Medicare. He presented with a range of depressive symptoms that had lasted for 3-4 years. He added that the symptoms had worsened over the last three months. These symptoms include depressed mood, poor concentration, lethargy, reduced appetite, sleep disturbance, and suicidal ideation with no intent or plan. He reported recently having two weeks off work due to depression. He had seen a number of practitioners in the past including his GP, psychiatrists, and naturopaths. In the past he had tried numerous medications and reported that he gained some temporary or mild relief. He was on Zoloft 100mg and reported a moderate level of improvement. He had never sought psychotherapy or counselling until now. He couldn't offer a reason why this was. There was no psychiatric/psychological history prior to the onset of his depression and no family psychiatric history.

Brendan was uncertain what triggered his depression but thinks it might be to do with difficulties at work. He is a carpenter and had difficulties with the way his supervisor talked to him. He still worked with

the supervisor and avoided him as much as possible. He reported that he had always been quiet at work and had never been 'one of the boys'. He enjoyed his work and says he couldn't imagine doing anything else.

Outside of work Brendan had one good friend who he had known since primary school. They saw each other once a fortnight because of his friend's new girlfriend. They usually went to the local tavern or nightclub. At school he had friends but they were never that close. He hadn't had a girlfriend for several years. He reported that he felt 'uncertain' around girls and found it hard to know what to talk to them about. He enjoyed fishing, running and playing computer games.

His mother died two years ago due to cancer. He reported that he thought that he was over it because he hadn't felt sadness for a long time, and then said he still felt upset when he heard information about cancer on TV. Sometimes he questioned whether life was worth living without his mother as they were very close. He had occasional contact with his father, but acknowledged that they were never as close as he was with his mother. His father had been more distant since the death of his mother. He had one brother who was older and because he lived in another state they only have occasional contact but enjoy each other's company when they do. He stated *'we get on great but sometimes we argue and I don't like arguments'*.

He used cannabis occasionally, but only if he went to a party or social event. He enjoyed a beer but didn't drink alone and never more than six mid strength beers. No significant medical history. At interview Brendan was pleasant, cooperative, smiled, had normal eye gazing but didn't say a lot unless you talk about an area of interest like football or fishing, and had depressed mood and restricted affect to a mild degree. He did not have an autism spectrum disorder.

IPT treatment intervention

Following an initial assessment including a standard clinical interview Brendan was diagnosed with a major depressive disorder, in partial remission. Various treatment options were considered and IPT was chosen primarily because of the evidence base

for depression and the interpersonal context for his presenting problems i.e., the difficulties with the supervisor, death of his mother, and impoverished social network. These are conceptualised within IPT as an interpersonal dispute, grief, and interpersonal sensitivity respectively. During the initial sessions an interpersonal inventory was completed including obtaining further information about key relationships with his parents, brother, best friends, and past friendships including girlfriends. The therapist was of the opinion that his attachment style was 'insecure avoidant'. He was contracted for an initial set of 12 sessions with the initial seven sessions being weekly, and then tapered to fortnightly for the next three sessions and the last two sessions being monthly. A formulation regarding his symptoms and contributing factors was presented at the initial session that served to 'create the IPT focus'. He was informed that the sessions would address the three problem areas relevant for him, and the focus would not be on symptoms specifically or on major points of intervention in other therapies such as cognition or the unconscious. The role of patient and therapist were also discussed.

Therapy then progressed into the middle sessions where the three problem areas were addressed directly whilst the therapist was mindful of Brendan's insecure attachment style, and that he was quite introverted. The decision to address the dispute with his supervisor first was made collaboratively based on the immediacy of the dispute. The therapist also believed that Brendan would need time to feel comfortable with therapy and the therapeutic relationship before he could address the more emotive issue of the death of his mother. Each session began with a check in with the aim of linking his mood with interpersonal events. During the middle sessions the therapist elicited affect from Brendan as required, whilst also attending to the therapeutic relationship. A core goal of IPT is to generate solutions to the problem areas and, with this in mind, solutions were generated on how to address his supervisor's behaviour. This involved assisting him to communicate his needs to the supervisor, but only once his expectations of the supervisor

and the potential solutions were reviewed. The review indicated that his supervisor's behaviour was not personal to Brendan. This was elicited via the technique of communication analysis. Nevertheless Brendan wanted to be more assertive with his supervisor. The therapist and Brendan brainstormed ways of doing this and practiced what to say and different scenarios using the technique of role-play. Once the dispute was addressed the therapy then progressed to the problem area of grief.

The link between the development of his depressive symptoms and the ill health and death of his mother was made explicit. He was asked to describe the sequence of events related to her illness and death. He was then encouraged to 'recreate' his relationship with his mother. The full spectrum of process affect was elicited, not just acceptable affect such as sadness. In particular, he expressed anger and guilt regarding her death, two emotions he had not acknowledged before.

Therapy then proceeded to utilise new and existing social supports and develop new interests to improve his interpersonal functioning and life in general. This dovetailed well in to the problem area of sensitivity. Brendan wanted to develop new confidantes and he therefore sought to develop a stronger relationship with a maternal aunt and a family friend. He also started socialising more with some of the quieter men from work and joined a weekly pool tournament at a local tavern. Whilst he was anxious and distant at first he was starting to relax more at these events. There were girls involved and he was also starting to talk to them more often. He felt confident that many of the girls had similar interests to him. He also 'made friends' with his best friend's girlfriend so he wasn't alienated from his best friend's life. Brendan acknowledged that he was unlikely to attempt these activities without the knowledge that he could count on the therapist for support and guidance. The therapist considered this to be analogous to the 'secure base' function of the patient-therapist relationship.

Once the problem areas were addressed effectively, the therapy proceeded into the termination sessions. This included traditional

termination interventions such as relapse prevention, as well as planning for future interpersonal issues that arose, and recognising the interpersonal competencies that Brendan had established. The opportunity to discuss feelings about the termination of sessions was provided to prevent symptom intensification or other maladaptive forms of communicating concerns or discomfort with regard to termination. Brendan advised that he would miss the sessions as he enjoyed having someone to talk to openly, but he felt ready to put more emphasis on his new and developing relationships. He was advised that maintenance sessions were available should he relapse.

IPT research

Although IPT was developed in the 1970s, it came to prominence in the *National Institute of Mental Health Treatment of Depression Collaborative Research Program* (Elkin et al., 1989). This was a multi-centre study of over 250 depressed adults who were assigned randomly to one of four treatments: IPT, cognitive-behavioural therapy, imipramine, and placebo ('clinical management'). Amongst more severely depressed patients, IPT was comparable to imipramine on several outcome measures, and had a mean outcome better than placebo. Subsequent re-analysis of the data also concluded that IPT was superior to placebo, and superior to CBT for the severely depressed group. Two subsequent studies have reinforced the efficacy of IPT for major depression, although the most recent study has suggested that CBT was superior to IPT for severe depression (Luty et al., 2007). This study also suggested that patients with anxious and avoidant personalities perform better with CBT than IPT (Joyce et al., 2007).

Since the NIMH study, IPT has been adapted for the treatment of a range of conditions and the evidence base has continued to develop. IPT has demonstrated efficacy for bulimia nervosa (Fairburn et al., 1991), group therapy application (Wilfley et al., 2002), as a maintenance treatment for depression in old age (Reynolds et al., 1999), and as a maintenance treatment for recurrent major depression (Frank, 1991; Frank et al., 2007). Applications

of IPT have also been developed for a range of other conditions and either have demonstrated effectiveness or are being studied currently. This includes depression in adolescence, dysthymic disorder, social anxiety disorder, and borderline personality disorder (Weissman et al., 2007)

The inclusion of IPT in the focused psychological strategies for the *Better Outcome and Better Access* programs funded by Medicare is an acknowledgment of the value of the evidence base. Suggestions for further research include the optimal dosage and duration of sessions, identifying the 'active components' of IPT, and exploring who would benefit most from IPT in terms of how the patient explains the cause of their symptoms.

Why IPT?

There are many reasons why psychotherapists should consider IPT as a therapy worth learning more about and adding to their clinical expertise. This includes the following:

- a well documented evidence base as outlined above;
- IPT's minimal use of jargon and manualised format allows the therapist with good basic psychotherapy skills and experience to quickly become competent;
- the approach is modified easily for a range of conditions whilst still following the same evidence based format;
- the approach is intuitively appealing for many therapists especially for presentations related to grief and relationship problems;
- IPT is likely to be applicable to patients with a wide range of problems, as almost all illnesses involve interpersonal problems;
- it is important that practitioners are familiar with a variety of empirically based treatments.
- It is pure speculation as to why the uptake of IPT has been lower than other therapies such as CBT. Two possibilities include the following:
- the dominant paradigm of psychology training programs and the self-help movement has been on internal cognition, in contrast to the emphasis of IPT on interpersonal functioning and affect. This has resulted in the

potential complimentary nature of IPT with cognitive focused therapies being overlooked in favour of their competing differences, and at first glance IPT being viewed as 'counterintuitive'.

- Consistent with the above point, despite the evidence base of IPT it has been taught rarely in university settings, thereby preventing the dissemination of the modality to a broader audience. This in turn has led to a dearth of trainers and supervisors that frustrates many practitioners' attempts to receive supervision or advanced training in IPT. This is especially the case in Australia.

Further training in IPT

Training and accreditation standards in IPT have been a key concern for the International Society of IPT. Draft guidelines for level A to D certification were established but consensus was never reached. However, there is a general acknowledgment that an experienced psychotherapist can reach basic competency by completing an introductory workshop of 2-3 days duration, reading a manual, and then completing 2-3 supervised cases with an experienced IPT therapist including weekly supervision for the duration of the case with audiotaped or videotaped sessions. Becoming an IPT practitioner involves taking basic psychotherapy training and modifying it for use with a specific set of strategies and problem areas (Weissman et al, 2007). One study showed that selected, experienced psychotherapists can perform IPT competently at a high level after as little as one supervised case (Rounsaville et al., 1986). Competency should not be confused with specialisation or being recognised as an expert or at trainer level. In Australia there are difficulties obtaining the relevant training and supervision because of the small number of experienced IPT practitioners. Further information regarding training can be obtained from the *International Society of IPT* website www.interpersonalpsychotherapy.org.

Conclusion

IPT stands in contrast to other therapies through an emphasis on the effects of a person's external interpersonal environment upon their

mental health. There are sufficient clinical trials to conclude that IPT is an efficacious time limited treatment for a range of conditions, in particular, depression and bulimia. The structured and manualised format of IPT makes it relatively easy to learn and apply. Further research is required for different treatment durations, to establish the active components, and to determine minimum training standards. Nevertheless the research to date highlights its bona fides and supports its place alongside CBT within the Medicare funded focused psychological strategies.

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