Interpersonal Therapy: a brief and focal model

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Abstract
Psychotherapy is a particular form of treatment in Psychiatry. Its use is widespread and has many different approaches.

Objective: In this article, the author makes some considerations about Interpersonal Therapy (IPT), a brief and focal psychotherapy. Initially created to treat depression, other researchers had successfully increased its spectrum. It could be divided into three phases. Initial, when the therapist makes the diagnosis of the disorder and also the interpersonal problematic is pointed out, the patient received a sick role. Intermediary when the focus is treated, and the final phase when the therapist encourages the patient to recognize and consolidate gains and prepare the patient to use it in the future.

Methods: It is stressed that IPT is a testable form of psychotherapy and the scientific evidences of its efficacy are showed.

Conclusions: The results assure that IPT is an efficient form of psychotherapy for depression with a great acceptability from the patients.

Keywords: Psychotherapy. Efficacy. Depression.

Introduction
Psychotherapy is a form of treatment, which uses as its instruments the communication and the systematized relationship between the therapist and one or more patients (group, family and couple therapies). In this form of treatment, the therapist aims to enable patients to identify, understand and give a meaning to their conflicts, still aiming to correct the distortions in the perceptions that patients have about themselves and their environment, as well to improve their interpersonal relationships.1

The therapist, enabled by his/her theoretical formation, will show the patients the pathways to achieve the treatment goals. As a rule, therapists receive their formation after college. Besides this theoretical formation, it is desirable that therapists undergo a psychotherapeutic process to not harm their patients, by confusing their anguishs and conflicts with the patients’.1

Psychotherapies have diverse theoretical foundations, the so-called psychotherapeutic lines. Therapists use one or more lines to achieve their objectives. Some authors count even more than hundred different lines, what is pertinent due to the variation in the human being’s world visions. Actually, each therapist follows a basic theoretical line, which is deeply influenced by his/her particular way of interpreting the reality, the world, the relationships and the development of mankind.1

Most widespread psychotherapeutic lines are the psychoanalytical ones, which appeared with the works of Sigmund Freud between the end of the 19th and the beginning of the 20th centuries, with several followers and creators of particular aspects of practicing and understanding psychoanalysis such as: Adler, Melanie Klein, Bion, Lacan. Other lines known in Brazil are psychodrama, created by Moreno, Jung’s Analytical Psychology and the Existential Analysis of several psychiatrists such asBinswanger, Minkowski and philosophers such as Sartre and Merleau Ponty.

Some psychotherapies have already been tested within an empirical scientific model. Among them, Psychodynamic Brief Psychotherapy, Klerman’s Interpersonal Therapy,2 Beck’s Cognitive Therapy,3 and the Behavioral Therapy. All of them are efficient in treating several psychiatric disorders.

These brief psychotherapeutic forms are not so well-known in our society. Beck’s cognitive therapy3 and behavioral therapy are already practiced in some centers and there are some formation courses in Brazil. However, they are generally restricted to academic centers.

Interpersonal Therapy (IPT) has been used in several clinical trials, mainly in English-speaking countries. Many colleagues who read articles, in which IPT is referenced, are curious about
this form of treatment due to its good results. In Brazil there is a group in Porto Alegre, linked to a university center, which has been applying IPT for several years. Recently it was applied for the accomplishment of a clinical trial in São Paulo. This experience is extremely modest for such a big country as Brazil, which has a strong psychotherapeutic tradition.

**Interpersonal Therapy**

IPT was created in 1970 as a brief treatment for major depression. IPT was defined in a manual developed by Gerald Klerman et al. and tested in a series of controlled clinical trials for depression. IPT is also used in the treatment of other psychiatric disorders and in some special groups of patients: adolescents and elderly.

Studies about the efficacy of psychotherapies as a way of treating depression have been reviewed in some publications. IPT has been initially conceived to have a fixed duration (12 weekly sessions), and to be applied in non-hospitalized depressed subjects. This proposal is based on the ideas of the interpersonal school, although it does not perform etiological presuppositions (regarding the cause of depression). IPT makes connections between the beginning of the depressive symptoms and the current interpersonal problems, as a pragmatic treatment focus. IPT deals more with the current interpersonal relationships than with past ones, focusing on the immediate social context of the patients. The interpersonal therapist tries to intervene in the symptoms' formation and in the social dysfunction associated with depression than in personality aspects of the patients.

The original IPT has three phases (Appendix 1). The first one, normally has from 1 to 3 sessions and includes the collection of psychiatric history and diagnostic assessments. At this phase, the treatment focus is determined. The therapist reviews the symptoms, diagnoses the patients as depressed according to a standard criterion (such as the ICD-10 or the DSM-IV), and, therefore, attributes patients the 'sick role' while naming their complaints. The English sociologist Parson has demonstrated that when subjects are ill they have a differentiated role in Western society. They can be exempted from certain responsibilities, being cared in their state. Giving patients the 'sick role' can relief the excess of guilt for not being able to have a good social functioning, but indifference between peers. Depending on the stage the conflict is situated: at a phase of confrontation, dissolution or else at a temporary truce, when there is no explicit aggression, feelings of anger against the beloved person, which are conflictive, leading to a stagnation of the affective and functional life of the patients. In the intermediate phase, we work, therefore, the loss, trying to remove patients from this paralysis, opening the path for current relationships, which help them to get rid of the imaginary relationship with the beloved person.

The dispute of interpersonal roles is characterized by a conflict in a relationship, be it affective or professional. Among them, conjugal relationships are the most frequent. Regarding this focus, the therapist should try to classify at which point the conflict is situated: at a phase of confrontation, dissolution or else at a temporary truce, when there is no explicit aggression, but indifference between peers. Depending on the stage the strategy will differ, trying to establish communication and to achieve a new agreement between the participants in the conflict. The goal here is to help patients to recognize their conflicting feelings of anger, fear and sadness, and to find strategies to cope with them and to avoid situations in which those feelings may arise, by expressing directly their desires, reducing impulsive behaviors based on irrational distrusts. Depressed patients frequently have difficulty to be assertive in their needs and desires and to express adequately their anger in interpersonal situations.
When patients develop an sufficiently clear understanding about the role disputes, including their particular role, they can assess together with the therapist the possible consequences of a number of alternatives before starting their actions.5

The focus of interpersonal problems related to the role transition is diagnosed when the person has difficulties to deal with life changes. All of us have several roles in the social system and these roles become indistinguishable parts of our sense of identity. The roles per se and the statuses attached to them exert an important influence in the social behavior and in the patterns of interpersonal relationship of the subjects. A deficit in the social functioning occurs frequently as a response to a quick demand of adaptation to new and strange roles, especially those experienced by subjects as a loss. For example, we could think of retirement, of the acquisition of a superior hierarchical position which demands much responsibility or of the loss of power or of an economic condition or, else, of consequences of a disease, divorce and even subtler situations such as the loss of leisure due to the birth of a child. These are situations which modify the possibilities or projects of the subjects.

In this situation, they cannot adapt to this new role, do not create new references, starting and/or maintaining the depressive picture. Together with the therapist they will then assess their old and new roles, in a real way, with their pros and cons, seeking forms to face up the new role, to deal with the difficulties, pointing them out and reformulating their way of acting.

The most common issues related to the difficulties to deal with the role transition are: family/social loss of support and links; management of emotions that accompany them (e.g., anger or fear); a demand of a new repertoire of social skills for the new roles; and a decrease of the self-esteem due to not valuing these new roles as much as the old ones.

The problems which are usually associated with the role transition are: giving up the old role; expression of guilt, anger or loss; acquisition of new skills; development of new links and support, besides the difficulty in the positive identification with aspects of the new role.

For its being generally chronic, the last problematic area and the most difficult to be dealt with in IPT are the interpersonal deficits. These are characterized by the difficulty of the patients in their relationships due to their way of being. Patients with such a deficiency may have never established an intimate and lasting relationship as adults, or have persistent feelings of social loneliness and isolation, not specifically related to recent transitions or interpersonal disputes. In IPT patients many times are able to detect this problem and to relate it to their psychiatric disorder, leading to an improvement in the depressive symptomatology. In general, these patients should be referred to a form of traditional, non-focused psychotherapy after the symptomatic improvement.

The therapist will have three tasks in the management of the interpersonal deficit as the treatment focus: reviewing the past significant relationships, including the negative aspects; exploring parallel and repetitive problems in these relationships; and discussing with the patients the negative and positive feelings regarding the therapist and other parallel relationships.

In IPT, the current relationships are worked out, as the focus is the here-and-now. Many techniques used in IPT are common to psychodynamic psychotherapy. On the other hand, IPT differs from psychodynamic psychotherapy in important areas.24

Among the techniques there are the exploratory ones: 1) non-directive exploration means using open, general questions or verbalizations. It is better for the development of a free discussion of the material, especially in the first phase. Part of it is the supportive recognition, a non-directive technique which includes meta-communications such as saying ‘hum hum’, ‘I understand’, ‘go on’, or other encouraging comments of the speech. Extension of the discussed topic, when the therapist encourages patients to continue or to start a subject. Receptive silence, when the therapist keeps an interested and attentive attitude which encourages patients to keep on talking. Other exploratory technique is the 2) directive assessment of material when the therapist questions about a certain topic. Formal questionnaires with items about depressive symptoms can be part of this technique.5

Besides the exploratory techniques in IPT patients are encouraged to express their feelings. Depending on the nature of the affections and of each patient, the therapist should pursue three general strategies: facilitating recognition and acceptance of painful affections about events or questions that cannot be modified; helping patients to use their affective experiences for the desired alterations in the current interpersonal relationships; encouraging the development of new and desirable affects which may lead to growth and change.5

Clarification can be used to restructure and provide a recognition of the material produced by patients. This technique aims to make patients aware of what was actually communicated. Clarification techniques in IPT are: asking patients to repeat or rephrase what they said, which is particularly useful in cases of ‘Freudian slips’, when patients spoke in a surprising or unusual way or contradicted their previous statement.

Other resource of IPT is the analysis of the communication, which is used to examine and identify communication failures, in order to help patients to learn to better express themselves. Some common difficulties of communication are: 1) indirect, ambiguous communication, as a replacement of an open confrontation. 2) Incorrect recognition of the communication of others. 3) Incorrect statement that the other understood what was said. 4) unnecessary indirect communication. 5) Silence – closing the possibility of communication.

IPT uses the relationship with the therapist as a technique, when the feelings and perceptions of the patient about the therapist are discussed, being that the focus of the discussion.

Furthermore, IPT uses the technique of behavioral alteration through directive techniques which include education, modeling, or helping directly the patient to solve simple and practical problems. Other technique of behavioral modification is the analysis of decisions, when the therapist helps patients to consider a wide variety of alternative actions (and their consequences) which can be adopted to solve the problems. This is an important technique of IPT oriented towards action and should be explicitly taught to the patient for the use beyond the treatment. This technique generally uses the analysis of the communication. Role-playing is also used when the therapist (in
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can be scientifically assessed, should be more divulged in our environment.

References

Appendix 1

Outline for Interpersonal Psychotherapy in Major Depression

I. Initial Sessions.
   A. Dealing with depression.
      1) Review the depressive symptoms.
      2) Give the syndrome a name.
      3) Explain depression as a medical disorder and explain the treatment.
      4) Give the patient the ‘sick role’.
      5) Assess the need of medication.
   B. Relate depression to the interpersonal context
      1) Review the current and past relationships as well as their relation with the depressive episode. Determine with the patient:
         a) Nature of the interaction with significant people;
         b) Mutual expectations between the patient and other significant people, and which of them were achieved;
         c) Satisfactory and dissatisfactory aspects of relationships;
         d) Changes that patients would like to occur in the relationships.
   C. Identification of the main problematic areas;
      1) Determine the problematic area related to the current depressive episode and emphasize the treatment goals.
      2) Determine which relationship or aspects of it are related to depression and what can be changed.
   D. Explain the concepts and contract of IPT
      1) Explain your understanding of the problem
      2) Reach an agreement regarding the treatment goals, determining which is the problem to be focused.
      3) Describe the procedures of IPT: focus in the ‘here-and-now’, the patient should discuss important concerns, review of current relationships, discussion about the practical aspects of the treatment -duration, frequency, timetables, fees, absence policy.

II. Intermediate Sessions – problematic areas.
   A. Grief.
      1) Goals
         a) Facilitation of the mourning process
         b) Helping the patient to reestablish interests and relationships as a replacement of what has been already lost.
      2) Strategies
         a) Review the depressive symptoms
         b) Relate their beginning to the dispute with the significant person with whom the patient has a relationship.
         c) Determine at which stage is the dispute:
            i. Renegotiation (sooth the participants in order to facilitate the solution).
            ii. Standstill (increase the disharmony to facilitate the negotiation).
            iii. Dissolution (help in the process of grief).
         d) Understand how non-reciprocal expectations are related to disputes:
            i. Which are the disputed issues?
            ii. Which are the differences between expectations and values?
            iii. Which are the options?
            iv. Which are the possibilities of finding alternatives?
            v. Which resources are available to lead to a change in the relationship?
            e) Are there parallels with other relationships?
            i. What are the patient’s gains?
            ii. Which non-said attitude is hiding behind the patient’s behavior?
         f) How occurs the dispute?
   B. Interpersonal disputes.
      1) Goals
         a) Identify.
         b) Choose an action plan.
         c) Modify the flawed expectations or communications in order to achieve a satisfactory solution.
      2) Strategies
         a) Review the depressive symptoms.
         b) Relate the depressive symptoms to the difficulty of dealing with the recent changes in life.
         c) Review the positive and negative aspects of the old and new roles.
         d) Explore the feelings about what was lost.
         e) Explore the opportunities of the new role.
         f) Assess realistically what was lost.
         g) Encourage the appropriate release of affections.
         h) Encourage the development of a system of social support and of new skills demanded by the new role.
   C. Role transition.
      1) Goals
         a) Grief and acceptance of the loss of the old role.
         b) Helping patients to face up more positively to their new role.
         c) Recover the patient’s self-esteem by developing a domain of the new demands.
      2) Strategies
         a) Review the depressive symptoms.
         b) Relate the depressive symptoms with the difficulty of dealing with the recent changes in life.
         c) Explore possible ways of being involved with other people.
         d) Assess realistically what was lost.
   D. Interpersonal deficits.
      1) Goals
         a) Reduce the social isolation of the patient.
         b) Encourage the development of new relationships.
      2) Strategies
         a) Review the depressive symptoms.
         b) Relate the depressive symptoms to the problems connected to social isolation.
         c) Review the significant relationships of the past, including their positive and negative aspects.
         d) Explore repetitive patterns in the relationships.
         e) Discuss positive and negative feelings of the patient regarding the therapist and seek parallels with other relationships.

III. End.
   A. Make explicit the discussion about the end.
   B. Recognize that the end is a mourning process.
C. Show the patients the recognition of their competence and independence.
D. Deal with the lack of response to the treatment.
E. Continuation and maintenance treatment.

IV. Specific techniques.
A. Exploratory.
B. Encouragement of the affection.
C. Clarification.
D. Analysis of the communication.
E. Therapeutic use of the relationship.
F. Techniques to modify the behavior.
G. Accessory techniques.

V. Role of the therapist
A. Patient but not neutral listening.
B. Active, not passive.
C. The therapeutic relationship is not interpreted as a transfer
ence.
D. Therapeutic relationship is not friendship.