# 10 - 28.10 Interpersonal Therapy

# 28.10 Interpersonal Therapy

Raz A, Landzberg KS, Schweizer HR, Zephrani ZR, Shapiro T, Fan J, Posner MI. Posthypnotic suggestion and the modulation of Stroop interference under cycloplegia. Conscious Cogn. 2003;12:332. Santarcangelo EL, Busse K, Carli G. Frequency of occurrence of the F wave in distal flexor muscles as a function of hypnotic susceptibility and hypnosis. Brain Res Cogn Brain Res. 2003;16:99. Spiegel D. Negative and positive visual hypnotic hallucinations: Attending inside and out. Int J Clin Exp Hypn. 2003;51:130. Spiegel H, Spiegel D. Trance and Treatment: Clinical Uses of Hypnosis. 2nd ed. Washington, DC: American Psychiatric Press; 2004. 28.10 Interpersonal Therapy Interpersonal psychotherapy (ITP), a time-limited treatment for major depressive disorder, was developed in the 1970s, defined in a manual, and tested in randomized clinical trials by Gerald L. Klerman and Myrna Weissman. ITP was initially formulated as an attempt to represent the current practice of psychotherapy for depression. It assumes that the development and maintenance of some psychiatric illnesses occur in a social and interpersonal context and that the onset, response to treatment, and outcomes are influenced by the interpersonal relations between the patient and significant others. The overall goal of ITP is to reduce or eliminate psychiatric symptoms by improving the quality of the patient’s current interpersonal relations and social functioning. The typical course of ITP lasts 12 to 20 sessions over a 4-month to 5-month period. ITP moves through three defined phases: (1) The initial phase is dedicated to identifying the problem area that will be the target for treatment; (2) the intermediate phase is devoted to working on the target problem area(s); and (3) the termination phase is focused on consolidating gains made during treatment and preparing the patients for future work on their own (Table 28.10-1). Table 28.10-1 Phases of Interpersonal Psychotherapy

TECHNIQUES Individual Interpersonal Psychotherapy Initial Phase. Sessions 1 through 5 typically constitute the initial phase of ITP. After assessing the patient’s current psychiatric symptoms and obtaining a history of these symptoms, the therapist gives the patient a formal diagnosis. Therapist and patient then discuss the diagnosis, as well as what might be expected from treatment. Assignment of the sick role during this phase serves the dual function of granting the patient both the permission to recover and the responsibility to recover. The therapist explains the rationale of ITP, underscoring that therapy will focus on identifying and altering dysfunctional interpersonal patterns related to psychiatric symptomatology. To determine the precise focus of treatment, the therapist conducts an interpersonal inventory with the patient and develops an interpersonal

formulation based on this. In the interpersonal formulation, the therapist links the patient's psychiatric symptomatology to one of the four interpersonal problem areas—grief, interpersonal deficits, interpersonal role disputes, or role transitions. The patient's concurrence with the therapist's identification of the problem area and agreement to work on this area are essential before beginning the intermediate treatment phase.

Intermediate Phase. The intermediate phase—typically sessions 6 to 15— constitutes the "work" of the therapy. An essential task throughout the intermediate phase is to strengthen the connections the patient makes between the changes he or she is making in his or her interpersonal life and the changes in his or her psychiatric symptoms. During the intermediate phase, the therapist implements the treatment strategies specific to the identified problem area as specified in Table 28.10-2. Table 28.10-2 Treatment of Interpersonal Problem Areas Termination Phase. In the termination phase (usually, sessions 16 through 20), the therapist discusses termination explicitly with the patient and assists him or her in understanding that the end of treatment is a potential time of grief. During this phase, patients are encouraged to describe specific changes in their psychiatric symptoms, especially as they relate to improvements in the identified problem area(s). The therapist also assists the patient in evaluating and consolidating gains, detailing plans for maintaining improvements in the identified interpersonal problem area(s), and outlining remaining work for the patient to continue on his or her own. Patients are also encouraged to identify early warning signs of symptom recurrence and to identify plans of action. Ms. G is a 51-year-old woman who presented for treatment of binge eating disorder. She is college educated, has her own business, and is a divorced mother of one adult son in his early 20s. Before treatment, she had a body mass index (BMI) of 42 and had been binge eating approximately 10 to 15 days per month for the past 8 years. Along with her current diagnosis of binge eating disorder, Ms. G struggled with recurrent major depression. During the initial phase, Ms. G and her therapist began to review her history and the interpersonal events that were associated with her binge eating. Ms. G shared that she began overeating and gaining weight at age 14. When she was 18 years of age,

she moved to a foreign country with her parents. Soon after the move, Ms. G's father left her and her mother to return to the United States. Ms. G was enraged at her father for leaving them and still gets very tearful and angry when discussing the separation. She and her mother decided to stay abroad because she had started university and her mother was working. Both had developed strong social ties and felt comfortable in their new home. During this time, Ms. G continued to gain weight and started dieting. Shortly after graduating from university, Ms. G met and married a foreign national and, at the age of 28, delivered their only son. Two years later, she and her husband went through a very bitter divorce. Although Ms. G described this as a terrible time in her life, she maintained close ties with her friends and her mother. During this time, she began to diet and reached her lowest adult weight. At the age of 35, when her mother died of a heart condition, Ms. G had her first episode of major depression, which was treated and resolved with antidepressants and a brief course of psychotherapy. Although she had previous cycles of weight loss and weight regain, she did not evidence any sign of eating disturbance at this point. She continued to maintain close social ties and enjoyed her close relationship with her son. When Ms. G was in her early 40s, an economic downturn in her adopted country forced her to return to the United States. Having lost all of her savings, she struggled financially while she looked for work. During this time, she started binge eating and gaining weight. Within 1 year of this move, Ms. G's son decided to return to live with his father (who was very wealthy). Ms. G felt angry and betrayed.

Yet, when her son would visit, she would assume a subservient role with him, because she was afraid of losing his affection. He, in turn, became quite demanding and critical of her. Before seeking treatment, her heightened feelings of isolation and loneliness were leading to increased binge eating, depression, and weight gain. By session 3 of the initial phase, Ms. G's therapist began to consider which problem area would be the focus of the remainder of treatment. Ms. G had a history of important relationship losses and subsequent grief—the loss of her father, her husband, her mother, and, most recently, her son. However, none of these losses was associated with the development of binge eating problems (although her dieting was clearly linked to her feelings of anger after the divorce from her husband and her depression was intimately linked with her mother's death). Ms. G's anger at her son for returning to live with the enemy was clearly a role dispute, yet her binge eating had begun 2 years before his departure (although it clearly worsened after he left). Because neither of these problem areas was directly linked to the onset of the eating disorder, Ms. G's therapist decided that the focus of treatment would be to assist her in managing her role transition. Her move back to the United States, with the subsequent loss of her support and friendship networks, was clearly associated with the onset and continued maintenance of her binge eating. During session 4 of the initial phase, Ms. G's therapist shared her formulation of the problem area with her: "From what you have described, your binge eating really began after you returned to the United States. After that transition, you were more isolated and alone than you have ever been. It seems that binge eating was a way for you to manage that

transition and the subsequent feelings of isolation and loneliness. Your transition has also had a negative impact on your relationship with your son. Even though you are a very social person and enjoy the company of others, you have yet to develop the kind of support that you had before you moved. Although you have struggled with some very significant issues over the course of your life—your father leaving, the pain of the divorce, and the death of your mother—your friends and support systems sustained you. If we work together to help you find and develop more intimate and supportive relationships here, I believe you will be much less likely to turn to food and binge eating as a source of support or comfort." Ms. G agreed with the formulation and worked with her therapist to establish some treatment goals to help her resolve the problem area. First, she was encouraged to become more aware of her feelings (especially isolation and loneliness) when she was binge eating and of how binge eating seemed to be the way she managed those feelings. A second goal was for her to take steps to increase her social contacts and develop more friendships. The third goal, which was identified as a secondary problem area, centered on helping Ms. G resolve the role dispute with her son. Specifically, the therapist developed a goal with her to help her establish a clearer parental role with her son. During the intermediate phase, the therapist helped Ms. G grieve the loss of her previous role and the extensive support that she once had. Ms. G and her therapist worked to identify several sources of support and friendships of which she had not been aware. Soon after, Ms. G reported significant progress in initiating and establishing relationships with others. This change appeared to help give her confidence in her new roles. In fact, she had begun to receive a few social invitations. She was more attuned to the ways that she would rely on food, especially when she felt lonely or felt that she was not receiving enough time from others. The connection between the lack of supportive contacts and binge eating was becoming very clear to her in these intermediate sessions. During this phase, the therapist also assisted her in setting appropriate limits in her relationship with her adult son and in recognizing his adult-like responses in return. By the termination phase, Ms. G reported that she no longer felt so lonely and isolated and that her binge eating had all but disappeared. She remarked how the

quality of her relationship with her son had changed dramatically. He was more supportive and respectful, visited more frequently, and stayed with her for longer periods of time. In the final sessions, she talked about her need to let go of the past and move on with her life as it is now, assuming her new roles more fully. She worked closely with her therapist to develop a plan to maintain the gains that she had made in treatment and used the final session to review the important work that she had accomplished. (Courtesy of D. E. Wilfley, Ph.D., and R. W. Guynn, M.D.) Interpersonal Psychotherapy Delivered in a Group Format

A recent approach in the ongoing development of ITP has been its use in a group format. ITP delivered in a group format has many potential benefits in comparison with individual treatment. For example, a group format in which membership is based on diagnostic similarity (e.g., depression, social phobia, eating disorders) can help alleviate patients' concerns that they are the only one with a particular psychiatric disorder, while offering a social environment for patients who have become isolated, withdrawn, or disconnected from others. Given the number and different types of interpersonal interactions in a group setting, the interpersonal skills that are developed may be more readily transferable to the patient's outside social life than are the relationship patterns that are addressed in a one-on-one setting. Moreover, a group modality has therapeutic features not present in individual psychotherapy (e.g., interpersonal learning). The group format also facilitates the identification of problems common to many patients and provides a cost-effective alternative to individual treatment. Table 28.10-3 links the phases of ITP to the stages of group development. Table 28.10-3 Stages of Group Development in Interpersonal Psychotherapy (ITP) Timeline and Structure of Treatment. The typical course of group ITP lasts 20 sessions over a 5-month period. It is recommended that group size range from six to nine members, with one or two group leaders, depending on resources and training needs. The three individual meetings (pregroup, midgroup, and postgroup), sequenced to correspond with critical time points in the three phases of ITP, in combination with other techniques, were designed to maintain the exclusive and strategic focus on individual patients' interpersonal problem areas—the hallmark of ITP. Pregroup Meeting. The pretreatment meeting is crucial for facilitating a patient's individualized work in the first phase of group ITP. The focus of the 2-hour pretreatment meeting is to identify interpersonal problem areas, establish an explicit treatment contract to work on problem areas, and prepare patients for group treatment. After identifying a patient's interpersonal problem(s) (i.e., interpersonal deficits, role disputes, role transitions, or grief), the therapist works collaboratively with the patient to formulate concrete prescriptions for change, in addition to the specific steps the

patient will take to improve social relationships and patterns of relating. These goals of treatment are expressed in language that is as specific and personally meaningful to the patient as possible. Before the start of the group, each group member is given a written summary of his or her goals and told that these goals will guide his or her work in the group. Another important element of the pregroup meeting involves adequately preparing patients for group treatment. That is, patients are encouraged to think of the group as an "interpersonal laboratory" in which they can experiment with new approaches to handle challenging interpersonal situations. In this regard, patients are informed about the important interpersonal skills that are learned while participating in a group (e.g., interpersonal confrontation, honest communication, expression of feelings) and are encouraged to learn from others as they see changes occur. The therapist stresses to patients the importance of keeping their work in the group focused on changing their current interpersonal situations or intensifying important existing relationships and not using the group as a substitute

social network. Initial Phase. The first five sessions of the group treatment comprise the initial phase in group ITP. During this phase, the therapist works to cultivate positive group norms and group cohesion, while emphasizing the commonality of symptoms among members and how they will be addressed in the group context. During this phase, group members are encouraged to review their goals with the group and begin to make some initial changes in their respective interpersonal problem areas. As members begin to experiment with the changes outlined in their goals, the therapist works collaboratively with each group member to refine and make any alterations in the target areas before the beginning of the intermediate phase. Intermediate Phase. During the intermediate “work” phase of group ITP (sessions 6 through 15), the therapist works to facilitate connections among members as they share the work on their goals with one another. In contrast to other interactive group approaches, the group interpersonal psychotherapist is much less likely to focus on intragroup processes and relationships unless they are specific to the work on a member’s interpersonal problem area (e.g., interpersonal deficits). The therapist, however, consistently and continuously encourages group members to practice newly acquired interpersonal skills both inside and, most importantly, outside the group. As is the case with individual ITP, an essential task throughout the intermediate phase is to strengthen the connections the group members make between difficulties in their interpersonal lives and their psychiatric problems. MIDTREATMENT MEETING. The midtreatment meeting is held midway (usually between sessions 10 and 11) through the intermediate phase. This meeting provides an opportunity to conduct a detailed review of each group member’s progress on his or her individual problems and to refine interpersonal goals. The therapist(s) recontracts with group members during this meeting as a means of outlining and emphasizing the work

---

Revision #1
Created 2026-01-04 19:51:33 UTC by Omar Ayman
Updated 2026-01-04 19:51:33 UTC by Omar Ayman