Interpersonal Psychotherapy and Mentalizing – Synergies in Clinical Practice

Abstract: Interpersonal psychotherapy (IPT) is an evidence-supported relationally-focused treatment for people living with depression and other psychiatric disorders in the context of stressful life events. Mentalizing, also relationally focused, promotes the ability to perceive, understand and interpret human behaviour in terms of intentional mental states of others or oneself in order to support social learning. IPT and mentalizing-based treatments (MBT) both seek to improve interpersonal effectiveness, albeit it with different emphasis in the therapeutic process: IPT promoting interpersonal problem solving and MBT promoting understanding of the obstacles to this outcome. Our proposition is that the central intentions of IPT and mentalizing are essentially linked and complimentary - understanding others and oneself in relationship facilitates interpersonal problem resolution and symptomatic recovery, and enhances resilience. The clinical synergies of IPT and mentalizing are elaborated and illustrated through a case example of a socially isolated individual with depression and interpersonal sensitivities.

INTRODUCTION

Interpersonal psychotherapy (IPT) is an evidence-supported relationally-focused psychological treatment for people living with symptoms of psychiatric disorders and interpersonal difficulties (1-3). IPT focuses on ameliorating interpersonal problems, whereas mentalizing seeks to understand what processes can prevent or facilitate interpersonal problem resolution. The capacity to mentalize and remain open to social learning is linked to the central proposition of IPT for depression - that in understanding oneself and others in relationship, interpersonal effectiveness is strengthened for resilience and illness recovery. This paper reviews the therapeutic goals and strategies of IPT for depression, and the theory and principles of mentalizing, and then highlights their clinical synergies through a case example.

INTERPERSONAL PSYCHOTHERAPY

The efficacy of IPT is well established globally with diverse clinical populations across the lifespan including in low-income countries. A transdiagnostic meta-analysis of IPT (90 RCTs, N=11,434) found a moderate to large effect size as compared with controls, equal efficacy to CBT and medication, with sustained effects at reducing relapse (2). The goals of IPT are to reduce symptoms and improve functioning by enhancing interpersonal effectiveness. IPT strategies guide affect-focused exploration to understand, resolve or adapt to current stressful relational experiences and life events that are associated with symptom onset or worsening (see Figure 1). These life events are reflected in four focal areas which frame depression in an interpersonal context (1). When worsening symptoms are linked: to the death of a significant person, the grief focus is chosen; to life changes, role transitions is chosen; and to conflicts in a close relationship, role disputes is chosen. The interpersonal sensitivities focus is chosen for individuals who struggle to form or maintain relationships in IPT depression treatment, “when

none of the other interpersonal problem areas exist" [p. 72, (1)]. The person in treatment with interpersonal sensitivities is assisted to reduce their social isolation and interpersonal estrangement associated with their current symptoms, and to encourage the formation of new relationships. This involves affectively-guided exploration of past relationships to identify repetitive interpersonal problems and positive and negative feelings in relationships. Difficulties with perspective-taking and understanding others are targeted to promote resilience and recovery. IPT focuses primarily on relationships outside of therapy, differentiating it from psychodynamic and psychoanalytic models where transferences within therapy play a central role (4). However, when the focal area is interpersonal sensitivities, how the therapist is experienced by the individual in treatment is also explored [p. 105, (1)]. It is in this IPT focal area that mentalizing is especially salient to the therapeutic process.

MENTALIZING

Mentalizing describes the distinctly human capacity to imagine motivation and perspective in our own and others' minds that underly overt behavior. It is the work of a lifetime, emerging in infancy as the advantageous outcome of a secure attachment and practiced across the life span. At the heart of human relatedness and the social systems in which we live, effective mentalizing is argued to be central to mental health and a basis of all forms of effective psychotherapy (5). Mentalizing theory offers an explanatory model for the evolutionary advantage of making accurate inferences about others' motivation. The experience of being accurately understood and reflected back confers the ability "to learn from social experience [social learning] that enables people to respond effectively to adversity and challenge," and be resilient in the face of stress [p. 73 in: (6)]. Insecure attachment patterns of relating (7, 8) can result in mentalizing impairments and poor reflective functioning and are postulated as key features of depressive psychopathology

(9). Difficulties in identifying and interpreting one's own and others' mental states may underlie an inability to recruit or utilize social supports in a state of depression (10). Attention to social learning and mentalizing in the wider interpersonal network are thus relevant to the key objectives in IPT practice (11, 12).

In mentalization based treatments (MBT), the therapeutic context is used as a vehicle through which mentalization and social learning are promoted. Lapses in mentalizing in the individual and the therapist alike are used to explore the blind spots that may undermine moments of relational effectiveness and satisfaction. Mentalizing theory aids this recognition by highlighting the impacts of an unhelpful dominance of either pole within 4 dimensions of: (i) automatic versus deliberate processing; with mis-attention to (ii) feelings versus cognitions, (iii) self versus others, and (iv) internal experiences versus external actions (See Figure 1). Connection with supportive others in times of need relies on our ability to process social information and move fluidly along each of these mentalizing dimensions. Examples of ineffective mentalizing include unwarranted certainty, unsubstantiated presumptions about feelings and beliefs, or insistence on actions to demonstrate intention.

IPT and MENTALIZING SYNERGIES IN CLINICAL PRACTICE

The resolution of interpersonal problems and a felt security in close relationships both require and promote mentalizing which is hypothesized as a mechanism of change in IPT and other therapeutic models (11-16). Individuals in IPT treatment with interpersonal sensitivities may from a mentalizing perspective be understood to occupy a state of epistemic mistrust, compounded by current depressive symptoms. Epistemic trust is a concept that describes optimal conditions for social learning in which the recipient can discern when the other is reliable, trustworthy and helpful (5, 17). Put simply when an individual feels safe in a

relationship, they might think, 'you understand me, I trust you and I am interested in what you have to say, and will bring my understanding in line.' The IPT therapist works with the person in treatment to collaboratively discover interpersonal patterns that arise inside and outside of the therapy room. Where these patterns relate to epistemic mistrust, they can contribute to worsening depression, perpetuating isolation and interpersonal problems.

[Insert Figure 1: Clinical Guidelines of IPT and Synergies with Mentalizing]

Fonagy et al.'s collaborative framework of social learning in psychotherapy process (2014) highlights the provision of a convincing model to understand experience, fostering the emergence of mentalizing in the therapeutic relationship, and attention to social learning in the wider interpersonal network. Clinical synergies of IPT and mentalizing are summarized in Figure 1 and illustrated within a social learning framework through the following case example of an individual with depression and interpersonal sensitivities.

CASE ILLUSTRATION

Ethyl is a 53-year-old single, socially isolated, white woman whose symptoms meet DSM 5 criteria for Major Depressive Disorder. She describes low mood, anhedonia, decreased energy, poor concentration, and feelings of worthlessness. She is not suicidal nor does she misuse substances. She was referred to IPT for treatment of depression that worsened following the death of her dog 6 months ago. She conveys the significance of this loss and her epistemic mistrust by saying, "I am a dog person and not a people person," Her dismissing attachment style presumes that relationships with others including the therapist are not necessarily worth pursuing. She enters therapy reluctantly, unsure how it can help her.

<u>Beginning Phase of IPT and the Provision of a Convincing Model to Understand Experience</u>

Early in IPT and following detailed discussion of Ethyl's current symptoms, the therapist offers psychoeducation and a no-blame diagnosis of depression understood in its interpersonal context. The therapist approaches this discussion gently with Ethyl, recognising that she prides herself in her pragmatic self-sufficiency and is inclined to see depression as weakness. However, Ethyl also reveals that she struggles to find a way through the isolation and depressive symptoms that have worsened her day-to-day experience since her pet dog and main companion Brandy, died. Her discomfort is expressed with tearful frustration during the first meeting, "Here I go, it's ridiculous. I have to get over this and I'm just not." The therapist recognises that Ethyl does not know how to think about her situation. He invites her to reconsider her symptoms as a treatable mood disorder, closely linked to heightened isolation dating to the loss of a much-cherished companion.

Ethyl's reticence toward human interaction becomes evident when the relational focus of IPT is introduced. Ethyl is not practiced at reaching out to others and reacts, "You ask me to talk about my relationships. I told you, I don't really have any. I am a dog person not a people person." By recognising her dilemma when embarking on an interpersonally focused therapy, the therapist has an opportunity to empathically acknowledge Ethyl's underlying distress, which she finds difficult to share openly. Rather than directly challenging her stance of certainty, the therapist focuses on the depth of her distress – for many years she invested in a relationship with her pet which provided an uncomplicated source of affection and emotional support. "I can understand why talking about other people seems misplaced when you miss Brandy and not other people, but I also notice that without Brandy you find it even more difficult to face the world. Maybe keeping to yourself feels safe but that seems to play a part in maintaining your painful feelings."

Having her experience compassionately reflected invites Ethyl's deliberate revision of her self-view. However, the emotional intimacy of this experience risks activating dismissing automatic self-reliance, seen in her rebuttal that she does not need to be "mollycoddled." The dimensions of mentalizing illuminate the knife's edge on which explicitly reflective practice operates in IPT. Ethyl's inability to imagine her therapist's intention creates a roadblock to epistemic trust. Alive to her internal state and emotions, the therapist wonders aloud if Ethyl's current sense of worthlessness and shame might be heightened in the uncomfortable, unfamiliar position of seeking support, unnecessary when she had Brandy. The loss Ethyl recognises is used as a platform to tentatively draw attention to her struggle to engage others without her pet companion by her side.

The therapist learns about Ethyl through a historical time line of relational stressors associated with evolving symptoms, and conducts an interpersonal inventory during the beginning IPT phase. The symptom story is populated and contextualised and it is this integrated narrative that can begin to shed light on a previously unspoken sense of collapse. Feeling slightly more understood, Ethyl reveals more and reflects that after losing Brandy, "it's hard to get out without him," expressing the difficulty in facing life alone. With continued interpersonal enquiry Ethyl reveals her experience of being routinely rejected, "I am under no illusions. I am not the world's most pleasant, sunshiny person. I don't blame people for not wanting to be around me." Ethyl's sweeping conclusion exemplifies ineffective mentalizing. Her sense of being rejected is felt with such certainty that she is convinced it is a fact that is in the mind of even casual acquaintances and her therapist. The therapist validates her emotions and encourages more reflection, to counterbalance the automatic and cognitive biases of Ethyl's view. The intention is to help Ethyl connect to her feelings and to gently shake her conviction that everyone has the same experience

of her. In keeping with an IPT interpersonal sensitivities focus, exploring past relationships, the therapist asks, “How did it feel to turn up at the park each day and stand with the other dog owners while Brandy ran off and played? What was it that they did that gave you clues about how they felt about you?” She reflects that she didn’t feel altogether uncomfortable or unwelcomed, and actually did not have the sense that others didn’t want to be around her.

Ethyl describes having had few opportunities to develop relationships during her life. Her mother lived with untreated depression and was a passive background presence. Her father struggled to cope with the responsibility of parenting and retreated into his work life and alcohol, making him an inconsistent and sometimes volatile presence. The IPT therapist comments that growing up, her parents were not able to be as present or responsive as she needed. Ethyl accepts this observation and adds that she spent much of her childhood on her own in a lonely and unpredictable household. The uncertainty of her home environment made her reluctant to foster friendships and this instinct was reinforced when she was victimized by peers at school for being a loner. This early bullying experience compounded her view of others as threatening and unreliable, which in combination with childhood neglect and adversity conferred significant vulnerability for depression. On reflection Ethyl wonders if some of the feelings she is experiencing now might first have been evident in her adolescence, although this was never discussed or acknowledged.

The IPT therapist develops a formulation with Ethyl to place depression in an interpersonal context and help her understand why she has become depressed, how she might recover and the relevance of an interpersonal approach to achieving that. By suggesting the interpersonal sensitivities focus, the therapist looks further into Ethyl’s experience of losing her dog, in an effort to understand why that loss meant so much. “The solitude you experienced growing up

may not have provided you with opportunities to understand the gaps or links between what people do and why they do it. Brandy never tested or confused you in the way other people have. It is no wonder that you feel his loss so deeply, but we have also come to understand that your current distress is about feeling alone in an unpredictable world that you don't feel confident in managing without his presence."

Mentalizing theory can guide an understanding of the cost of Ethyl's isolation. She cannot make the imaginative leap required to consider how her actions might make others think and feel. Her persistent withdrawal may be off-putting to others and deprive her of the closeness needed to learn from and sustain relationships. Mentalizing effectively needs to be reinforced by daily practice through collaborative social interactions; however, she is unable to do this on her own. In the absence of frequent social contact with others, unbalanced mentalizing takes hold in Ethyl and beliefs about herself and others come to be taken as facts. The IPT therapist wonders aloud how her early relational experiences may contribute to her difficulty experiencing others as worthy of her trust, including her therapist. With this lived experience of being mentalized within the therapeutic alliance, Ethyl begins herself to reflect more deeply about how she might inadvertently keep others at a distance.

<u>The Middle Phase of IPT for Interpersonal Sensitivities and Fostering the Emergence of Mentalizing</u>

For people with interpersonal sensitivities and a paucity of present relationships, the IPT middle phase strategies include a collaborative review of past relationships to identify recurring patterns. In mentalizing terms, this is an invitation to Ethyl to become curious about her own thoughts, feelings, intentions, motivations, and impacts within relationships including those her mind has

been closed to. Ethyl and her therapist recognise that she routinely sees herself being a target for others, imagining them to be rejecting. Consequently, she maintains her distance and when Brandy was around, she concealed herself behind him. This often resulted in her being ignored or overlooked, feeling safe but lonely. If others are more persistent, Ethyl tries to dissuade them with irritable or minimal responses, which either leads people to back off or elicits a critical response reinforcing her view of others as rejecting or threatening, and the cycle repeats. This interpersonally distancing manner of relating, which originated early in life, continues into the present and is compounded by the instinctive withdrawal that exacerbates depression. It is this understanding of her here-and-now presentation, enriched by awareness of its origins that serve as a foundation for IPT interpersonal sensitivities work. Ethyl begins to consider her self-protective motivation and how its assumed necessity may obscure others' intentions. The IPT therapist's careful and emotionally attuned navigation of this previously unconsidered territory helps Ethyl reconsider the social capital surrounding her. By becoming mutually alive to the possibility that Ethyl's emotional experience can cut short her capacity to consider what she and others think and intend, the therapeutic relationship becomes a vehicle for new learning and the potential for epistemic trust beyond the relationship to the therapist.

In a subsequent session, the therapist offers positive feedback to Ethyl on being more open with him, and she retorts that he is only listening to her because he is being paid. The historical weight of Ethyl's experience overwhelms her capacity to be present in this moment as she reverts to an internalized model of purely transactional human interaction. The therapist draws on the work they have done in identifying repeating patterns, to create an opportunity to apply this new learning in the moment. This pause and rewind in the session allows them to transition from an automatic and externally focused assumption about the other, to deliberately explore feelings

provoked in Ethyl in the here-and-now. The therapist invites Ethyl's consideration of both her own and the therapist's perspectives and the possibility of personal emotional investment that may exist within this and other transactions.

The shared understanding of repeating patterns is used in IPT to navigate and highlight how Ethyl can be easily triggered into habitually spiky responses concealing a vulnerability she may feel. The work within the therapeutic relationship is used to cast light on current examples outside of therapy, and as a core strategy for interpersonal sensitivities work in IPT. This supports Ethyl to be curious about the alternatives available for new experiences of connection in relationships. In the therapeutic frame of IPT, experiences of mentalizing with near misses and recoveries unfold. The impact of these small incremental missteps and realignments opens Ethyl to the communication of others. With such engagement epistemic trust begins to be restored and the capacity to mentalize inside, and crucially for IPT, outside of therapy is promoted.

<u>Connecting with supportive others - social learning in the wider interpersonal network</u>

In IPT, understanding and noticing problematic interpersonal patterns that are associated with low mood aid connecting with supportive others. This creates a platform for social learning, to collaboratively examine and recover when mentalizing with others or herself falters in order to more effectively engage in a wider interpersonal network. For example, Ethyl experiences feelings of sadness and excitement in an online chatroom conversation which prompts her to consider getting another dog. Her feelings remain unexpressed at the time, fearful that others will criticise her. Highlighting the similarity of her unexpressed feelings early in therapy offers a perspective to aid reflection. The IPT strategies of communication analysis and role play are then used to reconstruct the chatroom discussion step by step, working with Ethyl to consider

alternative responses. These strategies, congruent with mentalizing, slow the pace through micro-slicing interactions during which emotions can be better regulated, and the overwhelming fear of rejection is held at bay. In a following session Ethyl describes the surprise and comfort she felt on hearing other dog owners describe pain reminiscent of her own when they lost a pet. At this point in therapy both Ethyl and her therapist are able to acknowledge the simultaneous reduction in the intensity of her depressive symptoms with the opening of her social communication, bypassing a retreat into an earlier strategy of self-sufficiency.

Mentalizing theory suggests that Ethyl's avoidance is maintained not only by her symptoms of depression but by the poorly mentalized understanding of others' attitudes this affect state generates. Epistemic hypervigilance is maintained by the automatic application of prior learning, unencumbered by awareness of novel experience leading to a revised perspective. Reciprocal emotional attunement in IPT helps Ethyl to disrupt this vicious cycle and begin to open herself to learning from current relational experience. As mentalizing is more reliably albeit not necessarily consistently established, interpersonal sensitivities work can focus primarily on relationships beyond the therapeutic.

Ethyl's interpersonal inventory is revisited to explore previously unimagined opportunities for social connection, such as resuming her daily walks in the park, although now pausing to share a coffee with the people previously only known to her by their pets' names. The incremental interpersonal changes achieved in interpersonal sensitivities work often appear objectively small. Though incremental, they reflect a significant relational reorientation to aid recovery from depression, and continue beyond therapy's conclusion. Ethyl's depressive symptoms resolve as she is able to more safely connect and engage with both her therapist and others in her social universe.

CONCLUSION

IPT targets depression by helping people connect to social supports and resolve interpersonal problems. Whereas mentalizing targets lapses in the accuracy with which people understand their own and others' motivations underlying their actions. IPT may assume implicitly that mentalizing is operating, offering guidelines within which to understand interpersonal problems and life events associated with depression onset or perpetuation. It is especially in the focal area of interpersonal sensitivities that IPT and mentalizing circle each other's orbits.

Mentalizing theory can provide IPT therapists with an enhanced road map to work within the fluctuations of the therapeutic alliance and beyond that can be emblematic of maladaptive patterns of relating (18). Learning to attend accurately to the mental states of oneself and others fosters social learning for people in whom this has been eroded by social isolation, interpersonal estrangement and depressive states. Crucially for IPT depression treatment with a focus on interpersonal sensitivities, an activation of self-correcting interpersonal learning has potential to generalize from the alliance to relationships outside of therapy (19, 20). Through understanding oneself and others in relationship, resilience can be strengthened for interpersonal problem resolution and illness recovery.

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1. The use of mentalizing theory and practice are salient to IPT treatment of individuals with depression and interpersonal sensitivities.
2. Promote social learning in IPT and explore epistemic mistrust in relationships to improve interpersonal effectiveness and resilience.
3. Use mentalizing concepts to detect and collaboratively repair therapeutic alliance tensions that can be emblematic of maladaptive patterns of relating to others.
4. Apply IPT strategies to micro-slice social network interactions and encourage understanding of oneself and others' perspectives, intentions and feelings.
5. Adopt a collaborative not knowing therapeutic stance, modelling genuine curiosity and mentalizing within the alliance to foster reflection, enhance the capacity to mentalize and address interpersonal problems.