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least 10 beds, and would need special funding arrangements. It may be that this is how New South Wales will approach the problem.

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JANE MORRIS

# Interpersonal psychotherapy – a trainee’s ABC?

## Psychotherapy training for general psychiatrists

A recent article in the *Bulletin* (Rees, 2000) suggests that cognitive–analytic therapy (CAT) “may emerge as the preferred form of psychotherapy within the NHS”. I would question Rees’ claim that CAT “uses an understandable language and straightforward techniques”. For many patients – and therapists – it is too ridden with jargon and complex diagrams. Moreover, as he admits, “formal CAT training is long [2 years for basic qualification] . . . this is impractical for most psychiatrists”. In addition, “research has yet to provide a robust evidence base for its effectiveness”. CAT in expert hands is an attractive and powerful model, but does not suit the needs of junior psychiatrists striving to rapidly acquire and integrate broad effective psychotherapeutic techniques. I suggest that another of the ‘newer’ therapies, interpersonal therapy (IPT), would fit the bill better.

## Background to IPT

The IPT of Klerman *et al* (1984) is both flexible and integrative. It is a time-limited, structured psychotherapy designed pragmatically but with theoretical roots in attachment theory. It has been manualised as a treatment for depression and for bulimia nervosa (Fairburn, 1997), and extended as a group treatment for binge eating disorder (Wilfley *et al*, 1993). Recent work has modified and extended the model for treatment of anxiety, dysthymia, primary care disorders, chronic fatigue, mood disorders associated with HIV, somatisation, adolescent disorders and depression of later life, and for use with couples and groups (all described in Weissman *et al*, 2000).

IPT, although relatively new to Britain, is welcomed enthusiastically by both patients and multi-disciplinary professionals. Unlike CAT, it has already been subject to

large-scale randomised controlled trials involving CBT and medication, so it fits into mainstream medical research and evidence-based practice.

The model incorporates psychoeducation, it is ‘medication friendly’ and agrees with a medical model of psychiatric illness. Its rationale sits well with family and other systemic models of psychotherapy, and indeed offers a way of accessing systemic resources within individual therapy. Like CBT, it is structured and open, using a collaborative therapeutic relationship without invoking transference issues. Rating scales monitor each patient’s progress. IPT does not involve formal ‘homework’ or rely on extensive paperwork. However, patients are encouraged to develop skills and experiment actively with these between sessions.

A full description is beyond the scope of this article (see Klerman & Weissman, 1993; <http://www.interpersonalpsychotherapy.org>), but therapy (12–20 sessions, contracted in advance) has three parts, see Box 1. The first stage closely matches a standard psychiatric assessment. The medical model of depression is emphasised to the point of prescribing ‘the sick role’ to the patient. A key feature is the compiling of an interpersonal inventory that lists and examines all the patient’s relationships. This is charted on rating scales or as a ‘spider’ diagram, which becomes a key resource for future therapy. By session four, one of four prescribed foci is selected: grief, role transitions, role disputes or interpersonal deficits.

The second and longest stage comprises active work on the chosen focus. The therapist becomes less active but holds the focus, relates symptom change to interpersonal events and encourages the patient to devise and experiment with new interpersonal strategies. Whereas CBT may conceptualise painful feelings as symptoms, and expect these to diminish when negative cognitions are

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**Box 1. Stages of a 16-session course of interpersonal psychotherapy**

Stage	Sessions	Tasks
(1) Assessment	1–4	Information gathering, psycho-education about diagnosis and medication, conferring the sick role, formulating the problem in interpersonal terms, drawing up an interpersonal inventory, choice of an interpersonal focus for therapy.
(2) Active work	5–12	Therapist role is now to encourage strenuous patient activity in addressing the chosen focus, analysing the interpersonal problem and elaborating and trying out possible solutions, using detailed communication analysis, role play and support in tolerating difficult affect.
(3) Termination	14–16	Ending is mentioned early, and increasingly discussed before the final sessions, but is now explicitly highlighted. Sadness and achievement both acknowledged, new independence discussed, need for continuing interpersonal work and ways of dealing with relapse.

challenged, IPT helps patients to identify and deliberately tolerate feelings.

The final sessions are devoted to termination, review, relapse prevention, grief over ending and the transition to independence. There is an explicit expectation – backed by research – that the full benefits of IPT do not appear immediately, but after a lag.

## Application of IPT to general psychiatric practice

IPT is a suitable brief psychotherapeutic intervention for general clinics with economic constraints and need for measurable effectiveness. It has already been manualised, and lent itself readily to modifications, making it attractive for research and audit. It is so medication-friendly that its first stage could work as a form of compliance therapy. For a reasonably experienced clinician the training for IPT is brief – courses typically last 4–5 days – and for those trained in other models of psychotherapy, such as CBT, systemic therapies or dynamic therapy, there is no clash.

Elements of IPT may be usefully incorporated piecemeal into ordinary clinics. Explicit structuring of patient contact offers a clarity and expectation of progress too often missing, particularly when junior doctors simply ‘inherit’ patients without a clear agenda. The psychoeducational aspect of IPT is helpful in liaison or primary care settings, and extending this to ‘giving the sick role’ may

help validate a psychiatric diagnosis for patients and their families. Many clinicians who have trained in IPT now incorporate an interpersonal inventory into standard patient assessments. This richly enhances understanding of the quality of an individual’s life and identifies both potential resources and obstacles to treatment. Practice in helping patients to identify and tolerate feelings is another useful psychotherapeutic skill.

Attention to termination is unusual outside the rarefied analytic environment. In general psychiatric settings patients are passed from hand to hand as doctors rotate through training schemes, and contact is open-ended, with ad hoc discharge when the patient seems well enough. Open discussion of time-limits allows realistic planning of what can be achieved, the use of a focus and humane discussion of the issues involved in ending or changing doctor. Acknowledging a time limit also imposes a useful pressure to work hard for improvement.

## Strengths and limitations

IPT is particularly accessible to patients who find dynamic approaches mystifying, or the ‘homework’ demands of CBT daunting. IPT has been specially modified for adolescents (Mufson *et al*, 1993), who may find CBT too much like school work, whereas IPT addresses relationships – a primary concern. IPT is abstemious in its use of technical jargon – a bonus for those who distrust ‘psychobabble’. Fairburn (1997) reports that both patients and therapists in his bulimia studies expressed a preference for IPT over CBT. This may have implications for compliance and therapist morale.

For general psychiatrists the major limitation of IPT is that the model has not so far been modified for the management of psychoses. However, this is true of most psychotherapies. The CBT model requires such expertise for use with this patient group that it would be a rash trainee who attempted its use without expert training and support.

## IPT and psychiatric training

In contrast to dynamic psychotherapy, CAT or even CBT, formal training in IPT involves a relatively short-time commitment, so could be available to consultants from general and liaison psychiatry as well as juniors. This would enable the IPT approach to be disseminated more widely, and trainees could be well supported and supervised in their therapeutic work after their initial training.

Markowitz (1998) usefully describes teaching IPT to psychiatric residents in North American teaching hospitals. In Edinburgh we have incorporated some IPT principles and skills into our introductory psychotherapy seminars for new senior house officers and they have been received with enthusiasm. We are now offering them fuller IPT training and would strongly recommend its consideration as a model for psychotherapy training within general psychiatry.

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IBRAHIM MURAD AND HARVEY GORDON

## Psychiatry and the Palestinian population

Palestinian sources estimated the population in 1992 on the West Bank as approaching 1.5 million, and that of Gaza as just under 800 000 (Abdeen & Abu-Libdeh, 1993), with an increase of about 45% anticipated over the next decade (Planning and Research Centre, 1994). Significant numbers of Palestinians also live in surrounding Arab countries, especially Jordan, where they may even be in a majority (Stendel, 1996). About 1 million Israeli Arabs also live within the borders of Israel. The majority of Palestinians are Muslim, but about 6% are Christian (Bin-Talal, 1995).

Previously under the Ottoman Turkish Empire, then subject to the British Mandate, then under Egyptian rule (Gaza) or Jordanian (the West Bank) and then, since 1967, the Palestinians became subject to Israeli military rule. But since 1993 they have undergone partial, albeit turbulent, autonomy in the framework of a potential future Palestinian state.

Aspects of the general and forensic psychiatric care of Palestinians have not been widely reported in the international medical press. This article, written jointly by a Palestinian Arab and a British Jew, seeks to describe some key issues in Palestinian psychiatry of historical and contemporary relevance.

The Arab countries may have been among the first in the world to establish mental health hospitals, at a time when European civilisation dealt with those suffering from mental illness by condemnation and punishment. Mental health hospitals were built in Baghdad in the year 705, then in Cairo in 800 and in Damascus in 1270 (Youssef & Youssef, 1996). In the Arab world, political and religious forces have always been intimately intertwined and Islam is a crucial factor in all aspects of life. In most Middle Eastern countries, until relatively recently, mental illness was thought to be due to possession by demons, failure to follow ritual, or fate – Inshallah (Alyahya, 1991). On the other hand the secular nature of western psychiatry has left it bereft of any significant spiritual focus.

Psychiatry in contemporary Arab societies is well established, though traditional and religious healers also play a major role in primary psychiatric care (Al-Subaie, 1994). Most Arab countries practise psychiatry in the context of legislation enacted during the colonial period or have none at all, although a draft Pan-Arab Mental Health Act is currently under consideration (Chaleby et al, 1996). The need for the human rights of those suffering from mental illness and learning difficulties to be legally protected is enshrined in declarations of the United Nations (Gostin, 2000). Human rights are also protected under regional systems, including those in Arab countries (Gostin, 2000). However, the extent to which such universal principles are consistent with all aspects of Islamic jurisprudence is an evolving dialogue (Chaleby, 1996). The individualism more characteristic in western societies has not been a feature of Islamic societies, which rather emphasise responsibilities and adherence to God's commands (Mayer, 1995). Notwithstanding the legal vacuum, criteria for involuntary hospitalisation in Arab countries are based on similar parameters to those in the west, namely the presence of mental illness, danger to self and others and the welfare of the patient. All Arab countries are undergoing social change towards modernisation, leading to conflicts in the role of women and increases in the level of drug and alcohol misuse (Okasha, 1993).

In the context of the national aspirations of the Palestinian population, a significant impact on its health during Israeli military rule has been recorded (El-Sarraj, 1991). According to El-Sarraj, the Intifada or Palestinian uprising that began in 1987 was a socially therapeutic process, replacing depression and hopelessness with pride and optimism. Statistics prior to and subsequent to the Intifada are unavailable, however, to test this supposition.

Since 1967, although subject to Israeli military rule, the Israel Mental Health Act has not applied, so there has been no legislative framework in which mental health has