SPECIAL ARTICLE

Interpersonal psychotherapy: principles and applications

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This article briefly describes the fundamental principles and some of the clinical applications of interpersonal psychotherapy (IPT), a time-limited, empirically validated treatment for mood disorders. IPT has been tested with general success in a series of clinical trials for mood and, increasingly, non-mood disorders; as both an acute and maintenance treatment; and in differing treatment formats. As a result of this research success, IPT is spreading from research trials to clinical practice in various countries around the world.

Key words: Interpersonal psychotherapy, mood disorders, non-mood disorders, formats, process, training

The recognition of depressive illness as prevalent, morbid, potentially deadly, and economically costly (1) has spurred interest in its treatment. Pharmacotherapy has shown clear benefits for the acute and chronic treatment of the major mood syndromes, namely major depressive disorder (MDD), dysthymic disorder, and bipolar disorder (2). Antidepressant medications work for most patients, and work for as long as those patients continue to take the medications, but all treatments have limits. A significant proportion of medication responders have residual symptoms that predispose to recurrence or relapse of their mood disorders. Other patients do not respond to medications, refuse to take them, or in many areas of the world simply cannot afford them. For all of these patients, psychotherapies may have utility.

The two principal empirically-based psychotherapeutic interventions for mood disorders are cognitive behavioral therapy (CBT) (3) and interpersonal psychotherapy (IPT) (4). Both are diagnosis-targeted, time-limited, present-focused treatments that encourage the patient to regain control of mood and functioning. IPT is based on the so-called common factors of psychotherapy: a treatment alliance in which the therapist empathically engages the patient, helps the patient to feel understood, arouses affect, presents a clear rationale and treatment ritual, and yields success experiences (5). On this foundation IPT builds two major principles:

- Depression is a medical illness, rather than the patient's fault or personal defect; moreover, it is a treatable condition. This definition has the effect of defining the problem and excusing the patient from symptomatic self-blame.
- Mood and life situation are related. Building on interpersonal theory and psychosocial research on depression (6), IPT makes a practical link between the patient's mood and disturbing life events that either trigger or follow from the onset of the mood disorder.

Research has demonstrated that depression often follows a disturbing change in one's interpersonal environment such as the death of a loved one (*complicated bereavement*), a struggle with a significant other (*role dispute*), or some other life upheaval: a geographic or career move, the beginning or ending of a marriage or other relationship, or becoming physically ill (*a role transition*). Once patients become depressed, symptoms of the illness compromise their interpersonal functioning, and bad events follow. Although these observations seem commonsensical, many depressed patients turn inward, blaming themselves and losing sight of their environment. Whether life events follow or precede mood changes, the patient's task in therapy is to resolve the disturbing life event(s), building social skills and helping to organize his or her life. If the patient can solve the life problem, depressive symptoms should resolve as well. This coupled effect has been borne out in clinical trials demonstrating the efficacy of IPT for major depression.

STRUCTURE OF TREATMENT

IPT is a time-limited (acutely, 12-16 weeks) treatment with three phases: a beginning (1-3 sessions), middle, and end (3 sessions). The initial phase requires the therapist to identify the target diagnosis (MDD) and the interpersonal context in which it presents. In diagnosing major depression, the therapist follows DSM-IV (7) or ICD-10 criteria and employs severity measures such as the Hamilton Depression Rating Scale (Ham-D) (8) or Beck Depression Inventory (BDI) (9) to reify the problem as an illness rather than the patient's idiosyncratic defect. The therapist also elicits an "interpersonal inventory", a review of the patient's patterns in relationships, capacity for intimacy, and particularly an evaluation of current relationships. A focus for treatment emerges from the last: someone important may have died (*complicated bereavement*), there may be a struggle with a significant other (*role dispute*), or the patient may have gone through some other important

life change (*role transition*); in the relatively infrequent absence of any of these, the default focus is on *interpersonal deficits*, a confusing term that really denotes the absence of a current life event.

The therapist links the target diagnosis to the interpersonal focus: "As we've discussed, you are suffering from major depression, which is a treatable illness and not your fault. From what you've told me, your depression seems related to what's happening in your life right now. You stopped sleeping and eating and began to feel depressed after your mother died, and you've had difficulty in coming to terms with that terrible loss. We call that *complicated bereavement*, which is a common, treatable form of depression. I suggest that we spend the next 12 weeks working on helping you deal with that bereavement. If you can solve this interpersonal problem, not only will your life be better, but your mood will improve as well". This formulation defines the remainder of the therapy (10). The connection between mood and life events is practical, not etiological: there is no pretense that this is what "causes" depression. With the patient's agreement on this focus, treatment moves into the middle phase.

Other facets of the opening phase include giving the patient the "sick role", a temporary status recognizing that depressive illness keeps the patient from functioning at full capacity, and setting treatment parameters such as the time limit and the expectation that therapy will focus on recent interpersonal interactions (4).

In the middle phase of treatment, the therapist uses specific strategies to deal with whichever of the four potential problem areas is the focus. This might involve appropriate mourning in *complicated bereavement*, resolving an interpersonal struggle in a *role dispute*, helping a patient to mourn the loss of an old role and assume a new one in a *role transition*, or decreasing social isolation for *interpersonal deficits*. Whatever the focus, the therapy is likely to address the patient's ability to assert his or her needs and wishes in interpersonal encounters, to validate the patient's anger as a normal interpersonal signal and to encourage its efficient expression, and to encourage taking appropriate social risks. In the last few sessions, the therapist reminds the patient that termination is nearing, helps the patient to feel more capable and independent by reviewing his or her often considerable accomplishments during the treatment, and notes that ending therapy is itself a role transition, with inevitable good and painful aspects. Since IPT has also demonstrated efficacy as a maintenance treatment for recurrent MDD, and since patients who have had multiple episodes are very likely to have more, therapist and patient may decide to end acute treatment as scheduled and then to recontract for ongoing treatment, perhaps of less intensive dosage: e.g., monthly rather than weekly sessions.

The IPT therapist's stance is relaxed and supportive. The goal is to be the patient's ally. The acute time limit pressures the patient to take action. No formal homework is assigned, but the goal of solving the focal interpersonal problem area provides an overall task. Treatment centers on the patient's outside environment, not on the therapy itself. The scheduling of sessions once weekly accentuates that the emphasis is on the patient's real life, not the office. In sessions therapist and patient review the past week's events. When the patient succeeds in an interpersonal situation, the therapist acts as a cheerleader, reinforcing healthy interpersonal skills. When the outcome is adverse, the therapist offers sympathy, helps the patient to analyze what went wrong in the situation, brainstorms new interpersonal options, and role plays them with the patient in rehearsal for real life. The patient then tests them out. Given this emphasis on interpersonal interaction, it is not surprising that depressed patients learn new interpersonal skills from IPT that they have not seen with pharmacotherapy (11).

CLINICAL APPLICATIONS

In the 1970s, Klerman, Weissman, and colleagues demonstrated the efficacy of IPT in treating MDD in repeated randomized controlled trials. The utility of IPT has been tested for other mood and non-mood disorders by several investigators in several countries, including the United States, Canada, United Kingdom, the Netherlands, New Zealand, Uganda, and elsewhere. From the start, the approach has been a scientific one. IPT has been tested in clinical trials for each proposed application; it has never been intended as a treatment for all disorders.

Mood disorders

The utility of IPT for MDD has been strengthened by landmark studies such as the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program, in which IPT was statistically comparable to imipramine on several measures and better than a placebo control for more severely depressed patients (12). This study, the first direct comparison with CBT, also provided a glimpse at potential differential predictors of treatment outcome (13). Other trials have found IPT efficacious in treating depression in medically ill patients (14,15), peripartum women (16-19), depressed adolescents (20), and geriatric depressed patients (21). Two trials have demonstrated benefits for monthly IPT as a three year maintenance treatment for recurrent depression (21,22).

Studies are also examining the benefits of IPT for dysthymic disorder (23) and as an adjunctive treatment to medication for bipolar disorder. Frank and colleagues have grafted IPT to a behavioral, social rhythms therapy, thus yielding interpersonal social rhythms therapy (IPSRT) for bipolar disorder. The behavioral component aims to stabilize diurnal activities, and in particular to help control sleep patterns and thus avoid manic episodes (24). Exciting preliminary neuroimaging studies have found that IPT

changes brain blood flow in a manner similar to that of serotonin reuptake inhibitors (25,26).

Non-mood disorders

Success with mood disorders has also led to the exploration of IPT as a treatment for other conditions. Two trials for substance abuse showed no benefits for IPT (27,28). On the other hand, there have been promising developments of IPT as a treatment for social phobia (29), posttraumatic stress disorder (30) – both anxiety disorders with clear interpersonal components – and eating disorders (31-33). Further explorations are adapting IPT to borderline personality disorder, primary insomnia, body dysmorphic disorder, and other disorders (4).

FORMATS

Developed as an individual psychotherapy to be delivered by mental health professionals, IPT has also been modified as interpersonal counseling (IPC; 4,34), a streamlined, heavily scripted treatment for subsyndromal mood and anxiety symptoms for use by non-mental health medical nurses. It is also being tested as a group (35), couples (4), and telephone (36) intervention.

More research is needed to determine the optimal use and dosage of all forms of IPT. Furthermore, it is unclear for it – as for all psychotherapies – when and how it is best to augment IPT with medication, and vice versa. IPT is also being transplanted to other cultures (37).

PROCESS

Most research on psychotherapy has been on process rather than outcome. IPT has been the exception to this rule, with research focusing almost exclusively on outcome: that is, whether treatment works. Now that IPT has demonstrated efficacy for various disorders, it makes sense to explore what the active ingredients of this treatment might be. There has thus far been little research in this area (38).

TRAINING

IPT was developed as a research intervention, and until recently essentially all practitioners of IPT were researchers. Research training requires reading the manual (4,39), attending an orientation workshop, and completing 2-3 cases supervised by review of audio- or videotapes of each session. This system has worked well for research purposes, but it is highly labor intensive.

The research success of IPT has led to its inclusion in clinical treatment guidelines and to growing interest in IPT among clinicians. The standards for clinical training for non-researchers are still being defined. The International Society for Interpersonal Psychotherapy (ISIPT), an international umbrella organization, has developed a web site (www.interpersonalpsychotherapy.org), is deliberating training issues, and is allowing countries to develop their own credentialing processes for IPT. IPT therapists in the United Kingdom have designed the most detailed and rigorous curriculum for clinical accreditation to date. There is interest in IPT training in Australia, Austria, Brazil, Canada, Finland, Germany, Ireland, Italy, the Netherlands, New Zealand, Norway, Spain, Switzerland, and elsewhere.

IPT is taught in some psychiatric residency programs in the United States, but it is not required training (37). Because IPT is an add-on therapy, not intended to apply to all disorders, all therapists who have learned IPT have come to it with backgrounds in other therapies, usually either psychodynamic or cognitive.

CONCLUSIONS

IPT is a relatively young psychotherapy targeted to particular psychiatric diagnoses. Relative to many other psychotherapies, its characteristics are well defined and its efficacy is well understood. Nonetheless, far more remains unknown about its indications for various conditions, its optimal dosing, its combination with pharmacotherapy, its utility in different formats, and so forth. Although one of the best studied interventions in outcome research, particularly for mood disorders, IPT is only now spreading into clinical practice. It is a fairly simple treatment for already experienced psychotherapists to learn, but its effectiveness in the hands of less trained therapists is moot. Thus the spread of this still relatively "pure" treatment carries both opportunities and dangers.

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