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Interpersonal psychotherapy (IPT) of depression

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Interpersonal psychotherapy (IPT) is one of evidence-based therapies for patients with depression. The interpersonal approach to depression focuses on four areas of interpersonal problem related to depression: grief or loss, interpersonal role disputes, role transitions and interpersonal deficits. Its efficacy on depression has been shown in both major depressive disorder and dysthymia. This article explains depression in biopsychosocial model and also introduces interpersonal psychotherapy as a new treatment option for patients with depression.

Key words : *Depression, Interpersonal psychotherapy.*

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Objectives :

1. To review clinical symptoms and treatment modalities of depression in biopsychosocial models.
2. To introduce interpersonal psychotherapy of depression as a treatment option for depressed Thai patients.

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พีรพนธ์ ลือบุญธวัชชัย. จิตบำบัดสัมพันธภาพระหว่างบุคคลของโรคซึมเศร้า. จุฬาลงกรณ์เวชสาร 2549 มี.ค; 50(3): 181 – 96

จิตบำบัดสัมพันธภาพระหว่างบุคคลเป็นการบำบัดรักษาผู้ป่วยอย่างหนึ่ง ซึ่งมีหลักฐานทางการแพทย์อ้างอิงถึงประสิทธิภาพในการรักษา แนวทางการบำบัดรักษาผู้ป่วยด้วยจิตบำบัดสัมพันธภาพระหว่างบุคคล มุ่งเน้นการแก้ไขปัญหาสัมพันธภาพระหว่างบุคคล 4 ด้านที่เกี่ยวข้องกับอาการของโรคซึมเศร้า ซึ่งได้แก่ ความเศร้าโศกเสียใจที่เกิดจากการสูญเสียชีวิตของบุคคลใกล้ชิด ปัญหาความขัดแย้งกับบุคคลที่สำคัญในชีวิต การเปลี่ยนแปลงของชีวิต และการขาดสัมพันธภาพกับบุคคลอื่น การมุ่งแก้ไขปัญหาหลัก 4 ด้านของผู้ป่วยจะช่วยให้อาการของโรคซึมเศร้าของผู้ป่วยดีขึ้น และพบว่าจิตบำบัดสัมพันธภาพระหว่างบุคคลมีประสิทธิภาพในการใช้รักษาผู้ป่วยโรคซึมเศร้า ทั้งในโรคซึมเศร้ารุนแรงและโรคซึมเศร้าเรื้อรัง บทความนี้ได้นำเสนอความรู้เกี่ยวกับโรคซึมเศร้าในลักษณะของรูปแบบชีววิทยาและจิตสังคม และแนะนำการรักษาด้วยวิธีการจิตบำบัดสัมพันธภาพระหว่างบุคคลเพื่อเป็นแนวทางใหม่ในการรักษาผู้ป่วยโรคซึมเศร้า

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Interpersonal psychotherapy (IPT) is a type of evidence-based therapies (EBT) in psychotherapy. The founders of the interpersonal school were Adolf Meyer[1]of Johns Hopkins University and his associate Harry Stack Sullivan.[2] The interpersonal approach to psychiatric patients is aimed to understand current psychosocial and interpersonal context of the patients; it is unlike psychodynamic psychotherapy which focuses on the past and the intrapsychic conflicts. [1] IPT was developed by Myrna M. Weissman[3], and originally used as a treatment of depressive disorders, major depressive disorder and dysthymia.[3] Several studies have shown that the treatment is effective in these groups of patients.[4-10] Laura Mufson adapted IPT for depressed adolescents. [11-14] There was an adaptation of IPT for late-life depression, bipolar disorders, depressive disorders in HIV-positive patients, depressive disorders in ante- and postpartum patients.[15] Moreover, IPT was also adapted to use for non-mood disorders such as anxiety disorders, eating disorders, somatization disorder. [15,16] Now IPT is widely studied for the treatment efficacy in many psychiatric disorders and widely used. IPT therapeutic manual for the therapists was developed by Myrna M. Weissman, John C. Markowitz for using in psychotherapeutic practices and also in teaching and training in IPT. [15]

1. What is depression and interpersonal psychotherapy of depression?

Depression

Depression is a group of clinical conditions, the common feature of which is the patient's sustained depressed mood during a period, leading to their impaired interpersonal, social, or occupational functioning. Patients with depression show disturbance of mood (depressed mood, decrease in or loss of interest), vegetative functions (decreased appetite, insomnia, decreased sexual activity), cognition (feelings of guilt, hopelessness, helplessness, worthlessness, difficulty to concentrate, thoughts of death or suicidal ideation), and psychomotor (psychomotor retardation, psychomotor agitation). [17-21] According to DSM-IV criteria, depressive disorders are classified into two types: major depressive disorder and dysthymic disorder.[22] The former is a severe form of depressive disorders, characterized by sustained depressed mood or loss of interest or pleasure during a two-week period with five or more of the following symptoms: depressed mood, markedly diminished interest or pleasure, significant weight loss or decrease or increase in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate or indecisiveness, recurrent thoughts of death or recurrent suicidal ideation or a suicidal attempt. These symptoms lead to significant distress or impairment in social, occupational, or other important functioning. [22] Dysthymic disorder is a mild and chronic form of depressive disorders characterized by sustained depressed mood for at least two years with two or more of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty in decision making, feelings of hopelessness. These symptoms cause significant distress or impairment in social, occupational, or other important functioning. [22] Depressive disorders

comprise of etiology in biological aspects: abnormality in neurochemistry such as neurotransmitters or hormonal systems; psychological aspects: adverse life events, developmental issues; and, social aspects: social and interpersonal context. The approach to depression is called biopsychosocial model of depression. This also leads to a broader spectrum of treatment modalities of depression: biological treatment – medication, electroconvulsive therapy; psychosocial treatment: psychotherapies – psychoanalytic psychotherapy, cognitive-behavioral therapy, and interpersonal psychotherapy. [20-21]

Interpersonal approach to depression

1. Symptom function

Symptoms of depression include depressed mood, vegetative symptoms (decreased appetite, weight loss, insomnia, fatigue, decreased sexual desire), negative cognition (worthlessness, hopelessness), and psychomotor retardation or agitation. The development of these symptoms is considered to include etiologies or precipitating factors in biological, psychological, and social components.[15,20,21]

2. Social and interpersonal relations.

There are supporting evidences show four main areas of interpersonal problem contributing to depression. [12,15,16] The first is loss and bereavement. There are evidences showing that people become depressed after losing their loved ones or when they have complicated bereavement. The second is interpersonal dispute such as marital disputes and interpersonal conflicts which lead to depression. The third is life change such as developmental change or change in life positions. All these may cause depression in people. Finally, social support is considered as a protective factor for depression. When people lack interpersonal skills or social support, it may lead them to depression. IPT emphasizes on interpersonal and social factors in these four main areas of the problem. Interpersonal psychotherapists try to understand patients in these four areas of interpersonal context leading to depression and try to resolve these areas of problem of the patients which contributes to improvement of the symptoms. [12,15,16]

3. Personality and character problems.

Some personality or character traits such as inhibited expression of anger or guilt, poor psychological communication with significant others, and difficulty with self-esteem determine a person's reactions to interpersonal experiences, and may predispose depression. [15] IPT does not focus on personality reconstruction because of the short duration of treatment. However, many patients of IPT gain new social skills that may help compensate for personality difficulties.

Characteristics of interpersonal psychotherapy

1. Time-limited psychotherapy

IPT is time-limited or short-term psychotherapy for immediate problems and for many Axis I disorders. This is different from long-term psychotherapy which is necessary for the treatment of patients with personality disorders (axis II disorder). IPT also avoids the adverse effects of reinforcing dependence and avoidance behavior which may be found in long-term psychotherapy.

2. Focused psychotherapy

IPT is a focused psychotherapy. IPT therapists focus on one or two areas of problem (core conflicts) in the patients' current or here-and-now interpersonal functioning. IPT is different from long-term psychotherapy which is an open-ended psychotherapy and relates to patients' intrapsychic issues from the past to the present.

3. Focusing on current relationships

IPT primarily focuses on patients' current relationship which is related to depressive symptoms. Although there is an assessment of patient's previous relationships in order to understand the patient's patterns of interpersonal relationships, IPT still focuses on patient's current social relationships.

4. Interpersonal focus

Unlike psychoanalytic psychotherapy, an IPT therapist does not try to explore patient's problem in terms of intrapsychic conflicts, but the therapist sees relationships with others within interpersonal context or interpersonal conflicts. Moreover, IPT is not like cognitive-behavioral therapy which focuses on thinking errors or distortion or maladaptive behaviors.

5. Not focusing on personality

IPT does not focus on patients' personalities or traits like in long-term psychotherapy. Patients without personality disorders work with IPT better than patients with personality disorders. Although IPT does not try to change personality structure of the patients, it still helps improve social skills of patients and may adapt maladaptive personality traits after patients have been relieved from their depressive symptoms.

6. Active and advocate therapist

An IPT therapist is active and serves as an advocate to the patient, not taking a neutral role like in psychodynamic psychotherapy. Nevertheless, an IPT therapist maintains nonjudgmental attitude, warmth, and unconditional positive regard; he or she is optimistic, helpful, supportive, and uses more reassurance and direct advice when it seems useful.

Goals and tasks of interpersonal psychotherapy

1. To relieve symptoms of depression

An IPT therapist helps the patient relieve the symptoms of depression such as depressed mood, loss of interest, vegetative symptoms, and also help the patient gain his or her normal functioning.

2. To improve interpersonal problems

An IPT therapist also helps the patient recognize the interpersonal areas of problem and then try to resolve them.

Areas of problem of interpersonal approach to depression

1. Grief (complicated bereavement)

Grief is complicated bereavement following the death of a loved one. In IPT, the therapist facilitates mourning, and gradually helps the patient find new activities and relationships to compensate for the loss.

2. Interpersonal role disputes

Interpersonal role disputes mean conflicts with a significant other: a spouse, other family members, a coworker, or a close friend. The therapist helps the patient explore the relationship, the nature of the dispute, and options to resolve it.

3. Role transitions

Role transition is any change in life status, for example, the beginning or the end of a relationship or career, a move, promotion, retirement, graduation, diagnosis of medical illness. The therapist helps the patient deal with the change by recognizing positive and negative aspects of the new role they are assuming, and assets and liabilities of the old role that is replaced.

4. Interpersonal deficits

Interpersonal deficits define the patient's lack of social skills, resulting in problem in initiating or sustaining a relationship. An IPT therapist aims to reduce patient's social isolation and encourages him or her to form new relationships.

Phases of interpersonal psychotherapy

Interpersonal psychotherapy is a short-term or time-limited psychotherapy. The length of treatment is about 16 weeks (12 – 20 weeks), once a week session. The length of session is about 45 - 60 minutes. IPT consists of three phases of treatment.

1. Initial phase

Initial sessions begin with a review of patient's depressive symptoms and patient's evaluation. The patient's history of depression should include a review of interpersonal context related to the depressive episode. After the diagnosis of depression is considered, the therapist gives education and information about depression and the treatment to the patient. The therapist tries to relate depressive symptoms to the interpersonal context of the patient and then identifies major areas of problem of the patient. After determining the treatment plan, the therapist explains the IPT concepts and sets treatment contract.

2. Intermediate phase

Intermediate sessions focus on the patient's areas of problem. In each session, therapist tries to relate depression to interpersonal events that patient met during the past week and work on the patient's areas of problem in order to relieve depressive symptoms.

3. Termination phase

Termination sessions, the last 3 - 4 sessions, should contain the discussion of the end of the treatment, the acknowledgment of the end of the treatment, and the patient's recognition of independent competence. If the patient fails to respond to IPT, the therapist will discuss other alternative treatments with the patient. The patients may need a continuation treatment to prevent relapse.

Methods and techniques and role of the therapist

Methods and techniques

1. Exploratory techniques

These techniques are used to gather information about the patient's symptoms and problems.

1.1 Non-directive exploration

Non-directive exploration means using general, open-ended questions to elicit information from the patient. This technique is usually used to facilitate a free discussion with the patient's material or issues at the beginning of the session. For example, "How have things been since we last met ?".

- Supportive acknowledgment

This technique includes the use of non-verbal and verbal communication such as nodding, raising eyebrows, or saying “Mm-hm”, “I see”, “And ?”, “Then what ?”, “Please continue,” to encourage the patient to continue talking. The therapist may also use phrases such as “That’s interesting,” to reward the patient and encourage him or her to continue.

- Extension of the topic discussed

The therapist may directly encourage the patient to continue discussion on the issues already spoken or to return to a previous topic of talk. For example, “What you told me about your sadness related to disagreement with your husband is very important. Let’s come back to this topic.” The therapist may repeat the words or phrases the patient has used in the conversation (paraphrase) such as “You felt depressed after you had a quarrel with your husband.”

- Receptive silence

Silence can be used in many ways in normal conversations. It can be used to indicate acceptance, approval, or even disinterest and disapproval. In therapeutic setting, silence can be used to make the patient feel accepted and approved. Receptive silence means a technique the therapist maintains silence and also an interested and attentive attitude that encourage patient to continue talking.

1.2 Directive exploration

This means a use of specific questions to gather details, specific information from the patient. This technique can be used in the interpersonal inventory, a systematically detailed exploration of the patient’s important relationship with significant others. For example, “Please tell me more about your relationship with your mother,” “Please tell me about the last time that you had a quarrel with your wife.”

2. Encouragement of affect

This technique includes many therapeutic techniques used to help the patient express, understand, and manage affect in psychotherapeutic and outside-therapeutic settings. The therapist may use this technique in three strategies.

2.1 helping the patient acknowledge and accept the painful affects related to the events or issues that cannot be changed such as depressed mood related to a grief or loss, anger related to disagreement. For instance, the therapist may help the patient acknowledge and accept his or her painful affects related to the death of his or her significant other by saying “You look sad and tearful when talking about the death of your husband. It may be painful and difficult to talked about. Everyone should have a time to grieve after someone so important dies. It’ll be very helpful to talk about this experience and share this experience with someone. Please tell me more about your grief experience.”

2.2 helping the patient use affective experience to bring about desired interpersonal changes. For example, the therapist can help patient with grief reaction by encouraging the patient to communicate his or her painful feelings to his or her family members in order to increase his or her social support.

2.3 encouraging the patient to develop new desirable affects or to express his or her affects more acceptably or efficiently. For example, the therapist may encourage the patient who has resentment with his wife and keep silence to communicate this feeling to her. This will make her wife know what he feels, so she can respond to his needs more effectively.

3. Clarification

This technique can be used by asking appropriate questions to inquire specific details in patient's experiences and make the patient understand his or her own experiences better. The therapist uses clarification to restructure and feedback the patient's material. Its short-term purpose is to make the patient more aware of what has actually been communicated. In a longer term, this may help the patient's discussion on previously suppressed matters.

For example, therapist can use this technique to clarify specific details in patient's disagreement with his wife by asking " Please tell me more about the last time you had a disagreement with your wife", "Can you remember what she said to you at that time ?", "How did you respond to that ?".

4. Communication analysis

This technique is used to examine and identify communication failures in order to help the patient learn to communicate more effectively. The therapist collects the information about the patient's communication patterns by asking patient to describe his or her communication styles, and observing patient's communication pattern in session. Then the therapist gives a feedback on the communication to the patient and motivate the patient to communicate more effectively.

Common communication problems that are found to cause interpersonal difficulties especially interpersonal role disputes are patient's inability to communicate his or her needs clearly and effectively, indirect nonverbal communication instead of clearly verbal communication, wrong assumption that others can understand his or her needs, or maintaining silence or closing off verbal communication.

5. Use of therapeutic relationship

Patient's thoughts, feelings, expectations, and behaviors toward the therapist in therapeutic relationship can represent as a model of other patient's relationships outside treatment setting. The therapist examines and discusses on the patient's thoughts, feelings, expectation, or behaviors toward him or her in session. The patient discusses about his or her feelings about the therapist and the therapy. The relationship and the interaction between the patient and the therapist can be used to help the patient learn about other relationships and develop better relationships to other people outside the sessions.

6. Behavior change techniques

These behavior change techniques include three types of techniques, namely:

6.1 Directive techniques

These techniques include interventions such as education, advice and suggestions, limit setting, modeling, or directly helping the patient solve the problems. The therapist educates the patient on his or her depressive disorders, the ways to solve the practical problems. Advice and suggestions should be given to the patient only when the patient cannot make a successful decision on his or her own. Therapists should set limit for impulsive patients whose behavior is destructive to themselves or to the treatment.

6.2 Decision analysis

This technique is used to help the patient consider many alternative actions and their

consequences that can be taken to solve a problem. It often follows communication analysis. The role of the therapist is to help the patient recognize broadening alternatives and to insist that action be postponed until each alternative is adequately explored. The therapist asks the patient to find out more alternatives to deal with the problem or suggests the solutions to the patient by asking "Have you considered…?", "I wonder if this method might be helpful ?", "What do you think ?". Then the therapist helps the patient choose the action after considering both advantages and disadvantages of each solution thoroughly.

6.3 Role playing

Role playing is a technique that the patient and the therapist use to show the interaction between the patient and his or her significant others. The goals of this technique are to explore the patient's feelings and the style of communication with others and also to rehearse new methods to interact with them. By using role playing, the patient may play as him or herself or play as a significant other, with the therapist taking the complimentary role. Therapist can also be a model of adaptive ways of communication for patient.

7. Adjunctive techniques

Other adjunctive techniques include contract setting and administrative details. Contract setting is aimed to educate the patient on IPT and to encourage the cooperation of the patient for the treatment. Administrative details are the discussion of appointment, time, and schedule for psychotherapy.

Role of the therapist

1. The therapist is a patient's advocate, not neutral.

The therapist maintains nonjudgmental attitude and remains unconditional positive regard to the patient. The IPT therapist is the patient's advocate and ally. The therapist is also optimistic and makes the patient feel that the patient's problem can be resolved. The therapist is supportive, and uses reassurance and direct advice when they seem useful.

2. The therapist is active, not passive.

IPT is a focused, short-term psychotherapy. The goal of treatment is to relieve depressive symptoms by relating the patient's depressive symptoms with interpersonal problems. Therefore, the IPT therapist's role is active and the therapist helps the patient focus on the current interpersonal problems in order to improve the patient's depressive symptoms.

3. The therapeutic relationship is not interpreted as transference.

The therapist-patient relationship in IPT is realistic, not seen as a repetition of the patient's relationships with others, or transference. The therapist provides the alliance, the assistance, and realistic understanding to the patient. The patient's positive feelings to the therapist are not explored, unless these interrupt the treatment process.

4. The therapeutic relationship is not a friendship.

Although the therapist is the patient's advocate, the therapist-patient relationship is neither social relationship nor friendship. The therapist can

answer personal questions and can give personal opinions when these issues are relevant to the treatment. However, the therapist does not participate or get involved in the patients' activities unrelated to the treatment.

2. Evidences in efficacy of interpersonal psychotherapy

There are evidences in efficacy of IPT for patients with ambulatory, nonpsychotic, and nonbipolar depression.

Boston-New Haven study

1. IPT for acute depression

The first comparative study of the efficacy of IPT and antidepressant was conducted in acutely depressed, ambulatory men and women by using IPT alone, amitriptyline alone, and the two in combination, against a nonscheduled treatment group for sixteen weeks. [23,24] IPT was administered by experienced psychiatrists. The eighty-one depressed patients entered the randomized treatment study. [23,24] The control group was the nonscheduled treatment; the patients in this group were assigned a psychiatrist with whom they were told to get in touch whenever they felt a need for treatment.

The results found that each treatment alone effectively reduced symptoms than the nonscheduled treatment and combination treatment had greater outcome than each treatment alone. [23] IPT alone and amitriptyline alone had no differences in symptom reduction at the end of treatment, although the treatment effect of amitriptyline on vegetative symptoms of depression appeared earlier. Amitriptyline initially affected on vegetative symptoms such as disturbance in sleep and appetite, while IPT mainly affected on the patients' mood, work performance and interest, suicidal ideation, and guilt.[24] The effects of IPT became statistically apparent after four to eight weeks of treatment, and were sustained throughout the course of treatment. [24]

2. Follow-up after acute treatment

Patients were followed up one year after treatment had ended. Patients who received IPT either alone or in combination with amitriptyline had better psychosocial functioning, as parents, family members. Generally, they were better than those who received amitriptyline alone. [25]

3. IPT as maintenance treatment

There was a study of the efficacy of IPT maintenance treatment in an eight-month trial for women recovering from an acute depressive episode. This study compared with a low-contact control, with amitriptyline, placebo, or no pill. The combination of treatments was the most efficacious. It showed a lower risk of relapse, and greater improvement in social functioning. [26,27]

NIMH TDCRP study

This was a multi-site National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH TDCRP). [28] This study randomly assigned 250 depressed outpatients to sixteen weeks of imipramine, IPT, cognitive-behavior therapy (CBT), or placebo. Treatment manuals were used to define each treatment, and the recorded tapes of sessions were used to monitor the treatment

sessions. Most subjects completed at least fifteen weeks or twelve treatment sessions. IPT had the lowest attrition rate among the treatments. Less symptomatic patients improved in all treatments, including placebo/clinical management. Among more severe depressed patients, imipramine/clinical management induced the most rapid response and was the most consistently superior to placebo. IPT was comparable to imipramine/clinical management on several outcome measures, and was most consistently superior to placebo. CBT produced an immediate level of improvement, and was not superior to placebo for this group.

According to both the Boston-New Haven study and the TDCRP, sixteen weeks of treatment could induce remission, but not guarantee the maintenance of recovery from depression. [25,28]

In conclusion, major depression tends to be a recurrent and relapsing illness for which no acute treatment, psychotherapy or psychopharmacology, is curative. This research shows that IPT can treat an acute depressive episode, but the continuation and maintenance treatment at monthly level may be necessary to sustain remission. [25,28]

Dutch studies

Blom and colleagues did the open trial of IPT for patients with depressive disorders in the Netherlands. They found that IPT was effective for patients with depression. [29] After the success of the open trial of IPT on depression, Hoencamp and colleagues are doing a randomized study in the efficacy of IPT on 200 depressed patients in the Hague by comparing the efficacy of IPT alone, nefazodone alone, their combination, and IPT plus placebo for acute major depression. [29]

Neuroimaging study

There was a neuroimaging study of patients who received antidepressant treatment and IPT. [30] They randomized 28 patients with major depression to receive either venlafaxine or weekly IPT. The subjects were assessed by using SPECT imaging at baseline and after six weeks. Both treatment groups improved markedly, but showed different patterns of single photon emission computed tomography (SPECT) change. Patients receiving venlafaxine showed angular gyrus and dorsolateral prefrontal cortical (DLPFC) normalization, while IPT patients showed DLPFC and limbic central cingulate normalization.

Predictors of response

There were studies of some factors predicting the treatment response of IPT.

1. Patient factors

Sotsky and colleagues found that many patient factors predicted treatment outcome of depressed patients. [31] Patients with low level of social dysfunction (or interpersonal deficits) responded to IPT better than those with severe social dysfunction. Patients with symptom of more severity and difficulty in concentrating responded poorly to CBT. High initial severity of major depression and of impaired functioning predicted superior response to IPT and to imipramine. Both IPT and CBT had significantly higher response rates for patients with atypical depression (mood reactivity and reversed vegetative symptoms: hypersomnia, hyperphagia, and weight gain) than imipramine. [32]

The study of efficacy of IPT on depressed patients with personality disorders showed that IPT was more efficacious than CBT for patients with obsessive compulsive personality disorder, while CBT had better response for patients with avoidant personality disorder than IPT. [33]

Single, separated, or divorced patients responded to IPT better than to CBT, whereas married or cohabiting patients responded to CBT better than IPT. [33]

According to a biological study, it showed that patients with abnormal sleep electroencephalogram (EEG), abnormal sleep efficiency, REM latency, and REM density, had poorer response to IPT than patients without sleep EEG abnormalities. [34]

2. Therapist factors

A study of IPT maintenance for recurrent major depression found that the focal purity of IPT (the ability of therapist to focus on interpersonal issues) was significantly correlated with the prevention of relapse. [35,36]

Another study showed that the strength of therapeutic alliance also influenced the treatment outcome of IPT. [37]

3. The manual of interpersonal psychotherapy and the training in interpersonal psychotherapy.

The manual of IPT

Treatment manuals provide a basis for relative homogeneity of therapeutic approach and techniques used by therapists.This makes psychotherapy a uniform treatment. This is beneficial for treatment, training, and also researches in psychotherapy. IPT is one of manualized psychotherapies. IPT therapeutic manual was initially released at the time of Boston-New Haven studies of the 1970s. In 1984, the manual became a book, "Interpersonal Psychotherapy of Depression". [4]

To develop the IPT treatment manual, it is necessary to know whether IPT will work for a particular diagnosis or subpopulation within a diagnosis requires testing its efficacy. These are steps preceding the actual treatment studies:

1. Clinical experience of the therapist in IPT and also in the specific population is required to develop a manual for that group of population.

2. A survey and an assessment of the psychosocial and interpersonal problems in the treatment population are needed to appropriately modify the IPT manual for subpopulation from the original IPT manual.

3. Modifications of IPT deriving from the survey and assessment can be addressed in the manual by using case examples and scripts. The cases and scripts provide examples of problems and guidelines for dealing with those problems.

4. When a new manual is developed, it should be first used in pilot group then in a treatment population. A therapist can add or adjust some issues when the manual is used in the pilot group.

5. Once the new manual is completed, the manual can be used for training therapists and for studying IPT efficacy in researches.

Training requirements for IPT

Prerequisites for the trainees

1. Advanced healthcare or mental healthcare degrees, e.g., M.D., Ph.D., M.S.W., R.N. IPT are designed to be used by psychiatrists, psychologists,

psychiatric social workers, nurses, internists, or other health professionals. The trainees should already have achieved proficiency in some forms of psychotherapy, skills of listening and talking to patients, and some clinical experiences in working with patients.

2. Experience as a psychotherapist (at least two years). The trainees in IPT should have clinical experience in psychotherapy for at least two years.

3. Experience in working with depressed (or other target diagnosis) patients. The trainees should have experiences in working with the depressed patients or treating these patients.

Training steps in IPT

1. First, IPT trainees should read IPT manual which provides instructions and guidelines to conduct IPT.

2. Secondly, IPT trainees should attend didactic courses, seminars, or workshops or enter IPT training program. They may also watch IPT-training videos.

3. After the didactic courses, seminars, or workshops, IPT trainees are assigned two to four cases for IPT training and also weekly supervision on a session-by-session basis. Supervision should be done by trained IPT therapists by using videotapes or audiotapes.

4. After the supervisors evaluate the IPT trainees' performance and approve the competence of the IPT trainees. They will be given a certificate to ensure their competency for the trainees in IPT.

Discussion and Conclusion

Interpersonal psychotherapy (IPT) is a short-term psychotherapy which is aimed to understand the patients' interpersonal context related to their psychiatric symptoms and relate the interpersonal context to psychiatric symptoms. Correcting interpersonal problems related to their symptoms results in improvement of psychiatric symptoms. IPT was originally used for patients with depression. The four main areas of interpersonal problem related to depression are grief (complicated bereavement) or loss, interpersonal role disputes, role transitions, and interpersonal deficits. The techniques used in IPT are clarification, communication analysis, use of affect, role playing, problem solving, homework, and use of therapeutic relationship. IPT has shown the efficacy for treatment of mood disorders especially in major depressive disorder, and dysthymic disorder; other mood disorders: bipolar disorder; non-mood disorders: anxiety disorders, eating disorders, somatization disorder, and borderline personality disorder. Now IPT is one of evidence-based therapies that has a treatment manual. IPT treatment manual makes IPT a uniform treatment. It is beneficial for practice, training, and researches in psychotherapy.

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กิจกรรมการศึกษาต่อเนื่องสำหรับแพทย์

ท่านสามารถได้รับการรับรองอย่างเป็นทางการสำหรับกิจกรรมการศึกษาต่อเนื่องสำหรับแพทย์ กลุ่มที่ 3 ประเภทที่ 23 (ศึกษาด้วยตนเอง) โดยศูนย์การศึกษาต่อเนื่องของแพทย์ จุฬาลงกรณ์มหาวิทยาลัย ตามเกณฑ์ของศูนย์การศึกษาต่อเนื่องของแพทย์แห่งแพทยสภา (ศนพ.) จากการอ่านบทความเรื่อง **"จิตบำบัดสัมพันธภาพระหว่างบุคคลของโรคซึมเศร้า"** โดยตอบคำถามข้างล่างนี้ ที่ท่านคิดว่าถูกต้อง โดยใช้แบบฟอร์มคำตอบท้ายคำถาม โดยสามารถตรวจจำนวนเครดิตได้จาก http://www.ccme.or.th

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คำถาม - คำตอบ

1. Which one is not the characteristic of interpersonal psychotherapy (IPT)?
   - A. IPT is a focused psychotherapy
   - B. IPT does not deal with intrapsychic conflict.
   - C. IPT is a long-term psychotherapy.
   - D. IPT focuses on current relationship.
   - E. IPT is not used to change the patient's personality structure.
2. A depressed patient became depressed after a move to live with the new family members. Which one is the most likely area of interpersonal problem?
   - A. grief
   - B. interpersonal role disputes
   - C. role transitions
   - D. interpersonal deficits
   - E. interpersonal crises
3. Which one of the following is the least likely used psychotherapeutic technique in interpersonal psychotherapy (IPT)?
   - A. clarification
   - B. interpretation
   - C. communication analysis
   - D. role playing
   - E. decision analysis

✂.....

คำตอบ สำหรับบทความเรื่อง **"จิตบำบัดสัมพันธภาพระหว่างบุคคลของโรคซึมเศร้า"**

จุฬาลงกรณ์เวชสาร ปีที่ 50 ฉบับที่ 3 เดือนมีนาคม พ.ศ. 2549

รหัสสื่อการศึกษาต่อเนื่อง 3-23-201-9010/0603-(1005)

ชื่อ - นามสกุลผู้ขอ CME credit ..... เลขที่ใบประกอบวิชาชีพเวชกรรม.....

ที่อยู่.....

1. (A) (B) (C) (D) (E)
2. (A) (B) (C) (D) (E)
3. (A) (B) (C) (D) (E)
4. (A) (B) (C) (D) (E)
5. (A) (B) (C) (D) (E)

4. What is the characteristic of IPT therapist ?
   A. neutrality
   B. advocate
   C. friendship
   D. passivity
   E. authority
5. Which one (s) is/are approved for the treatment efficacy of interpersonal psychotherapy (IPT) ?
   A. major depressive disorder
   B. anxiety disorders
   C. somatization disorder
   D. eating disorders
   E. all of the above

เฉลย สำหรับบทความ รหัสสื่อการศึกษาต่อเนื่อง 3-23-201-9010/0602(1002)
1. d 2. e 3. a 4. e 5. e
สำหรับบทความ รหัสสื่อการศึกษาต่อเนื่อง 3-23-201-9010/0602(1003)
1. จ 2. ค 3. ค 4. ก 5. ค
สำหรับบทความ รหัสสื่อการศึกษาต่อเนื่อง 3-23-201-9010/0602(1004)
1. ข 2. ค 3. ก 4. ค 5. จ

ท่านที่ประสงค์จะได้รับเครดิตการศึกษาต่อเนื่อง (CME credit)
กรุณาส่งคำตอบพร้อมรายละเอียดของท่านตามแบบฟอร์มด้านหน้า

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