

# Interpersonal Psychotherapy (IPT) for Schizophrenia

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Although developed in order to treat depression without psychotic symptoms, Interpersonal Psychotherapy (IPT) may prove to be a useful treatment for patients with schizophrenia. Conceptually, IPT may help to form and structure a treatment model that takes into account specific characteristics of schizophrenia, such as a disorganized thought process and pervasive interpersonal deficits. This paper provides a brief critique of two frequently used psychotherapeutic models, cognitive behavioral therapy (CBT) and insight-oriented therapy, which appear to be fundamentally incongruous with current conceptualizations of schizophrenia. It then lays out a preliminary conceptual adaptation of IPT for use as both an intervention and a maintenance therapy for patients with schizophrenia.

Schizophrenia is a psychotic disorder characterized by disorganized thoughts and behaviors, pervasive interpersonal deficits, and an array of symptomatology that can be divided into positive and negative symptoms. Positive symptoms may consist of delusions, hallucinations, disorganized speech or behavior, and inappropriate affect, while negative symptoms include flattened affect, anhedonia, poverty of speech, avolition, and social withdrawal (Cornblatt, Green, & Walker, 1999). It is an organic disease of the brain characterized by a chronic and pervasive course (Cornblatt, Green, & Walker, 1999).

The current trend in psychotherapeutic interventions for patients with schizophrenia falls into one of two conceptual spheres: cognitive behavioral therapy (CBT), and psychodynamic or insight-oriented therapy. Psychotherapy for any psychotic disorder is optimally put into place in conjunction with medications including, but certainly not limited to, antipsychotic medication. Because schizophrenia is an organic disease, at least in part, medication is necessary to bring about stability. Most medications target positive symptoms (Johns, Sellwood, McGovern, & Haddock, 2002), although they may exacerbate negative symptoms, as side effects include sedation, reduced drive, psychomotor retardation, and flattened affect (Beck, 2004). The goal of psychotherapy, then, should be to reduce and help patients cope with those symptoms medication does not alleviate, and to increase general functioning. Currently, even with the combination of antipsychotic medication and psychotherapy, 25-60% of patients continue to exhibit psychotic symptoms. The need for a more disorder-relevant treatment is thus abundantly clear (Jones, Despaul, & van Os, 2003).

## Cognitive Behavioral and Insight-Oriented Therapies

Cognitive behavioral therapy, or some variation of it, is the most widespread psychotherapeutic model used in treating patients with schizophrenia. In the cognitive behavioral approach, patients are first given a rationale for the treatment, including educational information about their diagnosis and symptomatology. The interaction between thoughts and behaviors is then explained in a clear, logical manner, and patients are taught “reality testing” skills in order to reduce positive symptoms. Finally, delusions are restructured using cognitive restructuring techniques (Gaudiano, 2005).

There is evidence that despite some efficacy, a cognitive behavioral approach may not be the best form of therapy for persons with schizophrenia. Indeed, it only proves to be significantly efficacious in approximately half of test subjects (Jones, Despaul, & van Os, 2003). One study examining the efficacy of CBT on patients with schizophrenia who had intellectual deficits showed that while 60% of subjects had improved scores on the Aberrant Behavior Checklist, only 40% of patients showed an increase in the frequency or nature of their community involvement (Kingdon & Turkington, 2005). In a study examining the efficacy of CBT for negative symptomatology, although subjects showed a significant reduction in avolition, they did not improve significantly in their negative symptoms, and there were no significant differences on the Subjective Experience of Negative Symptoms, a scale measuring awareness of negative symptoms in addition to associated disruption and distress (Johns et al., 2002).

The main problem with CBT is that the approach relies on the patient’s ability to understand his or her thoughts—delusional or otherwise—in a rational manner (Stuart & Noyes, 2005). People who have schizophrenia, however, are often characterized by “pervasive disabilities in social cognition that often seemed to conspire against a more

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complete clinical and social recovery” (Hogarty et al., 1997, p. 1505).

For similar reasons, psychodynamic, or insight-oriented, therapy has proven less effective than other psychotherapeutic techniques in the treatment of people with schizophrenia. Psychodynamic therapy relies upon a patient’s presumed ability to draw logical conclusions from insights, which may not be applicable for this patient population, most of whom have delusional thoughts (Hogarty, et al., 1997). Additionally, there is a high dropout rate in patients participating in studies of the efficacy of psychodynamic therapy for patients with schizophrenia, a finding that is at least partly due to the relatively high degree of “cognitive demands, which may exceed the patient’s capacities at different stages of recovery” (Hogarty et al., 1997, p. 1506).

The governing principles behind both cognitive behavioral and psychodynamic therapies expose a conceptual understanding of delusional thoughts as constructed and interpreted in the same manner as normal thoughts. In his text, Jaspers (1963) postulates that delusional thoughts are distinct from normal thoughts, in that the former involve a change in the mechanism of belief. Delusional thoughts differ from normal thoughts not in their content, but in their formation, such that the awareness of meaning itself is transformed. These thoughts are “impervious to counter-argument because of a change in belief fixation”(Jones, Despaul & van Os, 2003, p. 2). If this is indeed true, it is possibly the strongest argument against cognitive approaches, which rely most heavily on the very capacity that this population is characteristically lacking.

### Interpersonal Therapy

Unlike the cognitive behavioral and psychodynamic models, Interpersonal Psychotherapy does not rely on insight or the ability to transform abstract notions to concrete ones (Weissman, Markowitz, & Klerman, 2000). The basic premise of IPT is that symptoms are initiated and maintained through one’s interpersonal issues (Crowe & Luty, 2005). While the model recognizes biological, biochemical, developmental, genetic, and intrapsychic factors, it shifts the focus from the etiology of the disease to the triggers of symptom onset, making it, at its core, more tangible and achievable. IPT’s approach is further characterized by its focused, time-limited nature, which helps the patient address one or two specific problem areas while not becoming overly dependent on the therapist (Weissman et al., 2000).

Interpersonal Psychotherapy is conducted in three distinct phases, aptly named the initial, middle and final phases. The goals of the initial phase are to complete a diagnostic evaluation, obtain an in-depth psychological history (including an interpersonal inventory that reviews current social functioning, close relationships, etc.), and define the focus and structure of treatment. In the initial phase, the patient is assigned the “sick role,” which allows him or her to take leave of certain overwhelming social obligations,

recognizing that the patient is, in fact, sick, and unable to perform optimally at that point in time. In the initial phase, the symptomatology is linked to a problem area. IPT defines four major problem areas, or domains, which trigger symptoms, at least one of which is present for the patient: grief, interpersonal role disputes, role transitions, and interpersonal deficits. It is the latter two which relate to an IPT conceptualization of schizophrenic symptomatology. The last part of this phase involves explaining to the patient the principles of IPT, agreeing on treatment goals and duration of treatment, and discussing other logistical information (Weissman et al., 2000).

The middle phase focuses on the goals and strategies of treatment with regard to the key domain identified as the major problem area during the initial phase. The goals for a patient for whom interpersonal deficits are considered to be the primary domain, for example, include reducing the patient’s social isolation and encouraging new relationships. For a patient whose problem area is a role transition, the goals are geared toward mourning the loss of the old role while learning to accept and become comfortable in the new role. The strategies incorporated are to reduce those aspects of the patient’s interpersonal relationships which trigger or contribute to symptomatology. For example, strategies for those with interpersonal deficits involve reviewing symptoms, relating symptoms to the key domain, and reviewing past relationships realistically, thereby isolating patterns (Weissman et al., 2000).

The general treatment techniques used in the middle phase are consistent across all domains, but the specifics are tailored to the individual. The session always begins by focusing on how things have been since the last session. A main feature of the middle phase is the use of communication analysis in order to help the patient move from the general to the specific, and to get a sense of the patient’s actions, intents, expectations, and discrepancies between these and what was actually communicated. This grounds the treatment firmly in the present, and allows the patient to isolate and identify, in a concrete manner, specific incidents which are characteristic of patterns (Weissman et al., 2000).

The final phase begins in the last few weeks of therapy. This phase involves explicitly discussing termination, acknowledging that termination will likely have an effect on the patient and should be treated as a mourning period, and “[moving] toward patient recognition of independent competence” (Weissman et al., 2000, p. 24). The patient and therapist should also discuss the continuation and maintenance of treatment, when applicable (Weissman et al., 2000).

### Adapting Interpersonal Therapy for Schizophrenia

In order to begin to conceptualize how Interpersonal Psychotherapy can be adapted for use in helping patients cope with symptoms of schizophrenia, it is important to recognize several things. First and foremost, a prerequisite for treatment should involve a regimen of antipsychotic

medication. Schizophrenia is an organic disease, and without adherence to an appropriate course of medication, the efficacy of any psychotherapy is diminished significantly (Hogarty et al., 1997). Second, IPT treatment should be conceptualized in terms of two key domains, interpersonal deficits and role transition, recognizing that role disputes in this population are most likely a by-product of interpersonal deficits and that these deficits may also result in many of the negative symptoms of schizophrenia. A focus on role transitions would ostensibly be appropriate for those who have recently had their first psychotic episode, are recently diagnosed, etc., because coming to terms with this diagnosis is difficult—not only does the individual have to accept that they have a mental illness, but that this specific mental illness is characterized by its chronic and increasingly debilitating course (Helgeland & Torgeson, 2005). As interpersonal deficits are pervasive in this population, the goals and strategies of this particular domain will be consistently present. Lastly, because cognitive deficits are present to varying degrees, it is recommended that before progressing to the next phase of IPT, the patient should meet phase-specific criteria (Hogarty et al., 1997).

Thus far, there have been few trials examining the applicability or efficacy of IPT to patients with schizophrenia. There have, however, been empirical studies utilizing IPT for patients with hypochondriasis and dementia, the characteristics and symptomatology of which are conceptually, if not concretely consistent with characteristics of schizophrenia. For example, a person with hypochondriasis is persistent in his or her beliefs about somatic illnesses in the same way that a person with schizophrenia is about his or her delusional thoughts. Individuals in both groups exhibit a consistent failure to respond to external assurances and concrete proof that the illness (or the delusional thought content) does not, in fact, exist in any concrete manner. Lastly, both groups are characterized by poor insight regarding their illness (Stuart & Noyes, 2005). Like people with schizophrenia, people who have dementia have a difficult time “moving between abstract and concrete modes of thinking” (James, Postma, & Mackenzie, 2003, p. 451). Some forms of dementia are characterized by such symptoms as a “fluctuating cognitive ability... [and] hallucinations” (James, Postma, & Mackenzie, 2003, p. 452). Both illnesses are characterized by their increasingly debilitating course. It is reasonable to conjecture then, that characteristics of IPT that have been found to be effective in the treatment of hypochondriasis and dementia can be applied to patients with psychotic symptoms.

An interpersonal approach to treating patients with schizophrenia begins by mirroring that of traditional IPT (Hogarty et al., 1997). During this time, the patient and therapist should negotiate the treatment contract and discuss the importance of medication compliance, and the therapist should provide a basic education about the nature and course of the illness and its symptomatology. Though the patient should be assigned the sick role, due to the tendency of patients with schizophrenia to withdraw from social ac-

tivities, it may be necessary to also construct a comprehensive plan for the patient to resume daily activities. Patients should also be encouraged to explore the “relationship between stressors as possible triggers to symptom exacerbation” (Hogarty et al., 1997, p.7). In order to progress to the middle phase, the patient should meet the following criteria: symptom stability, medication stability, and social skills strategies application. Most important in the initial phase is to establish an empathic, mutually respectful therapeutic alliance and to develop excellent rapport with the patient. Especially for individuals with paranoid type schizophrenia, it is crucial that they learn to view the therapist, not as an omniscient and omnipotent being, but as one who is unequivocally and indisputably there for them.

The intermediate phase would include more advanced education about the nature and course of schizophrenia and the learning of adaptive strategies, tactics for successful rehabilitation, and early warning signs of psychosis or psychotic episodes. Ideally, it is in the intermediate phase that ideas from other therapies can be incorporated. The most useful aspects of the intermediate phase are probably communication analysis and decision analysis. Using communication analysis, the therapist can begin to introduce the notion that communication is challenging and multifaceted, misinterpretations are common, and intent is not always conveyed accurately (Stuart & Noyes, 2005). Once such notions take hold, it may be possible to begin to construct an understanding of psychotic symptomatology that is mutually acceptable to both patient and therapist. The interpersonal approach does not focus on the validity of the patient’s delusions, for example, but on his or her “ability to cope with them and to enlist social support to assist in that task” (Stuart & Noyes, 2005, p. 274). That is, it is not as important that the patient no longer experiences delusional thoughts as it is that he or she finds a way to recognize and cope with these thoughts in manner that makes him or her able to lead a less impaired existence.

Decision analysis is a method of helping the patient to explore options, eliciting opinions from the patient, and at times, retrospectively evaluating how the patient could have altered the course of an interpersonal interaction that did not go in the direction intended. The reason decision analysis is used in therapy with depressed patients is because they characteristically feel as though they have no options, that they have reached a dead-end. Exploring decisions with the therapist serves a triple purpose: to help the patient discover options, to elucidate that the patient has the ability to come up with options, and to act as the first step in beginning to implement these options (Weissman et al., 2000). Similar parallels can be drawn for the patient with schizophrenia. Decision analysis can have particular benefits for patients who hear voices. This process acknowledges that whether the voices are real or not (this is no longer a point of contention using an interpersonal conceptualization), the relationship that the person *experiences* with the voices is real. Helping the patient explore options for this relation-

ship, even avoidance tactics, is a very disorder-relevant treatment.

The final phase of this approach follows a traditional IPT approach; explicitly discussing termination, acknowledging this as a time to grieve, supporting the patient, and helping them to recognize their individual ability to manage and negotiate their own lives (Weissman et al., 2000).

Another factor to consider in employing an interpersonal approach with this population is that, unlike a traditional time-limited IPT approach, patients with schizophrenia may benefit from an open-ended treatment. This is due to the fact that schizophrenia is for the most part a debilitating, chronic disease in which impairment is increased with every psychotic episode, decompensation, and hospitalization (Hogarty et al., 1997). In part, this means that with every psychotic episode, the patient needs to reevaluate and redefine his or her primary support systems, including (and perhaps especially) that of the therapist. An open-ended treatment would allow the patient and therapist to establish a long term supportive relationship.

There have not been many studies examining the efficacy, or even the theoretical applicability of an interpersonal approach for patients with schizophrenia. A three-year study comparing the effectiveness of IPT to other therapies yielded the following results: all patients consistently and significantly improved, regardless of the psychotherapeutic model used during the first year of the trial. The data from the second year showed less dramatic but still consistent improvements across all test conditions. It was only after the second year of therapy that significant changes occurred. In every therapy except IPT, patients began to plateau in effects and improvements. Patients in the IPT group, however, continued to improve in residual symptoms. IPT patients continued to show improvements throughout the third year (Hogarty et al., 1997).

One of the measures included in determining efficacy of treatment was a social adjustment scale. According to the research, patients in the IPT group showed less impairment "regarding aspects of friction and distress experienced in their primary work role.... [Subjects exhibited] sensitivity in relationships, loneliness and self appraisal." (Hogarty et al., 1997, p. 9). Additionally, subjects in this group improved in their participation and level of involvement in leisure activities. The authors reached the conclusion that IPT has "pervasive effects on the social adjustments of patients with schizophrenia that are independent of relapse preventions." (Hogarty et al., 1997, p. 2).

### Conclusion

In conclusion, there is agreement that symptom management and coping are more realistic and functional goals for patients with schizophrenia than is symptom removal, and that unlike CBT or insight-oriented approaches, IPT offers "a means of engaging the patient that may be more effective than a challenge of the patient's firmly entrenched beliefs" (Stuart & Noyes, 2005, p. 280). A significant por-

tion of studies examining the efficacy of CBT and insight-oriented therapies indicate that a considerable number patients are fairly unresponsive to these forms of psychotherapy (Gaudiano, 2005). Rather than indicating that psychotherapy is useless in helping people with schizophrenia to cope with or reduce their symptoms, these findings may be the result of using therapies that are not disorder-relevant. In light of the fact that schizophrenia is, among other things, a cognitively-debilitating illness, it seems almost inappropriate to apply techniques which presume the patient's ability to examine rationally and logically his or her thought process, which may be impervious to logical counterarguments (Jaspers, 1963). Instead, patients may benefit from the introduction of an interpersonal approach, one which emphasizes current issues, disputes, and anxieties, and which helps patients perceive their symptomatology on a more concrete level than cognitive behavioral or psychodynamic approaches.

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## IPT FOR SCHIZOPHRENIA

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