Interpersonal counselling in general practice

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BACKGROUND

Interpersonal counselling (IPC) derives from interpersonal psycho-therapy (IPT) but is briefer in the number and duration of sessions and is particularly suited to the primary care setting. While depression and other psychological symptoms are not necessarily 'caused' by interpersonal problems, they do occur in a social and interpersonal context. Problem areas commonly associated with the onset of depression are unresolved grief, interpersonal disputes, role transition and interpersonal deficits such as social isolation.

OBJECTIVE

This article discusses IPC and how it can be used in the general practice setting.

DISCUSSION

The structure of IPC is of a brief treatment of six sessions, each with an explicit focus: assessment, education about the interaction between interpersonal relationships and psychological symptoms, identifying current stress areas and helping the patient deal with these more positively and termination of the IPC relationship. Interpersonal counselling can be utilised general practice to reduce psychological symptoms, restore morale, improve self esteem and the quality of the patient's social adjustment and interpersonal relationships.

Over the past two decades a number of controlled clinical trials have demonstrated the efficacy of psychological therapies for the treatment of psychiatric disorders.[1] Different psychotherapies share a number of features that contribute to their effectiveness. These include:

- a rationale for the patient's symptoms and for relieving these
- the provision of information
- experiences of success and improved sense of mastery
- a constructive therapeutic relationship, and
- facilitation of emotional arousal.[2]

A major difference is their conceptualisation of the causes of the patient's problems and consequently the ways in which these problems are tackled. To change personality dysfunction, long term treatment is needed. Where the goal is to deal with immediate problems and most symptomatic states, short term treatment is beneficial. Behaviour therapy, cognitive behaviour therapy and interpersonal psychotherapy are the three short term psychosocial treatments shown to be effective for a range of psychiatric disorders. Interpersonal psychotherapy (IPT) and its derivative, interpersonal counselling (IPC), are the focus of this article.

Interpersonal psychotherapy

Theoretical basis

The interpersonal approach has a long history dating from the work of Adolf Meyer[3] and Harry Stack Sullivan[4] in the 1950s. Meyer viewed psychiatric disorders as an expression of the individual's attempt to adapt to his or her environment and enlarged the scope of psychiatry's concern to include social and cultural forces. Sullivan extended Meyer's views, defining psychiatry as the field of interpersonal relations. Together with his associates, he developed a theory of the connections between psychiatric disorders and interpersonal relationships. Using this approach, the unit of observation and therapeutic intervention is the primary social group and the individual's closest relationships: family relationships, love relationships, friendship patterns, work relations, and neighbourhood or community relations.

Interpersonal psychotherapy draws on this theoretical background together with the work of clinicians such as Fromm-Reichmann, Bowlby, Arietti, Chodoff and Frank.[5,6] Importantly, IPT is also based on empirical research on the psychosocial aspects of depression. This includes evidence for the role of bereavement, marital

disputes and life changes in the onset of depression and of social supports as a protective factor against depression.[5,6]

Interpersonal psychotherapy was originally developed as a time limited (12–16 weeks) weekly intervention for unipolar nonpsychotic depression.[5] Interpersonal psychotherapy uses an interpersonal conceptualisation of depression; it assumes that the development of clinical depression occurs in a social and interpersonal context and that the onset, response to treatment, and outcomes are influenced by the interpersonal relations between the patient with depression and significant others.[6]

Practical application

Therapy is designed to help the patient master the context and uses the connection between the onset of depressive symptoms and current interpersonal problems as a practical and commonsense treatment focus. Therapy is focussed rather than nondirective and deals with current – not past – interpersonal relationships. The focus is interpersonal rather than intrapsychic or cognitive/behavioural. Personality is recognised but not a focus.[7] Four problem areas commonly associated with the onset of depression are explored:

- unresolved grief or loss
- interpersonal disputes
- role transition, and
- interpersonal deficits (eg. social isolation).

Attention is directed to the patient's particular interpersonal problem area as it relates to the onset of depression. Details of the IPT structure and techniques are provided in the book '*Interpersonal Psychotherapy for Depression*',[5] and further information about the procedures for IPT, it's adaptations for other conditions and for primary care, can be found in the latest IPT revision.[7]

Interpersonal counselling

Interpersonal counselling derives directly from IPT but is briefer in the number and duration of sessions. It is designed for patients who are in distress and have symptoms due to current stressors in their lives, but who do not have serious concurrent psychiatric disorders or medical conditions that can or should be treated more effectively by medication or other psychosocial treatments.

Two trials of IPC in primary care have demonstrated the treatment was effective in reducing depressive symptoms and improving self rated health status,[7] and it has been used (together with antidepressants) for the treatment of mild to moderate depression in general practice with good effect.[8,9]

Within the IPC framework, psychological distress is viewed as having three component processes:

- symptom formation – somatic signs and symptoms, eg. fatigue, sleep disturbance, headaches
- social and interpersonal relations, and
- personality – enduring traits and behaviours which may contribute to a predisposition to symptom episodes.

The goals of IPC are to intervene to:

- reduce psychological symptoms restoring morale and improving self esteem, and
- improve the quality of the patient's social adjustment and interpersonal relations (see *Case histories*).

Why choose IPC?

Essentially, the general practitioner needs to consider three questions:

- are the patient's problems amenable to, and best treated by, a psychological therapy
- is this patient likely to benefit from, ready for, and motivated to use a psychological therapy, and
- is IPC the most suitable psychological approach?

A patient's motivation and expectations are critical factors for a successful outcome with psychological treatments. Motivation is a dynamic variable that may vary with treatment successes or disappointments. Appropriate realistic expectations of the treatment and the patient's ability to be introspective, self reflective and reality oriented will also influence the likelihood of success. The IPC approach depends on the principle that life events and the social environment affect mood and that mood can affect social and interpersonal functioning and one's response to the environment. To use IPC, the GP needs to make both an

Case history 1 – grief

John is a 43 year old man who attends the clinic 'as needed' rather than on a regular basis. After three visits within 6 weeks for nonspecific physical complaints, his GP booked a longer consultation for review. John described tiredness, sleep disturbance, lack of enjoyment in and withdrawal from his usual social activities, and nonspecific somatic complaints of approximately 3 months duration. After discussion, John revealed these problems began a few weeks after his father's death from cancer.

John reported feeling guilty for not spending more time with his father. He felt particularly bad that his father had been living alone for the 2 years before his death and that he had not done more to assist him, particularly as he became more housebound due to his declining health. John felt he'd let his mother down too, by not being more supportive of his father after her death left him living alone. John was also angry that his younger brother, always regarded by John as their father's favourite son, did not seem upset by his father's death.

The GP initially focussed on having John discuss his feelings about his father, their relationship and the past few years of his father's life. The GP encouraged John to talk about the pressures he'd been under for the past few years and the conflict he had experienced trying to balance the demands of his business, his wife and children, and his unwell father. He also talked of his previously barely acknowledged anger toward his younger brother – a successful businessman with no wife or children to make demands on him.

In addition to talking about these key relationships and feelings, the GP helped John to review the various demands on his time, energy and emotions and make some key changes. Importantly, the GP helped John to identify the need to make time for himself and for some pleasant social and recreational activities.

Case history 2 – role transition

Jane is a 47 year old woman who has been a regular attendee of the clinic with her children. She has been in good health, but over the past 6 months has had several appointments to talk to her GP about anxiety. She has had palpitations, nausea and episodes of dizziness. Physical examination was unremarkable and simple investigations (including thyroid function tests and ECG) were normal. Jane had no significant past medical history and no past psychiatric history, although her GP had noted she had always been a little overanxious about her children.

As her GP explored what had been happening in Jane's life, she revealed that Tom, her older child, had moved out of home 2 years ago to live in a shared house with university friends. At the time, Jane had become quite stressed and miserable, but this settled as she threw herself into supporting her younger child Sally, negotiate her VCE year. After successfully completing this, Sally also commenced university, initially still living at home. However, 6 months ago, Sally too had moved out of home.

Jane had been a devoted mother. As she didn't work, Jane had channelled her time and energy into activities supporting Tom and Sally. Much of her social network focussed on activities with other parents, both at school and in the sports groups Tom and Sally were involved in. When Sally left school, much of Jane's social network collapsed. Her feelings of isolation and difficulty knowing how to fill in her time markedly increased when Sally moved out of home.

The GP spent considerable time talking with Jane about her role as a mother, examining the many positive aspects of this, but also identifying those things which that role had prevented her doing. Together, Jane and the GP identified the opportunities now available to Jane, and Jane began to engage in a new range of activities and interests she'd previously not had time for.

Table 1. The structure of IPC

Visit	Purpose
1	• Establish rapport
	• Rule out physical illness as a cause for symptoms
	• Determine the presence of any specific psychiatric diagnosis
	• Introduce IPC and suggest the possible relationship between the patient's symptoms of distress and current life stress
	• Explore the patient's current interpersonal and social situation (interpersonal diagnosis)
2	• Identify with the patient the specific current stress areas that are contributing to the symptoms (interpersonal formulation)
3, 4, 5	• Help the patient deal more positively with the specific stress area identified
	• Homework assignments are used to accelerate the process of change for each area
6	• Termination of the IPC relationship

illness diagnosis (eg. depression) and an interpersonal diagnosis. The latter, which identifies recent changes in relationships which can be temporally related to the onset of mood symptoms, provides the interpersonal focus for treatment.

The structure of IPC

The structure of IPC is that of a brief treatment of six sessions, each with an explicit focus or purpose (*Table 1*).

Visit 1 – the treatment contract

In the first visit – usually the longest session – the GP determines the patient's suitability for IPC and introduces IPC to the patient. Patients with major depression, bipolar disorder, or who are psychotic or suicidal are not suitable for IPC. In order to establish an interpersonal diagnosis, the GP asks the patient about recent changes in life circumstances, mood and social functioning, and explores how life circumstances relate to the onset of symptoms. By the end of the session the GP should develop an explicit treatment contract with the patient that emphasises:

- the nonpsychiatric motive of the intervention, ie. the focus is on understanding how life stresses are contributing to feelings
- the short term duration of the intervention (up to six sessions of up to 30 minutes each)
- the expected benefits – to reduce symptoms to find better ways of coping, and
- that IPC is in addition to usual medical care.

At the end of the visit, the GP gives the patient homework – a life events scale[10] to complete and bring back to the next visit.

Visit 2 – determining the specific problem area(s)

The GP should review the life events scale, incorporate previous patient knowledge,and use any other information provided in the session to identify current stress area(s) in the patient's life that may be contributing to the symptoms. This interpersonal formulation lays the framework for planning treatment.

In order to identify problems and to assist the patient make sense of his or her symptoms and their onset in relationship to life circumstances, it is useful to review the following:

- onset and duration of present symptoms
- current life circumstances
- close interpersonal relationships, and
- any recent changes in any of these.

Overall, the GP's task is to assist the patient to identify the key person(s) with whom he/she is having difficulties, what type of problems are being experienced, and whether there are ways to make the relationship more satisfactory.

Table 2. Specific stress areas and treatment goals

Problem area	General goals of treatment	Strategies
Grief or loss	• Facilitate the mourning process • Help the patient re-establish interests and relationships that can substitute for what is lost	Relate symptom onset or exacerbation to death/loss of significant other Talk of the deceased – the type of person he/she was, relationship with them, circumstances of illness and death *Homework:* ° Look over old photographs, see old friends and discuss at subsequent sessions ° Encourage involvement in new social activities
Interpersonal disputes	• Identify the dispute • Guide the patient in making choices about a plan of action • Encourage the patient to reassess expectations or poor communication in order to bring about satisfactory resolution of the interpersonal disputes	Relate symptom onset to overt or covert dispute with significant other *Key questions:* ° What are the issues in the dispute? ° How likely is change to occur? ° How do the patient and person they are in dispute with usually work on differences? Is there a pattern? – Has this happened before in other relationships? *Homework:* ° eg. more direct expression of wishes to family/friends ° eg. in work relationships seek opportunity to talk and explain point of view and see the other person's point of view
Role transitions	• Mourn and accept loss of old role • Enable the patient to regard the new role in a more positive, less restricted manner, or see as an opportunity for growth • Restore self esteem by developing in the patient a sense of mastery in relation to the demands of the new role related attitudes and behaviours	Relate symptoms to difficulty in coping with recent life changes Similar to those for grief – giving up old role – facilitate evaluation of what has been lost, encourage release of affect and develop social support system *Homework:* ° To assist the transition, seek transitional objects, eg. old picture, furniture from former place in life into new role ° Make new contacts, eg. prescribe a social outing with new neighbour, work colleague
Loneliness and social isolation	• Reduce the patient's social isolation • Find examples of relationships in the past which have been meaningful • Assist to form new relationships	Relate symptoms to problems of social isolation or unfulfilment Review past relationships, identify the best and worst part of each Identify difficulties in relationships in past: ° Role play a social situation ° Identify any correctable deficits in patient's communications skills *Homework:* ° Make contact with old friends ° Seek out social situations, eg. clubs, sports, church

Visits 3–5 – working on specific stress areas

The GP works with the patient to deal with specific problem areas. The most common problem areas, which are not mutually exclusive, are shown in *Table 2*. Given the brevity of treatment, it is usually prudent to choose one or two areas to work on. The broad goals of treatment in each problem area are shown in *Table 2*. Strategies and techniques, including homework tasks to meet these goals vary with the problem area (*Table 2*).

Visit 6 – termination

This visit is usually held 2 weeks after visit five, but may be earlier if the patient feels they have achieved all they wanted. The GP should review the previous sessions and the patient's current state and discuss the termination of IPC. The GP should emphasise the progress made, the supports available to the patient, and bolster the patient's sense of his/her ability to cope with future problems. The GP should work with the patient to identify potential sources of stress and ways in which the patient could cope with these, especially referring to strategies that the patient found effective during counselling.

Many patients will show concern about termination. In some instances, an additional visit to complete the termination process will be appropriate. For those patients who are still symptomatic and have shown little or no improvement with IPC, alternative treatment should be considered.

Training and supervision

Mental health professionals access 'supervision' as a matter of course in their professional lives. Supervision helps to maintain and increase clinician's knowledge, understanding and skills, as well as providing ongoing support.[11] By contrast there is no expectation of, or specific framework for, supervision of GPs involved in mental health related work.[12]

While a treatment manual is available to guide the use of IPC, training is required. In general, this includes an overview of the rationale for, structure and techniques of IPC, and review of the IPC manual. This is generally followed by a practicum during which the GP treats two or three patients under supervision (eg. audiotaped sessions which can later be discussed).[13] Ongoing supervision can also be useful, providing a formal structure for GPs to: conceptualise and formulate patients' mental health difficulties (eg. illness diagnosis, differential diagnosis, identifying the problem areas and linking the problem areas to the illness diagnosis), increase knowledge, understanding and use of treatment skills, discuss issues in a supportive and educative environment, and explore and discuss issues with their peers and an external 'expert'.

As with other treatment approaches, a variety of problems may be encountered. These include worsening of symptoms or the patient remaining chronically distressed necessitating other or additional treatment (eg. antidepressants). The patient may avoid positive experiences, not complete homework tasks, be silent, avoid or change topics, or terminate IPC early. These actions by the patient must be actively dealt with; supervision can be very helpful in identifying the reasons for these behaviours and strategies to deal with them. Likewise, supervision is of benefit in managing the patient who becomes excessively dependent and does not wish to terminate IPC.

Conclusion

Interpersonal counselling is a practical and effective approach for the treatment of common mental health problems that can readily be integrated into general practice. The focus on life events, social, and interpersonal problems is familiar to GPs. The frequency and duration of sessions required is feasible and can be supported by the new 'focused psychological strategies' Medicare Benefits Schedule item number.

Resource

An IPC training video for use in treating depression in general practice can be obtained from the Department of General Practice, Monash University, Victoria.

Conflict of interest: M Weissman receives royalties from her books on IPT.

SPOT CHECK

IPT does not assume interpersonal problems 'cause' depression – whatever the cause, the current depression occurs in an interpersonal context

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