Journal of Affective Disorders 226 (2018) 108–123

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Review article

Changes in interpersonal problems in the psychotherapeutic treatment of depression as measured by the Inventory of Interpersonal Problems: A systematic review and meta-analysis

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ARTICLE INFO

Keywords:
IIP
Interpersonal problems
Depression
Psychotherapy
Systematic review
Meta-analysis

ABSTRACT

Background: Interpersonal problems are commonly reported by depressed patients, but the effect of psychotherapeutic treatment on them remains unclear. This paper reviews the effectiveness of psychotherapeutic interventions for depression on interpersonal problems as measured by the Inventory of Interpersonal Problems (IIP).

Methods: An electronic database search identified articles reporting IIP outcome scores for individual adult psychotherapy for depression. A systematic review and, where possible, meta-analysis was conducted.

Results: Twenty-eight studies met inclusion criteria, 10 of which could be included in a meta-analysis investigating changes in the IIP after brief psychotherapy. Reasons for exclusion from the meta-analysis were too few participants with a diagnosis of depression (n = 13), IIP means and SDs unobtainable (n = 3) and long-term therapy (n = 2). A large effect size (g = 0.74, 95% CI = 0.56–0.93) was found for improvement in IIP scores after brief treatment.

Limitations: Paucity of IIP reporting and treatment type variability mean results are preliminary. Heterogeneity for improvement in IIP after brief psychotherapy was high ($I^2 = 75\%$).

Conclusions: Despite being central to theories of depression, interpersonal problems are infrequently included in outcome studies. Brief psychotherapy was associated with moderate to large effect sizes in reduction in interpersonal problems. Of the dimensions underlying interpersonal behaviour, the dominance dimension may be more amenable to change than the affiliation dimension. Yet, high pre-treatment affiliation appeared to be associated with better outcomes than low affiliation, supporting the theory that more affiliative patients may develop a better therapeutic relationship with the therapist and consequently respond more positively than more hostile patients.

1. Introduction

Interpersonal problems are both a cause and consequence of depression. They are apparent even in mild depression (Luyten et al., 2005) and are a frequent complaint of those seeking psychotherapy (Horowitz et al., 1988). Furthermore, several theories have proposed that depression arises when there is a frustration of the basic human need to form and maintain strong and stable relationships (Baumeister and Leary, 1995) (see Table 1). This article will examine the evidence to date for changes in interpersonal problems after psychotherapy for

Abbreviations: A-CT, Acute-phase Cognitive Therapy; BASIS-24, Behaviour and Symptom Identification Scale; BDI-II, Beck Depression Inventory-II; BSI, Brief Symptom Inventory; CAT, Cognitive Analytic Therapy; CBT, Cognitive-Behavioural Therapy; CBGT, Cognitive-Behavioural Group Therapy; CCT, Client-Centred Therapy; C-CT, Continuation-phase Cognitive Therapy; CT, Cognitive Therapy; EFT, Emotion-Focused Therapy; ES, effect size; HADS, Hospital Anxiety and Depression Scale; HRSD, Hamilton Rating Scale for Depression; IIP-C, Inventory of Interpersonal Problems-Circumplex; IPT, Interpersonal Therapy; ISTDP, Intensive Short-Term Dynamic Program; LTPP, Long-Term Psychodynamic Psychotherapy; MDD, major depressive disorder; MDE, major depressive episode; MHI, Mental Health Index; OQ-45, Outcome Questionnaire 45 item; PA, Psychoanalysis; PCT, Person-Centred Therapy; PET, Process Experiential Therapy; PIT, Psychodynamic-Interpersonal Therapy; PD, Psychodynamic Psychotherapy; PP, Psychoanalytic Psychotherapy; RCT, randomised controlled trial; SCL-90-R, Symptom Checklist-90-Revised; SET, Supportive–Expressive Dynamic Psychotherapy; SFT, Solution-Focused Therapy; STPP, Short-Term Psychodynamic Psychotherapy; TAU, treatment as usual

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http://dx.doi.org/10.1016/j.jad.2017.09.036
Received 8 March 2017; Received in revised form 15 July 2017; Accepted 23 September 2017
Available online 25 September 2017
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Table 1
Interpersonal theories of depression.

Author(Year of main publication)	Assumptions
Sullivan (1940, 1953)	Depression results as a frustration of one of two basic needs: security (feeling loved and safe to bond with others) and self-esteem (feeling of self-worth)
Lewinsohn (1974, 1975)	Deficiencies in social skills (ability to elicit positive reinforcement from others) results in depressive symptoms
Coyne (1976)	Depressive behaviour initially engages others, but they soon tire of it and begin to display 'non-genuine reassurance'. Depressed individual becomes aware of this and experiences the other as critical and rejecting, maintaining depressive state
Arieti and Bemporad (1978, 1980)	Depression results when the sense of self is threatened by the loss of either 'dominant other' (esteemed other – initially a parent – relied upon for gratification self-esteem) or 'dominant goal' (a fantastical and fanatically pursued goal)
Swann (1990) Swann et al. (1990) Swann and Schroeder (1995)	Negative feedback sought from others to confirm negative views of the self, locking individual into a mutually maintaining negative relationship with the response of others
Segrin (1996) Segrin and Flora (2000)	Poor social skills are a diathesis in the development of depression, i.e. depression results when individuals with poor social skills experience stressful events because they are unable to elicit social support from others
Joiner (2000)	Depression-related mechanisms actively produce a variety of interpersonal problems and stressors, which become strong predictors of future depressive symptoms: excessive reassurance seeking, negative feedback seeking, interpersonal conflict avoidance and blame maintenance
Blatt (1990, 2004, 2006, 2008)	Excessive preoccupation with one of two dimensions of personality: interpersonal relatedness (feeling abandoned/rejected by others) or self-definition (protecting the self at expense of relating to others) results in depressive symptoms
Evraire and Dozois (2011)	Individuals with depression prefer receiving negative, self-verifying feedback, while also engaging in high levels of reassurance seeking

depression as assessed with the Inventory for Interpersonal Problems (IIP), one of the most widely used measures to assess interpersonal problems. In addition, we examine whether pre-treatment IIP scores are related to outcome. Where feasible, we present meta-analytic findings.

The IIP (Horowitz et al., 1988) is the only self-report measure of interpersonal problems specifically (as opposed to non-interpersonal problems, e.g. trouble sleeping or eating, unwanted thoughts) and the level of distress caused by them. The IIP originates from interpersonal theories and Horowitz's interpretation of these approaches in particular. The theory behind the IIP postulates that behaviours are reciprocally influenced; that is to say, all behaviour invites a reaction. In its original version, the IIP-127 was produced with two sections representing the most frequent ways patients expressed complaints prior to therapy: "It is hard for me to…" and "these are the things I do too much…". Scoring is on a 5 point Likert scale ranging from 0- not distressed at all by this problem, and 4- extremely distressed by this problem. A shorter factor version of the IIP-127, the IIP-32 (Barkham et al., 1996a) was developed by selecting the items which loaded most highly on their factors and successfully replicated the 8 factor structure with an independent sample. A difference of < 0.10 in the alpha co-efficients of the scales in the IIP127 and IIP-32 indicated there was acceptable fidelity to the original IIP-127 version. However, it must be noted that the selection of subscale items differs from the other shorter versions.

Despite the apparent robustness of this version of the IIP-32, there is limited use of it in the literature. It seems likely that its demise was due to the increasing popularity of the circumplex versions of the IIP which were published shortly after in 2000 and which included a 64 item and a shorter, 32 item version. The circumplex models of the IIP redress the criticism of the previous factor versions that they fail to inform about the inter-relationship between the scales, resulting only in a list of unrelated factors and were constructed by selecting the 8 ipsatized items that maximised the multiple correlation with each octant identified by a principal component analysis of the IIP127. The IIP-Circumplex (IIP-C) is a 64-item circumplex version (Alden et al., 1990) of the IIP, guided by the interpersonal circumplex model of interpersonal behaviour (Wiggins, 1979; Wiggins and Broughton, 1985).

It provides a conceptual framework for mapping the relationships between interpersonal problems and is comprised of eight octants of eight items in a circular arrangement, each representing a domain of interpersonal problems, labelled *PA, domineering; NO, intrusive; LM, overly nurturant; JK, exploitable; HI, non-assertive; FG, socially avoidant; DE, cold and BC, vindictive.* The circumplex can be divided thereafter into quadrants, the top left representing problems associated with a *hostile-dominant* style, top right a *friendly-dominant* style, bottom right a *friendly-submissive* style and bottom left a *hostile-submissive* style. On the *dominance-submission* axis (y-axis), behaviours are reciprocal, and on the *love-hate* axis (x-axis) behaviours are similar, so that, for example, hostile-dominant behaviour solicits a hostile-submissive reaction and friendly dominance a friendly-submissive reaction. Interpersonal problems can be said to be experienced when an individual becomes stuck in a pattern of repeated unwanted and frustrating interpersonal interactions (Horowitz et al., 1997) and the task of the therapist is to break this 'vicious circle', first in the therapeutic relationship and later outside of treatment (Horowitz, 1996).

Later modifications, including renaming the octants (*domineering/controlling, vindictive/self-centred, cold/distant, socially inhibited, non-assertive, overly accommodating, self-sacrificing* and *intrusive/needy*) and producing new normative data, resulted in the IIP-64 (Horowitz et al., 2000). The IIP-64 is composed of the same 64 statements describing common interpersonal problems used in the IIP-C and can be used to evaluate a person's distress from these problems relative to a standardized sample from the US. Although the ipsatizing methods where different in the development of the IIP-C and the IIP-64, the factor loadings were very similar and the items in each scale are the same, making them easily comparable. It is this 64 item version which is now most commonly used by researchers. Since its manual was published, it has been favoured over the 127 item version except in follow-up studies where the original data was collected with the IIP127 prior to 2000 and where the IIP127 was used in a translated form.

An additional shorter circumplex version, the IIP-SC (Soldz et al., 1995) is a 32 item circumplex version based on the IIP-C (Alden et al., 1990). For each octant, the four items with the highest correlation with the whole scale were selected and verified as reasonable measures of that octant. The correlations between the four item subscales and the eight item subscales of the IIP-C were over $r = 0.9$ and the all the octant scales were within 25º of the expected IIP-C location in a sample of 355 out-patients being treated with psychotherapy, indicating acceptable circumplex properties. The IIP offers several scoring options. The *total score*, or *total mean score*, gives an indication of the overall level of distress. Mean subscale scores give a more specific indication of the

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