Second Edition

Interpersonal Psychotherapy

A Clinician's Guide

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The Structure of Interpersonal Psychotherapy

Introduction

This chapter is a brief overview of the structure of interpersonal psychotherapy (IPT), emphasizing a view of the forest rather than the trees. IPT is divided into four segments: the Assessment/Initial Phase, the Intermediate Phase, the Conclusion of Acute Treatment, and Maintenance Treatment (Figure 3.1).

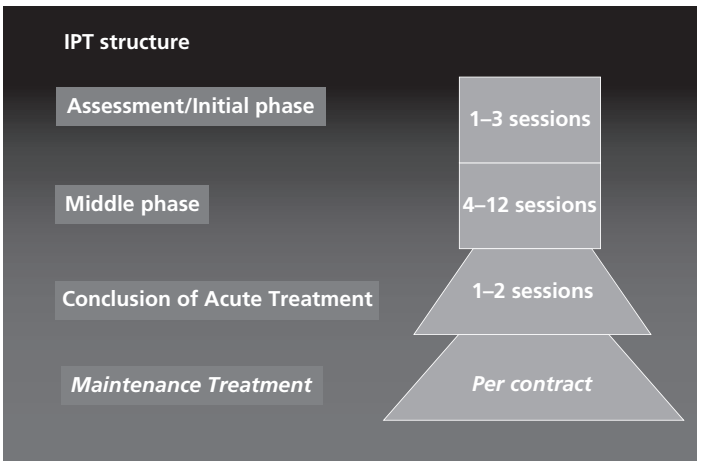

Figure 3.1 The structure of IPT

In the Assessment/Initial Phase, the therapist makes a determination about the patient's suitability for IPT. If IPT is indicated, the therapist completes an Interpersonal Inventory, develops an Interpersonal Formulation and negotiates a Treatment Agreement with the

patient. In the Middle Phase, the therapist and patient work at resolving the patient's interpersonal problems (the three IPT Problem Areas) using IPT techniques. When Concluding Acute Treatment, the therapist and patient review progress as well as planning for future problems. Maintenance IPT should be arranged by the patient and therapist depending on the patient's history, severity of distress, and risk for relapse. The Conclusion of Acute Treatment can be tapered so that sessions are less frequent as the conclusion approaches.

Assessment/Initial Phase

The first purpose of the Assessment/Initial Phase is to determine if the patient is a suitable candidate for IPT, and to determine whether IPT is the best treatment. During the assessment the therapist should focus on the patient's presenting problems and attachment style, and should ask about specific instances of interpersonal interaction in order to begin to understand the patient's typical style of communication. Much of this can be accomplished by constructing an Interpersonal Inventory.

The Assessment/Initial Phase of IPT includes a number of specific tasks. The primary goals are to construct an Interpersonal Inventory (Chapter 5) and to develop an Interpersonal Formulation, a detailed hypothesis describing and explaining the patient's interpersonal difficulties (Chapter 6). A Treatment Agreement should be established with the patient to proceed with IPT, and to work on several specific interpersonal problems. Note that the agreement, in contrast to a rigid contract, is flexible, so that a range of acute treatment sessions can be negotiated rather than a fixed number.

Middle Phase

In the Middle Phase of IPT the therapist and patient work together to resolve the patient's Interpersonal Disputes, to adjust to his Role Transitions, or to deal with Grief and Loss issues. In general, after identifying one or more Interpersonal Problem Areas during the Assessment/Initial Phase, the therapist gathers more information about the patient's specific Interpersonal Problems. Both patient and therapist then work collaboratively to develop solutions to each, usually coming in the form of improving the patient's communication skills or modifying his expectations about a relationship conflict. A suitable option is selected, and then the patient attempts to implement it between sessions. The patient and therapist then work in subsequent sessions to refine the solution and to further assist the patient to implement it if he has had difficulty in carrying it out completely.

The hallmark of the Middle Phase of IPT is a lot of implementation and practice. The key in IPT (as in all therapies) is practice and persistence.

Conclusion of Acute Treatment

The Conclusion of Acute Treatment is a mutually negotiated ending of the intensive time-limited part of IPT. It includes a review of the patient's progress in resolving the interpersonal problems first identified in the Interpersonal Inventory and planning for these and others which may arise in the future. The patient's (and the therapist's) reactions to the conclusion should be acknowledged so that they can be discussed if needed. If IPT is done well, however, the option to taper the frequency of sessions during the Conclusion of Acute Treatment can be utilized so that the transition to Maintenance is seamless and does not cause the patient distress.

Maintenance Treatment

A specific agreement regarding the provision of Maintenance Treatment should always be negotiated with all patients, though this can vary a great deal depending on the patient's risk for relapse and need for ongoing care. In cases where a patient's problems are likely to be recurrent, the patient and therapist should develop an agreement to meet for more frequent maintenance sessions (such as monthly) to monitor ongoing interpersonal problems and to help the patient continue to work on his interpersonal skills. In contrast, if the patient's risk for relapse is low, and his current episode has been mild, the therapist and patient may choose to meet once every 6 months, or even just to have phone or email contact if needed. The scheduling of maintenance IPT sessions requires clinical judgment based on risk and need for longitudinal care. The critical tactic in IPT is simply to have a crystal clear agreement about ongoing contact based on clinical judgment – all patients will benefit from the continuity of care that is provided.

IPT is not a terminable therapy, i.e. it does not come to a complete and final end at the Conclusion of Acute Treatment. IPT is structured so that it comes to a conclusion because all of the empirical data point to the need for Maintenance Treatment for most patients. Maintenance Treatment may differ in frequency and intensity based on the individual patient's needs, but it should be provided nonetheless.

The evidence is very clear that affective and anxiety disorders are relapsing and remitting disorders. In addition, IPT has been demonstrated to be a very effective maintenance treatment,[1,2] and it has also been shown that the frequency of Maintenance Treatment can be flexible, as equivalent outcomes resulted when weekly, biweekly, and monthly maintenance sessions were compared.[3] The logical evidence-based conclusion is that Maintenance Treatment should be flexible and based on the needs of the individual patient for whom it is being provided. IPT is much more effective if it is tailored to the individual rather than attempting to use it as a one-size-fits-all approach.

In addition, in contrast to the plethora of theoretical writing on the subject, there is no evidence that terminating psychotherapy leads to better outcomes.[4] Given the well-known risk for relapse, terminating therapy is simply poor clinical practice. Moreover, despite therapists' occasional wishes to the contrary, terminating therapy is in reality nothing more than semantics: there is absolutely nothing to prevent a distressed patient from paying a visit to your office the day immediately following termination, nothing to prevent him from presenting with a new crisis, and nothing to prevent him from suing you if you refuse to treat him again. Clinicians in settings in which the number of sessions are arbitrarily limited by convention are well aware of the many ingenious ways that patients (and therapists) can circumvent the termination rules.

Terminating therapy after a fixed number of sessions is also an affront to the quality of care that virtuoso IPT clinicians should be providing. No ethical or compassionate clinician would terminate IPT after 16 sessions if the patient was still symptomatic and would benefit from a few more sessions. No reasonable clinician would terminate therapy the session after a patient has had a miscarriage or has been diagnosed with cancer or has been assaulted or has experienced any of the innumerable tragic events that randomly occur in life. It would be nice to guarantee that nothing adverse would disrupt the life of a patient as they are coming to the end of treatment, but life happens. And it sometimes happens near the originally agreed upon end of treatment. And if it does happen then, treatment should be extended. Use your common sense and clinical judgment (Box 3.1).

Box 3.1 The structure and components of IPT

Assessment/Initial Phase
- Evaluate the suitability of the patient for IPT
- Evaluate the suitability of IPT for the patient
- Assess psychiatric and interpersonal problems
- Construct an Interpersonal Inventory
- Develop an Interpersonal Formulation
- Identify specific IPT Problem Areas: Disputes, Role Transitions, Grief and Loss
- Explain the rationale for IPT
- Collaboratively establish a Treatment Agreement

Middle sessions
- Attend to the therapeutic relationship
- Maintain the focus of discussion on the specific IPT Problem Area(s)
- Explore the patient's expectations and perceptions of the specific interpersonal problem(s)
- Help the patient to develop solutions to the interpersonal crises
- Help the patient to implement the proposed solutions
- Practice, practice, practice

Conclusion of Acute Treatment
- Review the patient's progress
- Anticipate future problems
- Positively reinforce the patient's gains
- Establish a specific agreement for Maintenance Treatment

Maintenance Treatment
- Focus on Problem Areas
- Monitor progress

IPT and the Biopsychosocial/Cultural/Spiritual model

IPT is based on the Biopsychosocial/Cultural/Spiritual model of psychological functioning, expanding beyond the Biopsychosocial model described in the first iteration of this book[5] and the long discarded and antiquated medical model. Biological diatheses in conjunction with early life experiences and attachment style lead to vulnerabilities in individual patients. Cultural and spiritual factors may also be vulnerabilities or strengths. Coupled with a sufficiently intense interpersonal stressor, individuals without adequate social support are likely to develop interpersonal difficulties. This explanatory model of distress is depicted in the Interpersonal Triad in Figure 3.2.

The structure used in IPT is directly linked to Attachment and Interpersonal Theory. The IPT therapist focuses on the patient's interpersonal relationships, particularly the way in which the patient's attachment is manifest in them. The therapist also examines the communication style that the patient uses in initiating, maintaining, and disengaging from relationships. This occurs within the time-limited Acute Treatment format of IPT, and focuses on here-and-now resolution of symptoms and distress rather than on the patient–therapist relationship.

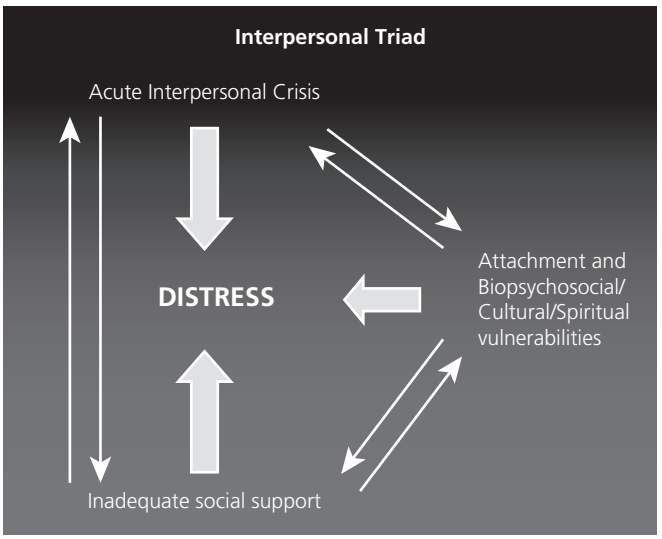

Figure 3.2 Interpersonal triad

IPT Problem Areas

IPT focuses on three specific Problem Areas which reflect the interpersonal nature of the treatment. These are: *Grief and Loss*, *Interpersonal Disputes*, and *Role Transitions*. Psychosocial stressors from any of the Problem Areas, when combined with an attachment disruption in the context of poor social support, can lead to interpersonal problems, psychiatric syndromes, or distress. The Problem Areas should be used as guidelines, not rigid categories. They are simply a way of focusing treatment as it proceeds.

- Though often understood as a reaction to the literal death of a significant other, the Grief and Loss Problem Area in IPT can best be conceptualized as any loss experienced by the patient. *That loss, whatever it may be, should be defined by the patient, not the therapist*. It is the therapist's job to understand the patient and his perspective, not to force it into a particular category. Thus if the patient conceptualizes his experience as a Grief and Loss issue, then it is. Common sense and therapeutic graciousness should prevail in a therapist who wishes to do IPT well. In addition to loss through death, losses such as divorce may be seen by the patient as Grief and Loss issues. Loss of physical functioning, such as that following a heart attack or traumatic injury, may also be considered in the Grief and Loss Problem Area.[6] Anticipatory grief in the setting of a terminal illness, or the anticipation of the death of a loved one, such as with caregivers of patients with Alzheimer's disease, are additional examples. There is no 'right' or 'wrong' way to use the Grief and Loss category – it is simply a way to focus treatment on the specific interpersonal problem.
- Interpersonal Disputes involve a conflict between the patient and another person, and may result from either the communication problems or unrealistic expectations of either. Like grief and loss, disputes should be patient defined.
- Role Transitions, as the name suggests, involve changes in a patient's social role and the changes in social support which may accompany such transitions. These include not only life-phase transitions, such as adolescence, childbirth, and aging, but also include many social changes such as leaving home, getting married, or changes in school or job status.

Therapists familiar with previous work in IPT will note that the Problem Area formerly known as interpersonal sensitivity or interpersonal deficits is no longer used in IPT. The reason is that these concepts describe a longstanding attachment style in the fearful range of attachment rather than an acute interpersonal crisis. There are patients with this style, and without doubt, they are more difficult to treat. They are difficult because they have a paucity of interpersonal support, and because it is difficult to form a therapeutic alliance with them. All of the IPT literature notes that these individuals are more complex, and that prognosis is not as good.[5,7–9] It is their fearful attachment style that leads to this complexity.

Therefore interpersonal sensitivities or deficits are best understood as a characteristic style of attachment in which the patient has difficulty forming satisfying interpersonal relationships. The poor social support network which is a consequence of this style often leads the patient to be more likely to become distressed when an acute interpersonal problem occurs. The acute problem – the Role Transition, Interpersonal Dispute, or Grief and Loss issue – should be the primary focus of IPT rather than the fearful attachment style. The fearful attachment style, manifested as sensitivities or difficulties in establishing relationships, is an additional psychological factor just like all of the other attachment styles, and it influences the way the patient will react to an acute interpersonal stressor.

There is *always* an acute crisis that leads a patient to seek treatment. Even if there have been longstanding attachment problems or a paucity of social relationships, something acute happens which finally leads a patient to make the decision to seek help – to seek therapy. It may be the death of a family member, it may be the loss of a job, it may be a perceived personal rejection, but something acute tips the balance just enough for the patient to make the decision to go to treatment. It is this crisis that should be the focus of treatment.

While the Problem Areas are very helpful as a means of focusing the patient on specific interpersonal problems, it is important for the therapist to be flexible when using them. Rather than providing the patient with the proper Problem Area 'diagnosis', the Problem Areas should be used primarily as tools to maintain focus upon one or two interpersonal problems, particularly as the time available in IPT for Acute Treatment is limited. The patient's view of the nature of the problem should be used – for example, if the patient feels that his recent divorce is a Grief issue rather than a Role Transition, then the Grief and Loss Problem Area should be used. The therapeutic alliance should not be sacrificed in order to impose the 'correct' Problem Area 'diagnosis' upon the patient.

The therapist should also be mindful that the interpersonal problems experienced by patients are similar in that they are all derived from the combination of an acute interpersonal stressor combined with a social network that does not sufficiently support them. In addition to addressing the specific problem, effort should always be directed towards improving patients' social support.

The Benefits and Limitations of Structured Psychotherapies

One of the more useful ways to describe psychotherapeutic approaches is to draw a distinction between 'structured' and 'unstructured' psychotherapies. Psychotherapeutic interventions can be placed on a spectrum on this dimension, with most of the short-term treatments at the more structured end of the scale, and most of the analytically oriented therapies at the other. There are obvious benefits and limitations to both structured and unstructured approaches – the point is to consider how specific treatments best

meet the needs of a given patient. Table 3.1 compares the 'structured' and 'unstructured' psychotherapies.

Table 3.1 Characteristics of structured and unstructured therapies

	Structured	Unstructured
Examples	IPT, cognitive behavioral therapy (CBT)	Psychoanalysis, self-psychology
Time frame	Time-limited	Open-ended
Focus	Improved functioning	Psychodynamic change and insight
Therapeutic		
Relationship	Supportive, active	Non-transparent, Passive
Discussions	Directed primarily by therapist	Directed primarily by patient
Transference	Not a point of intervention	Primary point of intervention

A helpful way of conceptualizing the place of IPT and other more structured psychotherapies in clinical practice is to compare them with pharmacologic treatments for physical problems such as diabetes or hypertension. From this point of view, IPT can literally be 'prescribed' as an appropriate and indicated treatment for the patient's specific problem. For example, the structure of IPT lends itself to a prescriptive treatment in a fashion analogous to the use of antibiotic therapy for pneumonia. Most patients with pneumonia require a structured course of antibiotics that is time limited and specific to one bacterial pathogen; this treatment is usually highly effective in resolving the illness. There are, however, a few patients who are prone to recurrent infections or who are immunosuppressed. These patients require longer term use of multiple agents, with marked variations in dosing and time course.

To carry the analogy further, all patients who are treated for acute pneumonia – literally all of them – receive maintenance care as well. A primary care physician would never 'terminate' treatment; instead, he would schedule the patient for a follow-up visit a week or two later, invite the patient to call him if the problem recurred, and would ensure that the patient was scheduled for a routine physical exam at some point in the future depending on the patient's age, health profile, and risk for additional problems. A primary care physician uses his clinical judgment and continues to care for his patient.

Similarly, many patients who present for mental healthcare tend to have acute and specific problems, and will benefit from an acute intervention. In these cases, a structured intervention like IPT is likely to offer the greatest benefit in a limited time frame. As in primary care, the IPT therapist should ensure that appropriate maintenance treatment is provided to all patients. In contrast, those patients who require ongoing and less structured interventions, such as those with severe and complex trauma experiences, profound disturbance in personality functioning, or severely debilitating mood or psychotic disorders, will likely require longer term and more transference-based psychological treatments. Borrowing further from this analogy, the concept of 'dose–response' can also be applied to the more structured psychotherapies. There is evidence that benefits to the patient accrue exponentially during the first 5–10 sessions of psychological interventions, with an

attenuation of improvement thereafter.[10] Though there continue to be benefits with more sessions, the amount of additional improvement appears to diminish with each additional session. Thus the benefit or 'response' to treatment must be considered in light of the 'dose' or number of sessions that are provided.

Research also suggests that there is a rapid decline in clinic attendance and continuation in psychotherapeutic treatments after 5–10 sessions.[11,12] One study found that 40 per cent of appointments with psychiatrists are 'one-off' (i.e. only one session), and that the average number of visits to a psychiatrist for a given patient is approximately seven.[13] There seems to be a brief window of opportunity for most patients, and that window opens when they experience an acute crisis that leads them to seek treatment. This window of opportunity is often best entered with a structured and time-limited treatment like IPT that focuses on the acute crisis.

Research aside, it is an unfortunate fact that the current climate of rationed healthcare and the emphasis on cost-effective treatments has had a profound effect on the healthcare system. If anything, this situation has gotten worse since the original iteration of our book in 2003; no doubt it will continue to be an issue for the foreseeable future. While there are many advantages to more open-ended treatments, IPT and other more structured interventions can often be provided within the constraints of managed care systems. IPT is also well suited to this environment because there is evidence supporting its efficacy, a point of emphasis for managed care.

Conclusion

The structure of IPT is one of its key virtues. However, maintaining structure should not supersede the fact that the patient's unique needs are of primary concern. A course of IPT that adheres concretely to a manual at the expense of the patient's needs is almost certain to be a less effective treatment than that provided by a flexible therapist who follows the principles of IPT using clinical judgment.

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