CBT and IPT – A Comparison

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Contents

Introduction

Cognitive behavioural therapy (CBT), combining principles from cognitive and behavioural psychology, and interpersonal psychotherapy (IPT), are both empirically validated therapy forms that are widely used. CBT and IPT are relatively structured and symptom-targeted (S. G. Zhou et al., 2017) therapies with a usually limited number of sessions. CBT is frequently between 10 and 20 weekly sessions, and IPT between 12 and 16. A main difference between

IPT and the cognitive aspect of CBT is the former's focus on external interpersonal communication patterns and the latter's focus on internal intrapersonal communication or cognitions. CBT tends to be more directive than IPT. However, due to IPT's key areas of grief, role disputes, role transitions, and interpersonal deficits, IPT still has a narrower focus on content than, for example, psychodynamic therapies.

Reflection and insight play a role in both therapies, though they are not as central as curative elements as in in psychodynamic psychotherapies, while psychodynamic elements have been added to IPT, in the form of dynamic interpersonal therapy (DIT) and psychodynamic interpersonal therapy (PI). Both CBT and IPT do not work as directly with emotions as some other therapies, which may also explain why patients with high levels of painful emotion tended to have poorer outcomes in CBT and IPT. (Coombs et al., 2002)[1].

IPT focuses primarily on distortions in interpersonal communication and reducing distress by improving interpersonal relationships and social functioning, which then leads to changes in thoughts, feelings, and behaviours in an outside to inside direction. CBT in turn focuses directly on challenging and changing internal cognitive distortions and thought content that lead to maladaptive beliefs and attitudes, patterns of thinking, a negative self-image, and maladaptive behaviours in an inside to outside direction.[2] Both the cognitive as well as the behavioural techniques in CBT are assumed to lead to a reversal of the cognitive distortions.[3]

[1] However, recent developments of CBT tend to focus also on the reaction to one's thoughts rather than the thoughts themselves, which offers a gateway also to more work on emotional states.

[2] Examples from a long list of maladaptive cognitions in CBT include "overgeneralizing, magnifying negatives, minimizing positives and catastrophizing" (Gloster et al., 2009)

[3] In vivo exercises and administration of intense cognitive exercises in CBT are both hypothesized to result in alterations of patients' cognitive appraisals and, for example, a reduction of panic and agoraphobia symptoms. (Gloster et al., 2009)

IPT, on the other hand, only targets maladaptive thoughts and behaviours as they apply to interpersonal relationships. While content appears to play a larger role in CBT and process in IPT, this seems to be changing, as both therapies learn from each other. For example, derivatives of CBT that focus more on process include acceptance and commitment therapy (ACT)[4], mindfulness-based cognitive therapy (MBCT), dialectical behaviour therapy (DBT), and behavioural activation (BA). (Hetrick et al., 2016)

How They Work

The mechanisms and moderators[5] that bring about change in CBT and IPT are likely to differ, which may explain differences in the therapy timeline and different patterns of sudden therapeutic gains (see Lemmens et al., 2020). The more global interpersonal approach in IPT can be contrasted with more narrowly defined CBT techniques. Empirically, changes in interpersonal skills in IPT seem to act as a non-specific mechanism in reducing depression (Bruijniks et al., 2022), while CBT skill improvement tries to target specific mechanisms to bring about improvement. (Bruijniks et al., 2021). Approaches seem to be more symptom-specific in CBT than in IPT[6]. Key areas in IPT are stressful life events of grief, interpersonal disputes, life transitions, or social isolation (Cuijpers et al., 2016).

Other than in IPT, the cognitive part of CBT aims directly at internal thought patterns. The goal is to replace maladaptive coping skills, cognitions, beliefs, emotions, and behaviours with more adaptive ones by challenging patients' way of thinking and the way that they

[4] ACT focuses on acceptance and awareness of one's thoughts in a non-judgemental way.
[5] Lemmens and colleagues also note the various moderators that have already been suggested as differential pathways of change. (Lemmens et al., 2020)
[6] IPT was originally conceptualized as a general treatment approach for depression.

react to certain habits or behaviours. In the case of back pain, for example, objectives are development of adaptive coping strategies by minimizing negative or self-defeating thoughts, but also changing maladaptive beliefs about pain specifically (Gatchel & Rollings, 2008). Targets are the function, content, and structure of cognitions associated with negative affect (S. G. Zhou et al., 2017). Patients learn to identify, explore and modify relationships between negative thinking, behaviour and depressed mood, (Hetrick et al., 2016) as well as revisiting problem-solving appraisal, which seems to play an important role in depression (Chen et al., 2016). At the same time, it is not entirely clear yet to which extent effects can be attributed to the cognitive elements (see Hundt et al., 2013).[7]

IPT, on the other hand, tries to resolve problems that originate in external interpersonal interactions and within social contexts, which influence internal states. Interpersonal problems and attachment insecurity, for example, have empirically improved significantly with IPT (Ravitz et al., 2008), although, interestingly, patients higher on attachment avoidance seemed to improve more on CBT as compared with IPT (McBride et al., 2006).[8] IPT techniques include the identification of interpersonal issues, prioritising and clarifying issues, and communication analysis in the individual patient, which seems to go significantly beyond manualized work on communication behaviours in CBT (e.g. see Sasaki et al., 2017). IPT attempts to enhance a person's social support resources and decrease interpersonal stress, which facilitates emotional processing and improves interpersonal skills (Hetrick et al., 2016; Lipsitz & Markowitz, 2013). Techniques promote the expression and exploration of emotions within social situations, the development of supportive relationships, and the use of role

[7] Hundt and colleagues in a meta study pointed to the uncertainty about the role of skills use on treatment outcomes. (Hundt et al., 2013) CBT based work on communication behaviours, however, seems to have had significant positive effects in the workplace (Sasaki et al., 2017)

[8] One may speculate that for a patient who is attachment avoidant, the lesser interpersonal focus in CBT may offer at least a short-term benefit.

play to improve communication (Hetrick et al., 2016). Attitude change, other than in CBT, does not appear to play a mediational role in IPT (Quilty et al., 2008).

IPT's greater focus on improving interpersonal relationships may also prepare individuals more comprehensively for the social challenges of daily life than CBT's more issue-focused approach (Hilbert et al., 2012).[9] On the other hand, personality disorders may lead to a poorer response to IPT than CBT (Carter et al., 2015).[10] One may speculate that this is due to the fundamental impact of personality disorders on interpersonal communication.

Both therapies work within the interconnected framework of psychology, biology and the environment, while cognitive and biological processes may have been studied more exhaustively in CBT. For example, activation of cognitive control regions appears to increase in CBT treatment of both major depression and PTSD. (Yang et al., 2018) Cognitively, CBT tends to include a component of effective problem-solving (Hetrick et al., 2016), which may help in depressed states with their perceived failure or inability to control aversive events. Another example is that the effects of CBT on agoraphobia, anxiety, and panic frequency have been explained in part by reductions in fear of fear. (Smits et al., 2004) However, greater insight into processes in one therapy does not necessarily prove greater effectiveness, as similar or the same downstream processes could be activated in both therapies.

[9] Deficits in mastering the social challenges of daily life could play a particular role in eating disorders.

[10] In a RCT with depressed outpatients, comorbid personality disorders symptoms predicted a poorer response to IPT but not CBT. Patient psychic distress, patient participation in therapy and patient alliance were associated with outcome in both CBT and IPT. (Carter et al., 2015)

The Therapist-Patient Relationship

A good therapeutic alliance is associated with better outcomes in any therapeutic approach and desirable in CBT and IPT. However, conceptually, the procedural relationship between therapist and patient, including feedback about it, is central to IPT given its external and interpersonal focus. The central importance of the therapeutic alliance is associated with the patient's expectations of the therapy.[11] Instilling a realistic and believable sense of hope is important. The importance of the interpersonal relationship has been shown to be at least or even more important than the school of therapy, which aligns with some core IPT assumptions.[12]

In CBT the quality of the relationship between therapist and patient is only of many factors[13], which may have contributed to the higher drop-out rates compared to other treatments, including IPT, which have been observed in several studies (see, for example, Slife et al., 1995). This may explain why facilitative conditions were associated with better outcome in CBT but not in IPT (Alexandersson et al., 2022). On the other hand, the lower interpersonal focus of several CBT techniques has made CBT available for self-help and web-based therapy through AI, while IPT requires the presence of a human therapist. However, in more recent trends, CBT has increasingly emphasized that the therapist (the "listener") should create an empathetic and cooperative relationship when working on dysfunctional cognitions. (Sasaki et al., 2017)

[11] Across both treatments, CBT and IPT, bulimia nervosa (BN) patients' expectation of improvement was positively associated with early- and middle-treatment alliance quality. (Constantino et al., 2005)

[12] Unfortunately, the CBT literature tends to explain therapeutic failure too often in terms of inadequate training or lack of adherence to a manualised algorithm and too infrequently in terms of the dynamics of the therapist-patient relationship.

[13] Although Aaron Beck trained as a psychoanalyst, the original focus in his writings seemed less on the therapist-patient relationship than the intrapersonal cognitive processes.

Therapy Phases

IPT, and less so CBT, are structured linearly over time in contrast to psychodynamic psychotherapies[14]. IPT has three defined phases, while CBT does so much more loosely. CBT and IPT have assessment, psychoeducation and skill acquisition, consolidation and follow-up phases (compare Cuijpers et al. (2016) and Gatchel & Rollings (2008)). IPT adds emphasis on an extended social history and interpersonal inventory, and it includes the choice of an interpersonal focus in the beginning phase and interpersonal problem-specific therapeutic guidelines in the middle phase. Interestingly, the first phase in IPT also emphasises 'instilling hope. (Cuijpers et al., 2016).

Applications

CBT has been used very widely from anxiety to depression, bulimia nervosa, panic attacks, substance use disorders, OCD, PTSD, and many other conditions. IPT was originally developed for major depression, but its use has widened considerably. Conceptually, symptoms should have at least some causal links with the previously mentioned IPT key areas.[15]

IPT has been used in depression[16], eating disorders, substance use disorders (alcoholism and drugs), anxiety disorders, and several others, where it has showed effectiveness, (Cuijpers et

[14] In psychodynamics psychotherapy progress is not strictly linear and depends more on the content that emerges in a particular session. Non-linearity may even signal significant therapeutic progress. 'Loops' with a seeming backward motion followed by a greater forward motion are actually quite common.

[15] The IPT key areas are grief, role disputes, role transitions, and interpersonal deficits.

[16] In a meta-analysis of thirty-eight studies, pharmacotherapy and IPT were more effective in preventing relapse than pharmacotherapy alone. (Cuijpers et al., 2011)

al., 2016) including also bipolar disorder and other mood conditions (S.-G. Zhou et al., 2017). Both therapies have adapted to different settings, such as primary care[17], and specific populations, such as adolescents or the elderly[18]. It has been noted that the vast majority of depression interventions developed thus far have been based on CBT and IPT (Hetrick et al., 2016), while it may be arguable what constitutes a separate intervention given the large number of narrowly defined interventions in CBT.

Effectiveness

The strongest meta-analytic support exists for CBT of anxiety disorders, somatoform disorders, bulimia, anger control problems, and general stress (Hofmann et al., 2012).[19] In the case of depression, binge eating disorder (Agras et al., 1995; Hilbert et al., 2012) and possibly bulimia nervosa[20], IPT and CBT seem to some extent comparable. Several studies have shown IPT is effective in treating depression (S. G. Zhou et al., 2017). CBT probably has an edge when treating panic disorder, while IPT may be superior for social anxiety,[21] as would be expected from the external communication focus of IPT. Different population

[17] For example, a shorter, 6-week therapy for primary care settings called Interpersonal counselling (IPC) has been derived from IPT.

[18] Both IPT and CBT have also been developed for adolescents and the elderly. (Coombs et al., 2002)

[19] This was the conclusion from a study of 269 meta-analytic studies. (Hofmann et al., 2012) Still, one should not forget double-blind studies have not yet been devised for psychotherapy. Also, measuring instruments can play an important role in judging effectiveness. In a large meta study on MDD, CBT showed an advantage over IPT according to the BDI, but not according to the HRSD and HAM-D6. (S.-G. Zhou et al., 2017)

[20] In a studies on binge eating, CBT and IPT treatments did not differ in recovery rates (Hilbert et al., 2012) and IPT led to no further improvement for those who did not improve with CBT. (Agras et al., 1995) In the case of bulimia nervosa, there seemed to be no significant differences between treatments at follow-up.

[21] Vos and colleagues found in their study of ninety-one adult patients superior effects for CBT over IPT in treating panic disorder with agoraphobia over four months, particularly for agoraphobic complaints and behaviour and negative interpretations of bodily sensations, all of which decreased more in CBT. (Vos et al., 2012) However, for social anxiety empirical data from 40 college students suggested that IPT significantly decreased social phobic symptoms and social interaction anxiety in comparison to CBT. The results also showed, however, that there was no difference between the two psychotherapies in improvement to the fear of negative evaluation. (Tavoli, 2013)

characteristics[22] and the measurement instruments used are likely to have accounted for some differences in the determined effectiveness between CBT and IPT that have been described in the literature. For example, In a metanalysis of ten studies, CBT showed an advantage over IPT for major depression according to BDI, but there was no significant difference between the two according to the HRSD (S.-G. Zhou et al., 2017) Another problem is the absence of double-blind studies of psychotherapy, which can lead to hidden variables, such as different expectations and hopes about a therapeutic intervention.

When choosing between CBT and IPT, individual patient characteristics may be as important as the actual diagnosis. In depression, higher CBT (but not IPT) efficacy was associated with lower age, high initial depression severity, and no adjunctive antidepressant medication[23] (Whiston et al., 2019). In the case of CBT for generalized anxiety disorder, the effect on pathological worry was largely moderated by age and modality of treatment. (Covin et al., 2008) Cultural differences may also influence the effectiveness of therapies with different interpersonal strategies.[24]

The divergence in empirical findings underscores the problem of studying different therapies primarily along diagnostic fault lines. In a meta–analyses of thirteen studies, DeMello and colleagues concluded that for depressive spectrum disorders (DSD) IPT was significantly better than CBT (De Mello et al., 2005), while in another study, CBT alone was superior to IPT

[22] In a study of 380 high school students CBT and IPT skill training for adolescents seemed both equally effective against depressive symptoms, although the effects seemed to be rather short-term (Horowitz et al., 2007). Interestingly, Horowitz and colleagues observed in the study that for the whole sample, sociotropy and achievement orientation moderated the effect of the interventions. (Horowitz et al., 2007)

[23] Higher efficacy of CBT (but not IPT) was also associated with the individual format of administration (Whiston et al., 2019).

[24] In a study with Puerto Rican adolescents, CBT produced significantly greater decreases in depressive symptoms and improved self-concept than IPT, (Rosselló et al., 2012) which can also be due to cultural influences.

alone[25] for major depression (Whiston et al., 2019). IPT, on the other hand, has shown to be a preventative therapy for preventing women at risk of postnatal depression (PND). (Lal et al., 2021) The specific effectiveness of IPT and medications in reducing suicidal ideation was shown in another study[26]. (Weitz et al., 2014) There can be a wide spectrum of explanations for the divergent findings. For example, there may be a selection bias if CBT has more easily measurable parameters[27] that could be associated with likely future improvement. In single studies, therapists may also use a psychodynamic variation of IPT, such as DIT or PI, which have shown to an effectiveness comparable to CBT in some studies. [28] On the other hand, a study population may consist of college students, which may be a group with distinct interpersonal communication capabilities and needs. Furthermore, cognitive distortions may be a symptom rather than a cause, which makes process-focused comparisons conceptually more difficult.

Effect duration

Even meta studies may lead to inaccurate conclusions about comparative effectiveness if their constituent studies have different or no follow-up periods. In a studies on binge eating,

[25] and to combined treatment, while IPT alone was non-inferior to combined treatment

[26] The result was largely a consequence of their more general effects on depression.

[27] "If the goal was to decrease the behavior, then there should be a decrease relative to the baseline. If the critical behavior remains at or above the baseline, then the intervention has failed." (Kaplan & Saccuzzo, 2013)

[28] Dynamic Interpersonal Therapy (DIT) has empirically shown effectiveness for depression and anxiety and effect sizes comparable with CBT. DIT lead to statistically significant reductions in depression (PHQ-9) and anxiety (GAD-7). (Wright & Abrahams, 2015) In another study, DIT was associated with a significant reduction in reported symptoms in all but one case, to below clinical levels in 70% of the patients. (Lemma et al., 2011) In a third study, the DIT and CBT arms showed equivalence on most outcomes. (Fonagy et al., 2020) Another example is psychodynamic interpersonal psychotherapy (PI), which has shown to achieve results comparable to CBT in patients with depression and other conditions. In one study of 117 depressed patients, there was no evidence that CBT's effects were more rapid than those of PI, nor did the effects of each treatment method vary according to the severity of depression. (Shapiro et al., 1994) Another study of 62 patients concluded that the results show that PIT can yield acceptable clinical outcomes, comparable to CBT in a routine care setting, within the context of current limitations of the practice-based evidence paradigm. However, interestingly, PIT outcomes were worse for patients with high pre-treatment interpersonal problems (Paley et al., 2008).

CBT and IPT treatments did not differ in recovery rates (Hilbert et al., 2012) and IPT led to no further improvement for those who did not improve with CBT. (Agras et al., 1995) However, in a study of 220 bulimia nervosa patients, significantly more patients[29] recovered with CBT, while at follow-up, there were no significant differences between the two treatments. (Agras et al., 2000).

Since changes in interpersonal communication patterns may be more resistant to change than cognitive thought patterns due to the effects of feedback, relational experiences, and network building, one could hypothesize that a positive effect of the former in IPT could be more persistent, which some empirical research seems to support. Particularly, IPT for adolescents (IPT-A) has been shown to build greater resilience to mental health problems through better social functioning with family, friends and others. (Mufson et al., 2004) Changes in interpersonal communication patterns could lead to additional stabilising relational and social feedback. In a long-term follow-up study on binge eating disorder abstinence was more stable in the IPT group and relapse more frequent in the CBT group. (Hilbert et al., 2012) In another study, improved social and general functioning with IPT-A and consistent reduction in depression has been shown. (Mufson et al., 2004) IPT-A may be particularly helpful for depressed adolescents who are reporting high levels of conflict with their mothers or interpersonal difficulties with friends. (Gunlicks-Stoessel et al., 2010) The IPT-A group showed significantly fewer clinician-reported depression, significantly better functioning, significantly better overall social functioning, significantly greater clinical improvement, and significantly greater decrease in clinical severity. (Mufson et al., 2004) IPT has been viewed as a preventative treatment, which can address interpersonal stressors that

[29] 29% vs 6%

can contribute to mental disorders. (Cuijpers et al., 2016) Furthermore, groups, which lend themselves to an interpersonal approach, can also create longer lasting effects.[30]

Conclusion

CBT and IPT can both be effective in their different treatment emphases, internal and external communication. Research does not necessarily support an overall superiority in effectiveness of one over the other[31], although one therapy may be better suited for a particular patient than another. Given the different focus of CBT and IPT as regards interpersonal and intrapersonal processes, greater insight into individual patient characteristics may help to further elucidate how the different approaches work. Since their different foci on internal cognitions and external interpersonal interactions both seem effective, they may from different starting points work on the same or similar underlying psychological processes that lead to symptom improvement. The observed link between emotions and anxiety[32], for example, is probably targeted and used by both approaches.

Since CBT and IPT may share a considerable number of underlying target processes, integration of CBT and IPT in select cases could show significant synergies. For example, in a case study on bulimia nervosa, CBT techniques appeared to be most effective in eliminating binge behaviour, whereas IPT techniques seemed most effective in reducing purging

[30] In a study by Popolo and colleagues, participants in the metacognitive interpersonal therapy group (the MIT-G arm) had large symptomatic and functional improvements. Results were sustained at follow-up. (Popolo et al., 2019)

[31] It has been argued that research still needs "better measures reflecting the improvement of a social function which may demonstrate the difference between the two psychotherapies". (S.-G. Zhou et al., 2017)

[32] In one study, individual mediation models revealed that both anxiety sensitivity and emotional regulation significantly mediated the reduction in anxiety-related symptoms over the course of treatment. (Asnaani et al., 2020)

behaviour[33]. (Hendricks & Thompson, 2005) In another study[34], the integration of CBT and IPT was effective in decreasing the relapse rate in GAD after CBT[35]. (Rezvan et al., 2008) Thus, further exploration of possible applications and modalities of integrating CBT and IPT seems very worthwhile.

Boundaries on the edges of the two therapies already seem to blur, such as the ones between metacognitive and mindfulness-oriented versions of CBT and derivatives of IPT, while psychodynamic elements have been added to both. In the case of CBT, it has been suggested that the field may be approaching a shift in emphasis from cognitive to metacognitive assessment and interventions. (Dobson, 2013) In the case of IPT, there are variations that include internal reflection to a greater degree, as, for example, in the case of dynamic interpersonal therapy (DIT) and metacognitive interpersonal therapy (MIT), which have been well received and quite successful as treatments.[36] It may be that as the overlap between CBT and IPT is increasing, the seeming benefits of a hard and fast binary choice between an external interpersonal focus in the case of IPT and an internal cognitive and learning-behavioural focus in CBT may need to be revisited.

[33] Results revealed that the client was no longer experiencing clinically significant symptoms of bulimia nervosa, depression, or alcohol abuse at end of treatment and at follow-up (18 months after treatment onset).

[34] The sample consisted of 36 female undergraduate students who referred themselves and met the criteria for GAD. They were randomly assigned into two experimental groups and one control group. One of the experimental groups underwent CBT and the other one received treatment that integrated CBT and IPT.

[35] Statistically, the differences between the CBT and CBT with IPT groups on excessive worry and happiness in the post tests were not significant. But significant mean differences were observed in the follow-ups regarding pathological worry and happiness between the two groups.

[36] The former is designed to better understand the own thoughts and feelings and the latter, which is manualized, to treat personality disorders with emotional inhibition or avoidance. MIT has shown to be effective in a 2 year study of weekly MIT (Dimaggio et al., 2017). It seems that the addition of the metacognitive element has made it particularly successful in group settings (MIT-G) (Inchausti et al., 2020). MIT-G includes practice of awareness of mental states and “the use of mentalistic knowledge for purposeful problem-solving”. (Popolo et al., 2019)

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