

Evidence-Based Psychotherapies

The Interpersonal Fulcrum— Interpersonal Therapy for Treatment of Depression

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Interpersonal Psychotherapy (IPT), a time-limited, manualized psychotherapy, was first designed for the treatment of individuals with nonbipolar, nonpsychotic major depression (1). Currently, the Canadian and American Psychiatric Associations recommend IPT as a treatment for depression (2,3). Empirical evidence supporting its efficacy has grown since its early use, as has the breadth of its clinical application (4,5). This article reviews the principles and objectives of this type of treatment along with the relevant research supporting its efficacy. The model is briefly described, and the phases of therapy and the focal interpersonal strategies are discussed.

Klerman, Weissman and others (1,4) emphasized the scientific core of psychotherapy by articulating IPT in a research context and establishing its efficacy with empirical data. However, its practice remains an art (1,4,5). Bowlby commented that 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” (6, p 57). In IPT, we focus on the patient’s problems of depression and interpersonal distress. Psychiatric illness occurs in a social context with interpersonal antecedents and consequences. While recognizing the role of biological and psychological factors in the causation of and vulnerability to psychiatric problems, IPT focuses on social factors and current interpersonal problems. The treatment goal of IPT—what we are trying to do—is to alleviate patients’ symptoms with specific focus on interpersonal relationships as a point of intervention (1,2,5) (Figure 1).

The Interpersonal Fulcrum

Patients can experience depression when relationships are disrupted or unsatisfying (1,4–8). Once suffering from depression, patients often become more disengaged from their social network and develop a sense of helplessness

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Figure 1 IPT for depression

Suitability Criteria

Nonpsychotic, nonbipolar major depression in which the onset is associated with life events

Goals of Treatment

To remit depression, alleviate interpersonal distress, and assist patients to build or better utilize social supports

Those who are less likely to be helped by a time-limited, structured treatment include patients with a history of severe and complex trauma and those with profound disturbances in personality functioning (5, p. 42)

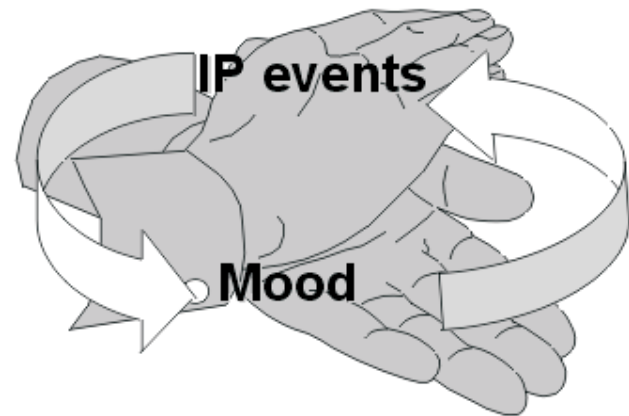
(9–11). This in turn can perpetuate isolation and passivity in individuals already suffering from depression. The goals for such patients are to help them break this cycle so that they can selectively and more effectively engage interpersonally in a way that bolsters their connections, affiliation, and sense of agency with their social environment.

IPT focuses on interpersonal (1,2,6) rather than intrapsychic or cognitive aspects of depression; it uses the biopsychosocial model (12) that frames depression as a medical illness occurring in a social context. Grounded in interpersonal theory (6,7,9,10) and the belief in the central importance of relationships for survival and adaptation (6,8), IPT integrates biological and psychosocial approaches into a practical, present-oriented and effective treatment (Figure 2). Stemming from the works of Sullivan and Bowlby, IPT places its emphasis on the relational aspects of individual experience (1,4). Stuart, Robertson and others (6,13,14) expanded and integrated psychological theories of attachment and interpersonal communication in their research and application of IPT.

Stuart and Robertson state that, “psychological problems occur, and interpersonal relationships break down, when an individual’s needs for attachment are not being met.

Figure 2 What is Interpersonal Therapy?

- **Focused, time-limited psychotherapy: 12 to 16 weekly, 1 hour sessions aimed at goals of symptom alleviation and improved social functioning**
- **Builds on empirical findings that interpersonal (IP) issues are linked to depressed mood and that depression impairs interpersonal functioning**
- **IPT uses the interpersonal context of depression as a pragmatic treatment; recognizes roles of genetic, biochemical, developmental and personality factors in causation and vulnerability**



This can occur both when the individual cannot effectively communicate his or her needs to others and when his or her social support network is incapable of responding adequately to his or her needs.” (5, p 16) Attachment theory proposes that relationships are both adaptive and crucial for survival (6,8). Bowlby described different types of attachment: secure and insecure. Securely attached individuals usually have had sufficient positive early relational experiences and are able to trust others. Insecurely attached individuals often have a history of parental misattunement, neglect or abuse in their significant relationships. These early attachment paradigms become “internal working models” that guide the individual’s relational perceptions, expectations and behaviours. Maladaptive patterns of communication can result from insecure attachment and interfere with contemporary relationships. Although it is not realistic to expect to change an internal working model of relationships or attachment style in a brief therapy, one of the tasks of IPT is to help patients communicate their needs and emotions more effectively. This can result in a positive experience of current needs being met, of interpersonal mastery and of differentiation—what was true then and there is not necessarily so here and now. IPT aims to help patients evaluate expectations and improve communication in current relationships.

Kiesler’s contemporary interpersonal communications theory (10) also springs from Sullivan and Bowlby’s work; it offers a helpful way to further understand and examine interpersonal forces and communication. Kiesler conceptualizes interpersonal patterns of “circular causality,” in which individuals continually affect and are affected by others through their interactions. When relationship problems occur, they can be exacerbated by an automatic, rigid style of communicating that pulls inadvertent, unwished for responses from others (10, p. 238).

In IPT, the therapist closely examines communication and tries to help patients to expand their interpersonal repertoire of behaviours, balancing selective affiliation, interpersonal flexibility and a sharing of responsibility in their current relationships.

What Happens in a Course of IPT for Treatment of Depression?

Beginning Phase

The therapy has three phases. In the beginning (sessions 1 to 3), a psychiatric assessment focuses on interpersonal relationships to assess suitability and establish the focus of the therapy. The need for medication is evaluated and depression is discussed as a medical illness in a social context, with interpersonal antecedents and sequelae. The focal problem areas are derived from research on the determinants of health and disease. This research has demonstrated the protective function of interpersonal support (15,16), as well as the associations between interpersonal adversity and depression (17–21). The focus of therapy is determined according to the current interpersonal problems that appear to be most related to the onset and perpetuation of the individual’s current depressive episode. The goals are then explained to the patient: to remit depression and to help resolve the selected interpersonal problem area(s), thereby instilling positive expectations. With more complex patients or patients with severe and chronic depression, combined treatment with medication is often recommended (1,4,22).

Middle Phase and the Focal Problem Areas

IPT focal areas guide therapeutic interventions through the middle phase of therapy, linking symptoms and affect to interpersonal events, losses, changes or isolation. Klerman, Weissman, and others (1,4) offer direct content guidelines to frame life experiences into four main focal

Figure 3 The interpersonal focal areas

- **Interpersonal Disputes—Non-reciprocal role expectations with a significant other**
- **Role Transitions—Life changes leading to a change in one’s interpersonal role and sense of self in a new context**
- **Grief—Prolonged, complicated bereavement**
- **Interpersonal Deficits—Paucity of supports; Absence of life events; Interpersonal sensitivity**

areas: inter- personal disputes, role transitions, bereavement and interpersonal deficits. In addition to focusing on specific goals, throughout its course the therapy highlights interpersonal patterns linked with dysphoric mood. Relationship expectations and communication are examined to develop social supports and a more effective interpersonal behavioural repertoire, in which empathic responsiveness and clearer expression of emotions and needs are encouraged (Figure 3).

Interpersonal Disputes. These are defined as “nonreciprocal role expectations” with significant others (for example, a marital dispute) and are often accompanied by poor communication or misaligned interpersonal expectations. During the course of therapy, behaviour patterns are often revealed in which the patient interacts with significant others in such a way as to inadvertently exacerbate conflicts through acts of commission or omission. Different ways of understanding and communicating within relationships are explored to facilitate more satisfactory interpersonal relatedness. In some instances, patients will decide to end relationships, and the focus of the therapy then shifts to role transition.

Role Transitions. These involve life events that lead to significant interpersonal changes. Examples might include becoming a new parent, moving, changing jobs, ending a relationship or adjusting to a loss of functioning. The tasks of the therapy involve systematically exploring both positive and negative aspects of the old role in addition to examining the challenges and opportunities of the new role.

Bereavement. This focus is chosen in IPT when the onset of major depressive disorder coincides with the death, or an anniversary event related to the death, of a significant other. Ambivalence is typical in these relationships, yet the lost other is sometimes idealized. Therapy facilitates grieving and examination of the relationship’s positive and negative aspects to achieve a more realistic view of the lost loved one. In the latter stages of the treatment, patients are encouraged to replace aspects of what was lost in the relationship and begin to move forward in their lives.

Interpersonal Deficits. This final focal area is chosen when specific life events coinciding with the onset of the depression are absent, particularly for individuals who have difficulty forming or sustaining relationships. These patients are often interpersonally hypersensitive (5, p. 209,18). Since they have few relationships in their social network, the therapeutic relationship can be used to build social skills through role plays.

Ending Therapy

In the concluding, or termination, phase of IPT, therapeutic gains are reviewed and consolidated along with contingency planning in the event of a recurrence of depression. Normative sadness is differentiated from clinical depression, and the feelings associated with the ending of therapy are openly discussed. In the spirit of not leaving things unsaid as the therapy comes to an end, this is opportunity for a “good goodbye” and for exchange of honest feedback. If the therapy has failed to achieve the goals of remitting the depression, one might contract to extend the course of treatment or re-evaluate it and suggest sequencing with a different form of treatment. In research protocols for acute major depression, the course of treatment is usually 12 to 16 once-weekly sessions; however, some authors suggest a tapering schedule and maintenance monthly sessions, especially for individuals with chronic or recurrent depression (4,5,23).

The Evidence

An undeniable strength of IPT is the evidence supporting its efficacy. Positive expectations predict better therapy outcomes, and IPT research shows encouraging results. As clinicians, we can confidently recommend IPT for treatment of major depressive disorder. Most randomized controlled trials of IPT focus on its efficacy as a treatment for depression. Research focusing on its effectiveness and applicability to other psychiatric conditions is still in its infancy, as is research examining the mechanisms underlying this approach. For a comprehensive review of IPT research, the reader is directed to Weissman, Markowitz and Klerman (4) or Stuart and Robertson (5).

The National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH-TDCRP, 24), still regarded as the gold standard for psychotherapy efficacy research, catalyzed the development of IPT. The NIMH-TDCRP compared IPT, CBT, imipramine and a placebo—clinical management arm for the treatment of patients with major depression. IPT was found to be superior to placebo and equal to CBT and

imipramine for mild-to-moderate depression. There was some evidence that IPT was superior to CBT for individuals with severe depression (25). IPT has since been found to be an effective treatment for depression patients from adolescence (26) to late life (27), for women with postpartum depression (28,29) and for patients with medical comorbidity (30,31). As well, group IPT has recently been tested in a large randomized controlled trial for patients in Uganda with major depression or sub-syndromal depression and found to be highly efficacious (32). For patients with recurrent depression in the continuation and maintenance phases of treatment, "low-dose," once-monthly maintenance IPT can reduce relapse rates and prolong periods between depressive episodes (23,33). IPT has also been found moderately beneficial for patients with dysthymia (34,35). The model has been adapted for other populations, including patients with eating disorders (36,37), social anxiety (38) and bipolar disorder (39).

Clinical Dissemination and Training Opportunities

The clinical dissemination of IPT has been slower than its research development. As a clinical intervention, it is becoming more widely used, especially in Europe, Australia and, increasingly, in Canada. IPT is included in many Canadian postgraduate psychiatry residency training programs: opportunities exist for continuing education (CE) courses through McMaster University, University of Ottawa and University of Toronto, and at the Canadian and American Psychiatric Association meetings. As well, the International Society of Interpersonal Therapists is hosting a conference in June 2004 in Pittsburgh, Pennsylvania, at which time both basic and advanced training in adaptations to the model will be offered (see www.interpersonalpsychotherapy.org). To acquire clinical competency in IPT, ongoing clinical supervision is recommended in addition to a didactic CE course.

Discussion

A strength and challenge of IPT is that it is manualized. Manuals clearly articulate therapy goals and standardize techniques, allowing for comparative psychotherapy research. As well, the techniques are put into practice with adherence ratings that can be measured and evaluated—an especially important element in this age of accountability with increasing attention paid to achieving and maintaining competence (40). Adherence is a necessary but not sufficient aspect of therapeutic competence (41,42). To achieve a good outcome and be competent in the application of IPT, therapists must be able to use the principles of the model while maintaining a good alliance. This requires the flexibility to be responsive to the affectively charged material that emerges in each psychotherapy hour.

Although there is a strong empirical base for IPT, stringent inclusion and exclusion research criteria might limit the generalizability to clinical settings where one tends to see more complex patients with comorbidity. Research is underway to establish the effectiveness of IPT, and

clinical experience supports its utility in community practice (5). The brief therapies are not suitable for all patients. However, their brevity and power allows clinicians to potentially help greater numbers of patients who suffer from prevalent and disabling public health-care problems such as depression (43). The challenge is to increase specificity in prescribing the different psychotherapeutic modalities so that we can better determine which patients are most likely to benefit

IPT offers useful therapeutic guidelines to assist clinicians to help patients with depression and commonly distressing interpersonal problems. The interpersonal fulcrum can effectively act as a lever to motivate adaptive changes and functional improvement. The evidence for IPT's efficacy for treatment of depression provides a strong empirical foundation to support its implementation as articulated in clinical practice guidelines (2,3). The research results regarding applications of IPT to other clinical populations are promising. It is hoped that this evidence-based psychotherapy will be increasingly embraced and translated into clinical practice.

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