**Interpersonal Therapy in IAPT: Information for Practitioners.**

**Introduction:**

IPT is used to treat a wide variety of conditions including eating disorders and trauma, but in IAPT it is used to treat **depression** only. IPT works primarily by considering the interplay between interpersonal difficulties and psychological problems such as low mood. Depression often causes disruptions or difficulties in a person’s relationships, for example someone may stop seeing friends or withdraw from family relationships because they feel low. Also, difficulties in a person’s relationships can both cause and maintain depression. IPT addresses both the depressive symptoms, and the specific issues in the patient’s relationships which are impacting on their mood.

**Inclusion/Exclusion criteria for IPT in IAPT**

**Inclusion:**

1. **Patient’s main presenting problem is depression (PHQ9 15+)**
2. **There is a clear onset to the depression.**
3. Depression is caused by an event or events which have impacted on their interpersonal network. This could be anything with a ‘before’ and an ‘after’. Bereavement, divorce, redundancy, marriage, partner’s retirement, becoming a parent, changing jobs, moving house, etc., etc., **or**
4. Depression is caused by interpersonal difficulties such as isolation, or a dispute/conflict with a significant other such as a partner, sibling, parent or boss, **and**
5. **Relationship issues will be evident in the patient’s problem statement.**

**The last item on the WASA is likely to score highly.**

The patient recognises the interplay between mood and relationships, and an interpersonal formulation of their difficulties is acceptable to them.

1. Ability to form a therapeutic alliance, to receive help and collaborate.
2. Enough ego strength and stability to tolerate structured therapy including challenge and with change on the agenda
3. Motivated to engage in therapy, explore new solutions including setting goals, and make the necessary pragmatic effort.
4. Able to commit to attending 16 weekly sessions.

**Exclusion:**

1. As for IAPT in general: Psychosis/personality disorder/severe early trauma/alcohol or drug addiction/poor impulse control/high risk/eating disorder.
2. Never been well/always been depressed
3. Wants to explore past issues (IPT is very present focused)
4. Memory difficulties which prevent retention of information between sessions.

IPT is carried out over 16 sessions. The first 4 sessions are used to assess, leading to formulation at session 4 which will clarify a primary focal area which will be used in therapy. Below are brief case histories exemplifying each of the focal areas.

Sensitivities is not generally used as a focus unless there are no transitions, bereavements or disputes ‘in bold’ in the person’s timeline: often there is more chronicity to the person’s problems and social isolation may be the main perpetuating factor in their depression.

**Nina: TRANSITION**

Nina had no previous history of mental health problems, but presented to IAPT services following the traumatic break up of her marriage. Assessment of events over time (the narrative of her depression) showed clearly that this was the main event which had triggered her depression. Assessment of her interpersonal network showed that she was isolated and the few relationships she did have were fraught. The chosen focal area allowed her to process more fully the trauma of the relationship breakdown, and the mourn all that she had lost subsequent to the relationship ending. Therapy also allowed her to explore and begin to develop the new skills and competencies she needed in her new role as a single, independent woman.

**Luke: GRIEF**

Luke presented to IAPT with depression which had lasted many years. The main issue he felt was impacting on his mood was the sudden death of his wife 8 years previously. Exploration of his current relationships showed that he was well supported a circle of friends he had met since his wife had died. Working in the grief focus, we reconstructed his relationship with his wife, and he realised early on that he needed to ‘get her down off a pedestal’ and think of her in a more realistic way. During therapy he was able to acknowledge that at the time of his wife’s death, he had felt completely alone and had had no-one to talk to about his loss. He also acknowledged how much anger, guilt and personal responsibility he felt about her death. Luke was able to release himself from much of this self-blame and negative emotion, and to reinvest in his current relationships.

**Karen: CONFLICT**

Karen had multiple stressors in her life and difficult relationships with her partner and teenage daughter who had behavioural problems and physical health issues. Karen found her husband unsupportive and dismissive. We used a conflict focus to explore in detail the issues she and her husband disagreed over, communication patterns and styles, and potential fresh ways to address the communication failures at home. Karen was able to put new communication ideas into practice and reaped the rewards (with some surprise) as her husband responded well to her new initiatives.

**Wendy: SENSITIVITY**

Wendy presented with a long history of depression which had recently worsened. She was a single mum to an adult child with profound physical disabilities, and had withdrawn gradually from almost all other relationships. As there were no significant bereavements, conflicts, or transitions in her timeline, and as her mood problems were long term, we decided to use a sensitivities focus. We explored the patterns of interaction that had characterised her relationships over the years, including successes as well as difficulties. Gradually Wendy was able to risk trying new and different ways of interacting with others, and began to reach out more and to take up new roles in the community. We used our therapeutic relationship to explore hunches about how and why other relationships in her life may have thrived or failed.