Introduction to Interpersonal Psychotherapy
Healing with a Relational Focus

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DISCLOSURES

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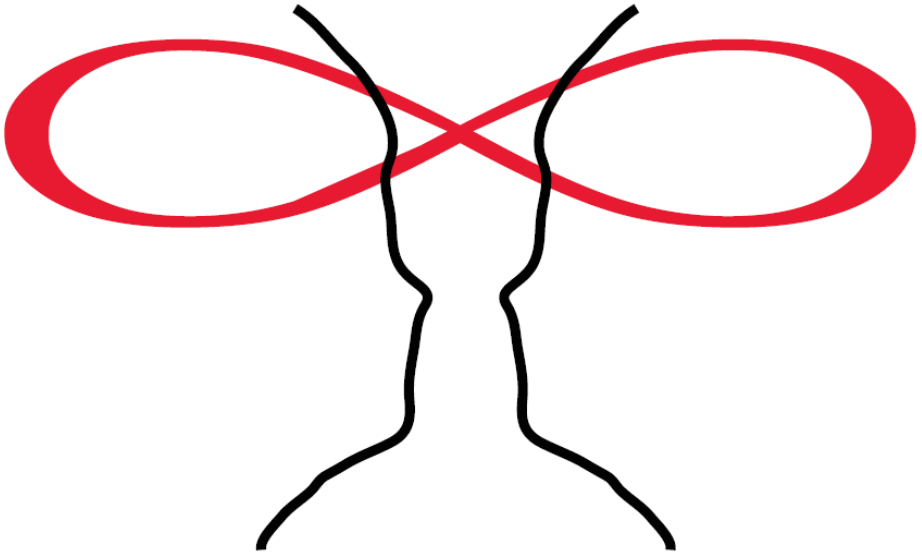
www.interpersonalpsychotherapy.org

Therapist Factors That Improve Clinical Outcomes

Therapeutic Relationship Elements	Clinical Effectiveness
• **Alliance** • **Empathy** • **Collecting patient feedback**	• Demonstrably effective
• **Goal consensus** • **Collaboration** • **Positive regard**	• Probably effective
• **Congruence/genuineness** • **Repairing alliance ruptures** • **Managing counter-transference**	• Promising

Norcross (2011), CanMAT Guidelines (2016)

What are the key therapist factors that improve clinical outcomes



The practice of psychotherapy "requires all the intuition, imagination and empathy of which we are capable. But it also requires a firm grasp of what the patient's problems are and what we are trying to do" John Bowlby

Learning Objectives
Using IPT and a Relational Lens

- Improve therapeutic effectiveness with depressed patients using IPT
- Attend to social roles, losses, changes, disputes and communication in relationships
- Help patients to identify and connect with supportive persons in their recovery

COMMUNICATION ANALYSIS: *An IPT strategy to foster reflection & work on interpersonal problems*

IPT is clinically relevant, culturally adaptable & effective across the life-span

Evidence-based, in consensus guidelines

- Acute & enduring effects

Theoretically grounded

FIGURE 1. Effects of Interpersonal Psychotherapy for Depression Compared With Control Conditions[a]

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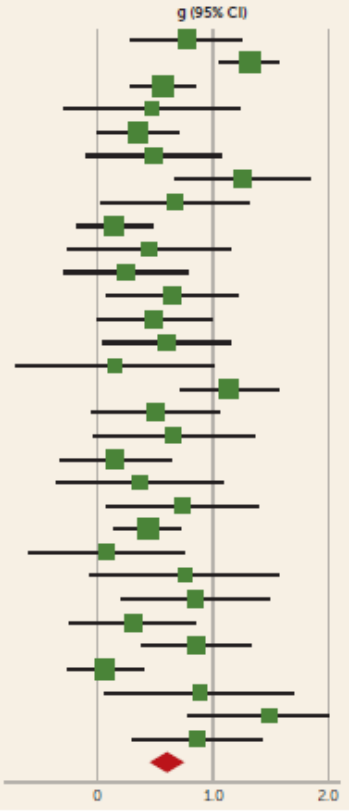
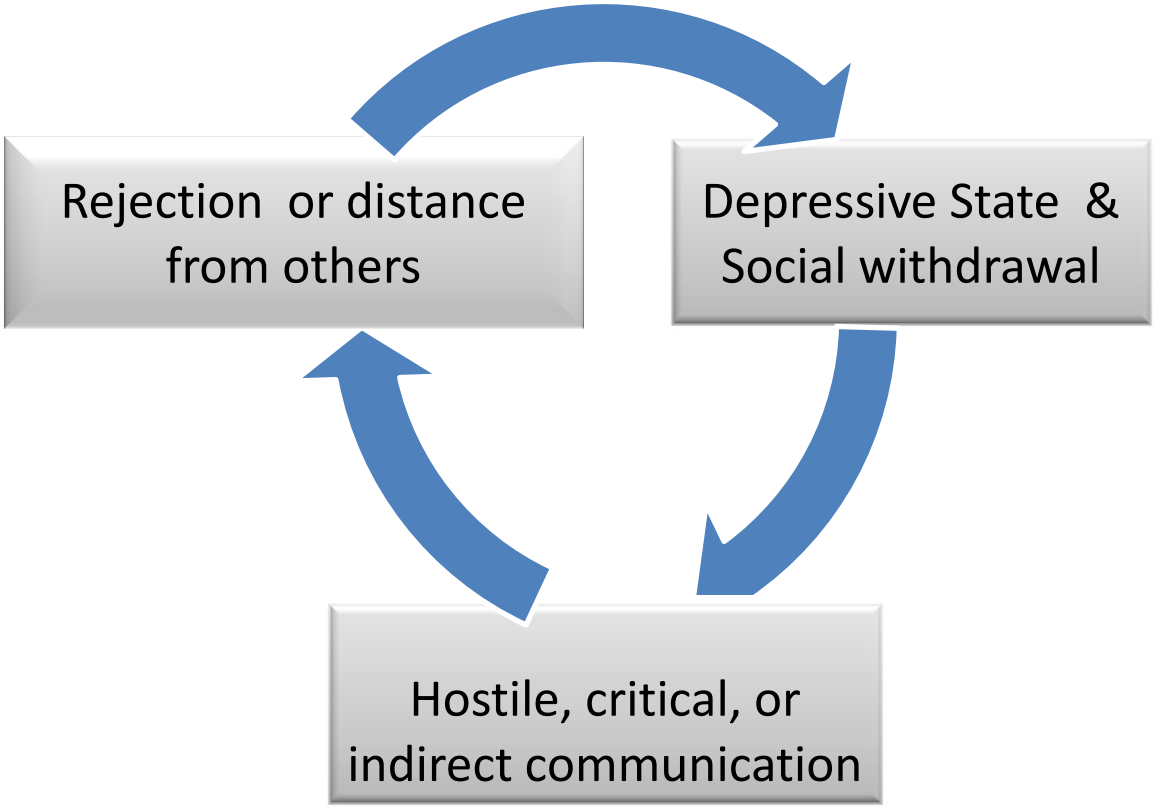


[a] The full study citations can be viewed in Appendix B in the data supplement accompanying the online version of this article. Hedges' g number needed to treat (NNT) for pooled effect size=3.05.

Depressogenic Cycles

Bidirectional Impacts of Depression & Interpersonal Experiences



When depressed, people can unwittingly evoke interpersonal distance, resulting in feeling disempowered, & perpetuating isolation and despair

Goals

- Remit symptoms & improve functioning
- Work through triggering, current interpersonal problems
- Engage with useful social supports with attention to communication

Indications

- **Depression** across the lifespan - adolescence to late life
- **Bipolar Disorder** (IPSRT) with mood stabilzing Rx to delay relapse
- **Binge Eating Disorder** (group)

…emerging evidence for **PTSD** and other disorders

IPT: 12*-16 Sessions, 3 Phases

Initial (first1-3 sessions)

Form an alliance, assess, interpersonal inventory, the ‘sick role’, instill hope, choose focus with agreement on goals

Middle sessions

Affect- and interpersonally-focused on experiences of grief, role transitions, role disputes that are associated with symptoms

Ending (final 1-2 sessions or discharge)

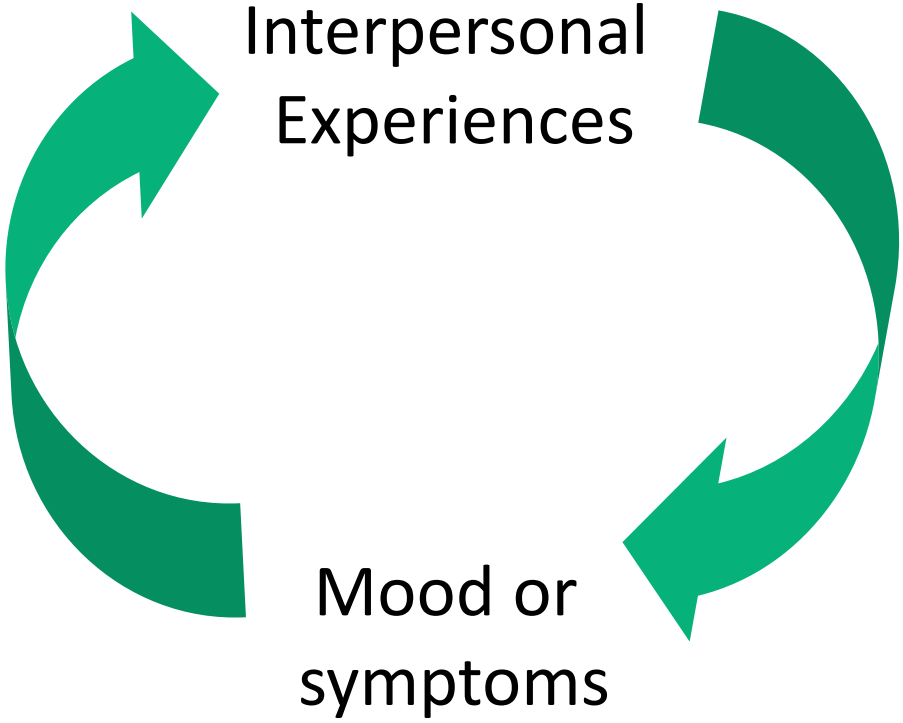
Review changes/gains & contingency plan in event of recurrence - a ‘good goodbye’

IPT Tasks

***Why now?* - Link symptoms & interpersonal events**	• Clarify associated, triggering problems
***'Who' ?s* - Identify people who help or hinder in patient's life**	• Connect w/ or repair useful social supports
Work through *interpersonal problems*	• Reflecting & problem solving

Throughout, at every session, link mood or symptoms to interpersonal interactions or life events.

Track symptoms/functioning/progress



*Homework: Notice & bring material in, as participant-observer

INITIAL PHASE: SESSIONS #1-3

- Establish therapeutic alliance with agreement on treatment goals
- Elicit the history of presenting illness
  - symptoms & context, why now?
- Psychoeducation about: depression (the "Sick Role") & IPT, instilling hope
- **Interpersonal inventory** ~ 2 sessions
- Formulate an ***interpersonal focus***

Cultural Sensitivity

Explore

Meaning of illness & symptoms

Care traditions, pathways & expectations

Kleinman

-

Adopt a not-knowing, mentalizing stance

"All psychotherapy is cross-cultural, as even a clinician & a patient from similar sociodemographic backgrounds may have widely differing constructs of MH, relationships, and indeed of the psychotherapeutic process itself… [cultural sensitivity is needed] to achieve the alliance, attunement and collaboration necessary for a positive treatment response."

Watson & Raju 2016

Psychoeducation about depression & the idea of the “sick role”

- Removes blame from the patient; destigmatizes
- Conveys hope (problem is well understood & treatable)
- Normalizes the problem (e.g. 1 in 5)
- Clarifies expectation that the patient will actively work to change

The Closeness Circle

Gathering the Interpersonal Inventory (sessions 2-3)

Who: are the important people in your life; do you confide in; confides in you; raised you?

Can you tell me about them?

Can you give me an example ?

[Opportunity for greater detail in middle phase; many right ways; aim for breadth in beginning; notice affect & lapses in narrative coherence.]

Types of Support

Practical

those who help with specific tasks but with whom there might not be sharing of more personal experiences

Social or community-based

those who have shared interests or values but aren't necessarily close friendships

Trusted confidantes

with whom feelings and more personal experiences can be shared.

Collaboratively Select the IPT Focus

After gathering the history of present illness *and* interpersonal inventory, reflect on which life events & relationships are:

- affectively charged &
- chronologically connected to the onset or worsening
- accepted by the patient

Ask the patient first!

1. **Stay on FOCUS, affectively guided**, link symptoms to focal area, use common factors (empathy, alliance) & monitor progress/outcomes
2. Help patients to engage social supports
3. Reflect on relationships & communication with brainstorming, role plays, problem solving & decisional analysis

MIDDLE PHASE

IPT: relationally focused, affectively guided

*Social Roles, *Social Supports, *Communication

Grief	• Bereavement
Role Transitions	• Adapt to life changes
Disputes	• Explore expectations & improve communication
Social Deficits; Interpersonal Sensitivity	• Decrease social isolation

IPT focus on Grief is selected when…

-Onset of current symptoms is temporally linked to the death of a significant other

-Often the patient displays emotion (verbally or non-verbally) or loses narrative coherence when talking about a lost significant other

-Significant sustained functional impairment & severe symptoms (e.g. neglecting self-care & suicidal ideation)

IPT Strategies: Grief

1. Recall sequence of events (before, during and after the death) & traditional bereavement practices

2. Reconstruct memories & emotions related to the lost other & the relationship

- Positive, idealized and negative (anger, ambivalence, sadness, guilt, regret)

3. Moving forward, explore ways to become involved with others and process associated feelings

Social Roles & Role Transitions

Multiple social roles are held by us all, that inevitably change over time

Developmental, vocational, social, biological

Planned/wanted or unplanned/unwanted

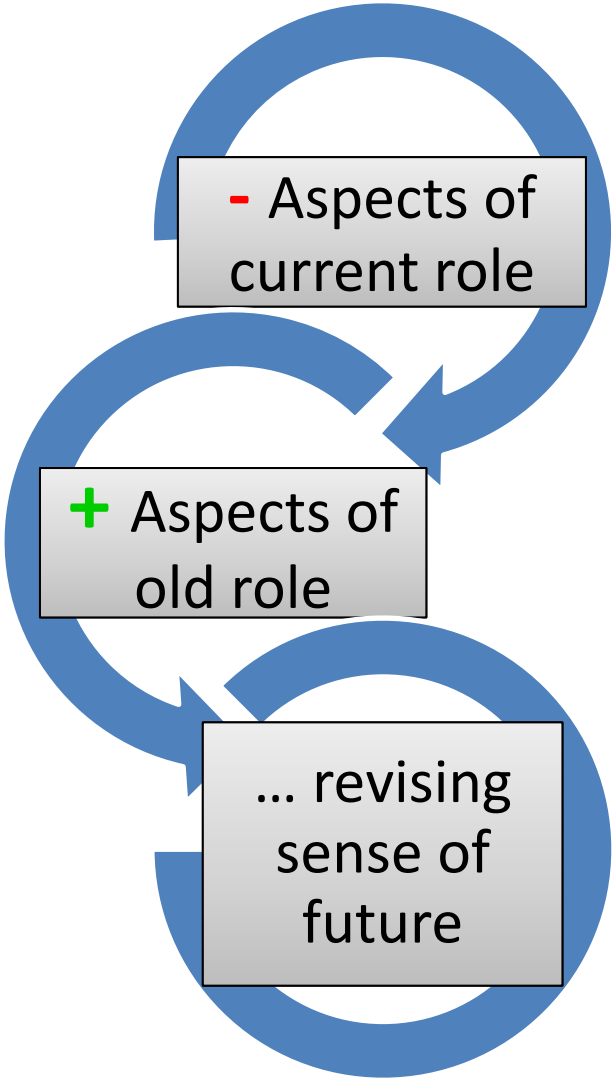
"What's changed? What do you miss?"

Link social role transition & depressive symptoms

Validate and explore what a patient misses, or struggles with in the context of their life change & social role transition

Even changes that might be considered positive, can be associated with depression.

Reflecting on challenges & opportunities helps patients to become *unstuck.*



Role Disputes

Non-reciprocal role expectations or values between patient and an important person in his/her life (e.g. romantic partner, parent-child, close friend, employer-employee)…overt or covert

- Communication problems
- Empathic failures
- Differences may or may not be reconcilable

Screen for domestic violence

Relationship problems that contribute to disputes

- Differing (or unrealistic) **expectations +/or** differing **values** (i.e. around child rearing)
- **Empathic or mentalizing failures** – poor understanding, perspective or inadequate response to the needs of one another.
- **Communication problems:** Patients may inadvertently contribute to the problem and inadvertently 'author what they dread instead of authoring what they wish'

Differences may or may not be reconcilable

Dispute Resolution Processes

<u>Impasse</u>

not talking, need to warm

<u>Renegotiations</u>

arguing/not listening,

need to cool

<u>Dissolution</u>

role transition to separate

- ↑disharmony; stir things up; open negotiations
- Calm down the participants to facilitate conflict resolution
- Adapt to the loss of the relationship, recruit or build supports

Disputes – Strategies/Tasks

1. Link disputes & depressive symptoms
2. Explore the relationship in greater depth
3. Identify core issues in disagreement
4. Explore communication to facilitate empathic understanding of reasonable & realistic expectations to bring about resolution (?misunderstanding ?mentalizing ?limitations of others)

If at cold impasse, then heat things up

If in heated arguments, then cool things down

Communication Analysis

A Win-Win Situation for Mood & Relationships

Explore affectively laden interchanges - feelings, expectations, understanding, intentions & interpersonal impacts, communication (in detail)

Imaginal or real role plays can generate empathy and ideas for alternative interactions with modified understanding & expectations to improve interpersonal outcomes (and symptoms)

Communication Analysis

Explore details of a recent, emotionally-charged interaction & link to interpersonal problem area.

Unpack

What did you say? How did they respond?

How did that make you feel? How did you respond?

Explore

What did you want him/her to understand?

Expectations: of self & other; realistic? reasonable?
Perspectives & understanding

Brainstorm for a future interaction

COMMUNICATION ANALYSIS

Explore an upsetting conversation, foster reflection & link to interpersonal problem area

WHEN THE THERAPIST CANNOT LOCATE TRIGGERING LIFE EVENTS IN THE HISTORY

INTERPERSONAL DEFICITS

Problems establishing or sustaining intimate relationships

(may have history of developmental trauma or severe disruption of important early relationships)

- Social isolation – lacking relationships w friends or at work, longstanding difficulties in development of close relationships
- Unfulfilling relationships – chronic low esteem despite seeming popularity or vocational success
- Persistent Depressive Disorder, Social Anxiety

Therapeutic Approach

Review past significant relationships, positive & negative

Tend to the therapeutic alliance.

Explore patterns , positive aspects & difficulties in these relationships. Discuss feelings, positive & negative about current relationships including with the therapist.

Interpersonal behavioral activation to decrease social isolation - *“How can you find friends & activities like those you used to enjoy in the past or new ones that you might enjoy?”*

[Foster Mentalizing]

Termination Phase
Concluding Treatment

An opportunity to engage in a healthy separation from a relationship that has usefully served its purpose

Joyce, Piper, Ogrodniczuk & Klein '07

Tasks of Termination - a *good goodbye*

-Reflect on goals, experience of & changes in treatment

-Emphasize patient's competence & gains

-Strategies to manage anticipated stressors

-Highlight supports & confidantes

-Feelings about ending (sadness v. MDD)

-Contingency plan in the event of relapse

-Wish them well…

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Review

For whom does interpersonal psychotherapy work? A systematic review

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HIGHLIGHTS

- Interpersonal psychotherapy (IPT) effectively treats depression and other disorders.
- It remains unknown which patients will benefit from IPT versus another treatment.
- Relatively few moderators have replicated across trials of IPT.
- A handful of patient characteristics may predict better or worse response to IPT.
- Obstacles to identifying moderators and possible remedies are discussed.

ARTICLE INFO

Keywords:
Interpersonal psychotherapy
Moderator
Aptitude-treatment interaction
Personalized medicine

ABSTRACT

The efficacy of interpersonal psychotherapy (IPT) to treat depression and other disorders is well established, yet it remains unknown which patients will benefit more from IPT than another treatment. This review summarizes 46 years of clinical trial research on patient characteristics that moderate the relative efficacy of IPT vs. different treatments. Across 57 studies from 33 trials comparing IPT to pharmacotherapy, another psychotherapy, or control, there were few consistent indicators of when IPT would be more or less effective than another treatment. However, IPT may be superior to school counseling for adolescents with elevated interpersonal conflict, and to minimal controls for patients with severe depression. Cognitive-behavioral therapy may outpace IPT for patients with avoidant personality disorder symptoms. There was some preliminary evidence that IPT is more beneficial than alternatives for patients in some age groups, African-American patients, and patients in an index episode of depression. The included studies suffered from several limitations and high risk of Type I and II error. Obstacles that may explain the difficulty in identifying consistent moderators, including low statistical power and heterogeneity in samples and treatments, are discussed. Possible remedies include within-subjects designs, manipulation of single treatment ingredients, and strategies for increasing power such as improving measurement.

If IPT is failing to help, formulate what more, or else is needed; consider extending. For those whom have recovered and have a history of recurrent or persistent depression, once monthly follow up is recommended to reduce relapse risk.

IPT: relationally focused, affectively guided

*Social Roles, *Social Supports, *Communication

Grief	• The death & relationship with lost loved one; Ways to move on
Role Transitions	• What's changed & is 'lost'; Challenges & opportunities of new role
Disputes	• The relationship & 'issues' of disagreement; Communication, non-shared expectations & understanding
Social Deficits; Interpersonal Sensitivity	• Review past & current relationships; decrease social isolation

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Join the Psychotherapy Practice Research Network:
www.med.uottawa.ca/pprnet/eng/index.html

Join the International Society of IPT:
www.interpersonalpsychotherapy.org

WHAT HAS COME TO MIND?
QUESTIONS, COMMENTS?

Interpersonal Psychotherapy (IPT) - for depression & mood disorders

This report summarizes the rationale, evidentiary support and clinical applications of IPT as a structured, evidence-supported psychotherapy depression and mood disorder treatment

Depression is a leading cause of disability and suffering (1, 2), thus there is an imperative to find ways to address it (3-6). National consensus depression treatment guidelines include Interpersonal Psychotherapy (IPT) and Cognitive Behavioural Therapy (CBT) in Canada (7),the World Health Organization(8), and other countries. It is imperative that Ontarians are offered a plurality of evidence-supported structured psychotherapies, because no one treatment (including differing medications or CBT) works for all patients. Improved access to IPT is needed in light of its effectiveness, low drop-out rates, and high levels of patient satisfaction. Training and scaling up of IPT is feasible in community-based clinical settings, and can translate into improved patient outcomes(9).

Interpersonal Psychotherapy (IPT) is a structured, time-limited psychotherapy with a strong evidentiary base of numerous randomized controlled trials over the past >30 years, and meta-analyses supporting its effectiveness most strongly as a depression treatment for diverse patients across the life span from adolescence to late life (10, 11). The therapeutic focus of IPT on relationships and interpersonal stressors of life changes, social role transitions, disputes, grief, and interpersonal sensitivity resonates with universal human experiences of suffering and the central role of relationships in health and well-being. IPT focuses on triggering stressful relational experiences with an emphasis on social roles, social supports and communication (12). IPT is in consensus treatment guidelines for depression and mood disorders, including as combined with pharmacotherapy to delay bipolar and depression relapse (8, 13). Its clinical applications include depression, eating disorders, bipolar disorder, anxiety disorders, post-traumatic stress disorder, and other psychiatric conditions across the lifespan in varied treatment settings.

In the IPT model, there is a focus on social roles, close relationships, the need for social supports (14), and bi-directional impacts of distressing symptoms and interpersonal stressors, compounded by loneliness and interpersonal sensitivity that can be amplified by states of mental illness (15, 16). Studies demonstrate interactions between depression and social stressors (17), and the importance of relationships for mental health. Poor social supports, insecure attachment, and adverse childhood and adult experiences of interpersonal trauma increase vulnerability and risk for mental illness, stress reactivity, substance misuse disorders, poor health and maladaptive patterns of relating (18-20); thus supporting the rationale for a psychotherapy that is rooted in the centrality of relationships and the gene-x-environment etiological interactions of psychiatric illnesses (21, 22).

Both CBT and IPT differ from long-term, open-ended psychodynamic psychotherapy in their time-limited duration, diagnostic treatment target – to decrease symptoms of a psychiatric disorder, focus on conscious aspects of current experiences more than early childhood and subconscious aspects of experience, and scientific support for their efficacy. IPT focuses on associations between stressful interpersonal life events and symptoms (23), whereas CBT focuses on the links between thoughts, feelings and behaviours. In light of their orthogonally distinct and differing foci, but similar formats of dose and delivery as talking therapies, numerous RCT comparisons have been conducted [e.g. (3-6)] with equal efficacy established in meta-analyses over time (10, 11, 24). *It is critically important for patients to have access to more than one of the structured, evidence-supported depression psychotherapies; just as it is important to have differing pharmacotherapy options to optimize population health since no one treatment works for all.*

The evidence: RCTs and controlled trials have established IPT as an effective treatment for depression across the lifespan in adolescence (5, 25, 26), the perinatal period (27, 28), mid-adulthood (10, 24), and late-life adulthood (29) . A recent trans-diagnostic meta-analysis of IPT for mental health problems

identified 90 RCTs that met inclusion criteria, of which 60 were depression studies, with an overall moderate-to-large effect size (30, 31) [see Figure 1, from Cuijpers et al. 2016]. For adolescents, mid-life adults, and women in the perinatal period, IPT can be used as a monotherapy. For patients with late-life depression, at high risk of relapse, a combination of medication and IPT is needed to sustain remission (32). IPT has also been effective for subclinical depression (33) and dysthymia (34), recognized as public health concerns (35) with significant suffering, disability and costs (33, 36, 37). For dysthymia, medication is more effective than IPT; however a combination of medication and IPT is more cost effective (36). For patients with a history of recurrent, chronic depression, medication is recommended; however even low dose, once monthly maintenance IPT can delay relapse (4). A subset of patients with a history of early onset and recurrent depressive episodes will develop bipolar disorder; and IPT, adapted for this clinical population has been shown to be helpful as an adjunct to medication, to increase the time between episodes of illness for patients with Bipolar I Disorder(38), and Bipolar II depression (39).

IPT for depressed individuals seropositive for HIV was found to be superior to CBT and supportive psychotherapy(40). Even in the face of existential and non-modifiable circumstances, such as living with chronic co-morbid medical illnesses, depression is treatable with IPT. A Ugandan study of Group IPT was amongst the first of large task-shifting trials that established feasibility and effectiveness of a structured psychotherapy in a low income, non-Western country(33). This set the stage for subsequent IPT studies with culturally diverse, underserved clinical populations, including in other low-and-middle-income (LAMIC) settings (33, 41, 42). Pragmatic depression studies of IPT have been conducted demonstrating efficacy with culturally diverse, underserved and socioeconomically disadvantaged clinical populations in North America (43-45), primary care (43, 46), non-psychiatric medical services (e.g. obstetrics clinics) and a growing range of settings, in schools (26), prisons (47), community-based, and inpatient settings. IPT can be effectively provided in differing formats, in-person, and by telephone, in briefer doses (<12 sessions), with a range of providers from mental health specialists to trained lay health workers. With good numbers of well-conducted outcome studies, meta-analyses have been conducted and effect sizes calculated (24, 48-60). IPT, with decades of comparisons is equally effective to CBT, feasible and acceptable in under-resourced community based settings in differing cultures. Dating to the historic multi-site Treatment of Depression Collaborative Research Program (TDCRP) in 1989 (3), over100 IPT controlled randomized, efficacy, and effectiveness trials have been conducted with clinical populations across the life span from adolescence to late-life adulthood (24, 61). For treatment and prevention of depression in adolescents, efficacy and effectiveness trials strongly support its use (5, 26, 62-64). Moderator analyses attempted to unravel the question of "what works best for whom," to guide personalized prescribing of differing psychotherapies according to differing patient characteristics (e.g. expectancy, preference, personality characteristics, perfectionism, or severity of symptoms), therapist, patient-therapist dyadic processes of the therapeutic alliance, model specific differences, and fidelity (65, 66) . The therapeutic alliance and therapist effects consistently predict outcomes, regardless of treatment, even for patients receiving pharmacotherapy in supportive care (67). For patients with severe, chronic or recurrent episodes of depression, medication in combination with psychotherapy is recommended (68). As above mentioned, studies and meta-analyses of IPT and CBT have established their equal efficacy as depression treatments (51).

In addition to the standard dose of IPT (12-16 sessions), brief, lower dose versions of IPT, "Interpersonal Counseling" (IPC – 3-8 sessions) (69, 70) and "Brief IPT" (IPT-B, 8 sessions with a pre-treatment engagement assessment) (71) are effective for non-treatment and culturally diverse patients in need, outside of academic specialized mental health clinics, such as in primary care with nurse practitioners, in shopping centres with free childcare provided, integrated with obstetrics care (72) and in community-based low-and-middle income country (LAMIC) rural settings(33). Task-shifting of care providers from mental health specialists to trained and clinically supervised health workers of differing professions has been tested in numerous LAMIC-based IPT trials, to address the gaps between the need for, and access to mental health care [for example, (73-75)].

In conclusion, with decades of research establishing IPT as an effective treatment for mental illnesses that addresses a core aspect of health-promoting experience through its focus on the centrality of relationships, in wellbeing, disease, vulnerability, recovery and resilience, there is a strong rationale to support its dissemination and improved access to patients in need. IPT provides an evidence-supported depression treatment option for culturally diverse clinical populations in need of care, across the life span, including those who are non-treatment seeking. No treatment works for all people including pharmacotherapies; thus it is essential that more than one structured psychotherapy be available to Ontarians. The World Health Organization has long included IPT in its mhGAP guidelines (8), and recently published a Group IPT manual (76), with another manual on Interpersonal Counselling that is in press. IPT is an effective and scalable treatment for numerous psychiatric disorders, especially depression across the lifespan in differing settings including rural and urban primary and community-based clinics and schools. In closing, there is strong support of IPT as a depression treatment and it is hoped that this summary of the rationale and research may help to advance improved access by Ontarians through policy reform and funding.

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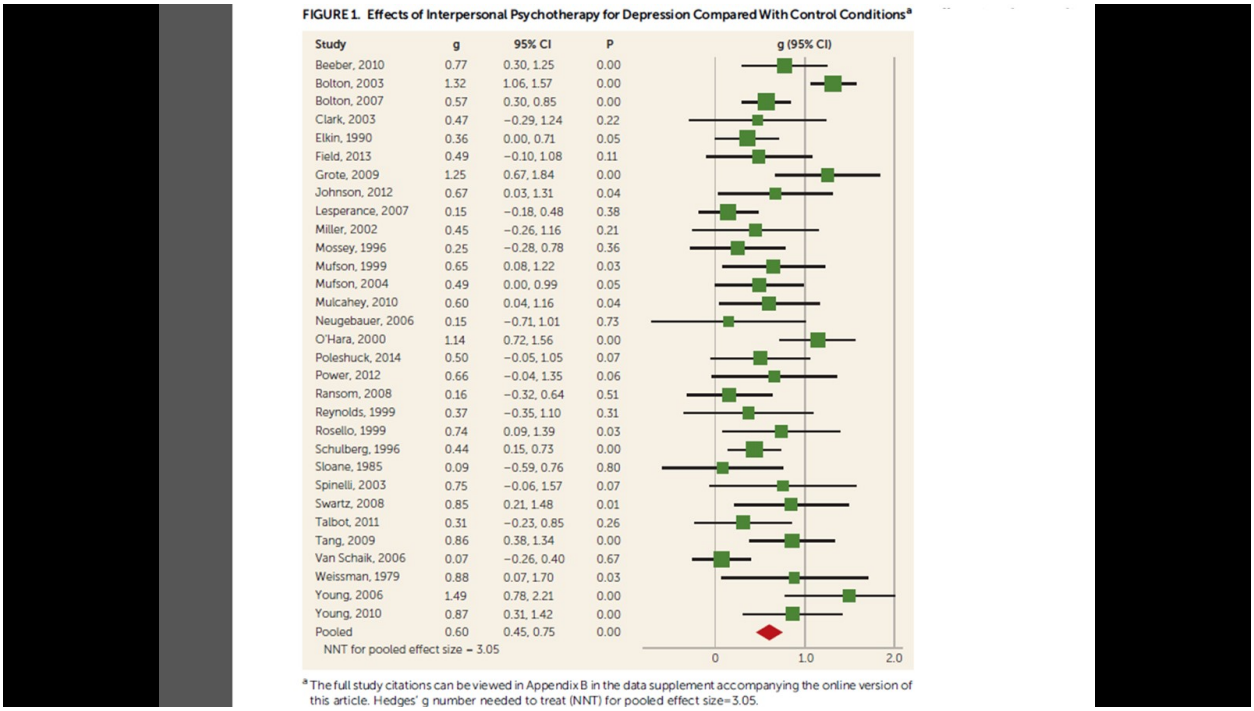

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[a] The full study citations can be viewed in Appendix B in the data supplement accompanying the online version of this article. Hedges' g number needed to treat (NNT) for pooled effect size=3.05.

From: Cuijpers et al., Interpersonal psychotherapy for mental health problems: A comprehensive meta-analysis 2016

IPT for Depression and Mood Disorders: A partial list of RCTs	
Life Stage; Clinical Population	**Authors (citations)**
Adolescent Depression	Mufson (5, 26); Young (62, 63)
Perinatal Depression	O'Hara(27); Spinelli(44, 77) ; Grote (43, 45)
Midlife adult Depression and Dysthymia	Elkin(3); Frank (78); Menchetti(70); Browne (36); Markowitz (55, 79)
Late life adult Depression	Reynolds (32)
Depression w/ comorbid anxiety, cardiac disease, HIV	Cyranowski (80); Lesperance (81); Markowitz (40)
Bipolar I Disorder & Bipolar II Depression	Frank(38, 82); Swartz (39)

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