Interpersonal Psychotherapy: Current Status

Myrna M Weissman

Department of Epidemiology in Psychiatry, College of Physicians and Surgeons of Columbia University and School of Public Health, Division of Clinical and Genetic Epidemiology, New York, NY, USA

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Abstract. Interpersonal psychotherapy (IPT), a time-limited treatment for major depression, was developed, defined in a manual, and tested in randomized clinical trials by the late Gerald L Klerman, MD, and collaborators. It has subsequently been modified for different age groups (adolescents-elderly), types of mood disorders (dysthymia, bipolar disorder, antepartum and postpartum patients), and non-mood disorders (bulimia, drug abuse, borderline personality disorder, social phobia, somatization, medically ill patients). It has been used as a long-term treatment, in a group format, over the telephone, and as a patient guide. It has been translated into Italian, German and recently Japanese. Having begun as a research intervention, IPT is only recently being disseminated among clinicians or in residency training programs. The publication of efficacy data, the appearance of two practice guidelines in the United States that include IPT among treatments for depression, the interest in defined treatments for managed care and the endorsement of Consumers Guide have led to increasing requests for information and training. This paper briefly describes the concepts and techniques of IPT and the current status of adaptation. In summary, evidence from controlled clinical trials suggests that IPT is a reasonable alternative or adjunct to medication as an acute, continuation, and/or maintenance treatment for patients with major or mild depression, patients who are human immunodeficiency virus (HIV) positive, or who have bulimia. It is a promising treatment for depressed adolescents and for geriatric patients, for patients with dysthymia and as treatment for depressed couples marital disputes. A final conclusion awaits the completion of clinical trials underway before substantial claims can be made. IPT is not effective, as compared to a standard drug program, for opiate and cocaine addicted patients. (Keio J Med 46 (3): 105–110, September 1997)

Key words: psychotherapy, treatment, major depression, clinical trials

Interest in time-limited psychotherapies has increased recently in response to demands for cost cutting efforts in mental health care in the United States. Interpersonal psychotherapy (IPT), a time-limited treatment for major depression, was developed and tested in clinical trials by the late Gerald L Klerman, MD, his wife, Myrna Weissman, PhD and several collaborators well before the popularity of these treatments. Having begun as a research intervention, IPT’s wide dissemination among clinicians began after his death in 1992. The publication of efficacy data, the recent appearance of practice guidelines for psychiatrists and primary care physicians that include IPT among recommended treatments for depression,2 the interest in defined treatments for managed care and the endorsement of Consumers Guide in 19953 have led to increasing requests for information and training. IPT has subsequently been modified for different age groups, different disorders4 and as a patient guide.5 The book describing the treatment has been translated into Italian and German and most recently Japanese.

Overview

Interpersonal psychotherapy was initially formulated as a time-limited, weekly outpatient treatment for

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 Reprint requests to: Dr Myrna M Weissman, Department of Epidemiology in Psychiatry, College of Physicians and Surgeons of Columbia University and School of Public Health, Division of Clinical and Genetic Epidemiology, New York State Psychiatric Institute, Unit 14, 722 West 168th Street, New York, NY 10032, USA, e-mail: Weissman@child.cpcn.columbia.edu

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depressed patients. IPT makes no assumptions about the "cause" of depression or other disorders but uses the connection between onset of symptoms and current interpersonal problems as a treatment focus. IPT generally deals with current rather than past interpersonal relationships, focusing on the patient's immediate interpersonal problem. It attempts to intervene in symptom formation and the social dysfunction associated with depression rather than on the patient's personality.

Phases of treatment

There are three phases. The first, usually the first 1–3 sessions, includes diagnostic evaluation and psychiatric history and sets the framework for the treatment. The therapist reviews symptoms, diagnoses depression by standard criteria, and gives the patient the sick role. The sick role excuses the patient from overwhelming social obligations, but requires the treatment to recover full function. During the initial session, the psychiatric history includes a review of the patient's current close relationships, their patterns and mutual expectations. Changes in relationships proximal to the onset of symptoms are elucidated, e.g. death of a loved one, children leaving home, worsening marital strife, or isolation from a confidant. This review provides a framework for understanding the interpersonal context of the onset of depressive symptoms and defines the focus of treatment.

The therapist assesses the need for medication based on symptom severity, past history and response to treatment and patient preference and then educates the patient about depression by explicitly discussing the diagnosis, including the constellation of symptoms that define the diagnosis and what the patient might expect from treatment. The therapist then links the depressive syndrome to the patient's interpersonal situation within the framework of one of four interpersonal problem areas: (1) grief; (2) interpersonal role disputes; (3) role transitions; and (4) interpersonal deficits.

In the middle phase, the therapist pursues strategies which are specific to the interpersonal problem area. For grief, defined as complicated bereavement following the death of a loved one, the therapist facilitates mourning and gradually helps the patient to find new activities and relationships to compensate for the loss. Role disputes are conflicts with a significant other: The spouse or other family member, co-worker, or close friend. The therapist helps the patient explore the relationship and the nature of the dispute and options to resolve it. Failing this, they may conclude that the relationship has reached an impasse and consider ways to change the impasse or to end the relationship and replace it. Role transition includes a change in life status: e.g. the beginning or end of a relationship or career, a move, promotion, retirement or graduation.

The patients are helped to deal with the change by recognizing positive and negative aspects of the new role they are assuming, and assets and liabilities of the old role this replaces. Interpersonal deficits, the fourth problem area, defines the patient with problems in initiating or sustaining relationships.

IPT sessions address present "here and now" problems rather than childhood or developmental issues. Sessions open with the question: "How have things been since we last met?" This focuses the patient on recent interpersonal events and mood, which the therapist attempts to link. Therapists take an active, non-neutral, supportive and hopeful stance.

The final phase, typically the last few weeks of treatment, encourages the patient to recognize and consolidate therapeutic gains and to develop ways of identifying and countering depressive symptoms should they arise in the future.

Use for Mood Disorders

Acute treatment of major depression

The efficacy of IPT as a treatment for acute depression was first demonstrated in a 16-week randomized trial of IPT and amitriptyline (AMI) alone and in combination and in a non-scheduled treatment control for outpatients with major depression. Depression of patients on IPT and AMI improved equally by the end of treatment. The effects of AMI were apparent earlier, after two weeks. Each active treatment more effectively reduced symptoms than did a non-scheduled control, and combined AMI-IPT was more effective overall than either active treatment alone. A one-year follow-up found that patients who received IPT developed significantly better psychosocial functioning, whether or not they received medication. This effect on social function had not been evident at the end of the 16-week trial for any treatments.

The most ambitious acute treatment study was the multi-site National Institute of Mental Health Treatment of Depression Collaborative Research Program which randomly assigned 250 depressed outpatients to 16 weeks of Imipramine (IMI), IPT, cognitive therapy (CBT), or a placebo. Mildly depressed patients improved across all treatments, including placebo. IMI induced the most rapid response and was most consistently superior to placebo. IPT was comparable to IMI in several outcome measurements, and was superior to placebo in reducing depressive symptoms for the more severely depressed patients.

Maintenance treatment

IPT was first developed and tested as an eight-month
treatment for patients who had initially improved on medication, to see if recurrence of depression or relapse could be prevented. One hundred and fifty acutely depressed outpatient women who responded to 4-6 weeks of AMI were randomized to receive eight months of treatment with weekly IPT alone, AMI alone, combined IPT-AMI, IPT-placebo alone, or no pill. Maintenance pharmacotherapy was found to prevent relapse and symptom exacerbation, whereas IPT improved social functioning. The effects of psychotherapy on social functioning were not apparent for 6-8 months. Patients who received both IPT and AMI had the best outcome.

In the longest maintenance trial, Frank and Kupfer in Pittsburgh studied 128 outpatients with severe recurrent depression who responded to 12 weeks of continuation treatment for the acute episode and 20 weeks of continuation treatment with IMI and IPT. IPT was modified for this maintenance trial primarily by emphasizing those problems that persist or develop as a consequence of remission. Due to the length of treatment multiple problem areas were addressed. Patients were randomly assigned to receive three years of monthly maintenance IPT either alone or combined with IMI, or combined with placebo; or medication clinic visits for either continuing high dose IMI or placebo, without further psychotherapy. This study was unique in using the highest dose of medication ever in a maintenance trial (mean 200 mg/day) and the lowest dose of IPT ever (monthly).

Findings showed the highest significant effect for maintenance IMI in preventing recurrence of depression, a modest but significant effect for IPT, and a trend for superiority of the combined treatment. After one year, major depression had recurred in 65% of placebo patients, 46% of those on IPT without IMI, 17.9% of those on IMI alone, and only 8% of those on IPT-IMI. At three years, the mean survival without recurrence of depression was 45 weeks for placebo, 74 weeks for IPT plus placebo, 82 weeks for IPT alone, 124 weeks for IMI alone, and 131 weeks for IPT-IMI. The authors concluded that IMI maintenance treatment, at a dose of 200 mg, is an effective means of preventing recurrence of major depressed disorder in patients with a history of recurrent episodes, and that monthly IPT serves to lengthen the time between episodes in the patient not receiving medication. The 82-week survival time without recurrence with IPT alone for patients with a history of recurrence would suffice to protect many women with recurrent depression, through pregnancy and nursing without medication.

**Geriatric depressed patients**

The first use of IPT in geriatric depressed patients was IPT added to a six-week clinical trial of medication vs placebo in order to enhance compliance. Grief and role transition, specific to life changes, were the prime focus of treatment. The authors suggested IPT modifications including more flexible duration of sessions, more use of practical assistance, such as arranging transportation, calling the physician; and recognition that major role changes such as divorce at age 75 may be impractical and detrimental.

A separate six-week clinical trial comparing IPT to nortriptyline in 30 geriatric depressed patients showed advantages of IPT, largely due to medication side effects that produce higher attrition in the medication group. A three-year maintenance study for geriatric patients with recurrent depression is underway in Pittsburgh.

**Depressed adolescents (IPT-A)**

Mufson at Columbia University has modified IPT to incorporate adolescent developmental issues, adding as a fifth problem area the single parent family, an interpersonal situation found frequently among adolescents. Telephone contacts are used more readily, and the school and parents are involved as appropriate. In a recently completed open trial, 14 patients after 12 weeks of IPT treatment were significantly less symptomatic and had better functioning. After 12 weeks, none were clinically depressed. A clinical trial is underway.

**Depressed HIV-positive patients:** Markowitz at Cornell has modified IPT for depressed human immunodeficiency virus (HIV) patients emphasizing concern about illness and death, grief and role transitions. In a pilot open trial patients felt that brief therapy was suitable for their situation, in which time was precious and quick results needed. A 16-week randomized clinical trial has just been completed, comparing IPT to CBT, supportive psychotherapy, and IMI plus supportive psychotherapy. Results in 101 patients showed a differential improvement in symptom reduction for IPT and for IMI at 8 weeks, as compared to supportive therapy or CBT. This improvement persisted at termination.

**Dysthymia:** In a modification of IPT for dysthymia, patients are encouraged to reconceptualize what they had seen as their character flaws as chronic mood-dependent symptoms. Contrary to expectation, two open trials found that dysthymics with lifelong chronicity had a reduction of depressive symptoms after 16 weekly IPT sessions. A total of 16 pilot subjects were treated; none worsened, and 11 remitted. A comparative study of 16 weeks of IPT, supportive psychotherapy and sertraline plus clinical management is underway at Cornell Medical Center.
Women with unplanned pregnancies are concerned. Among treatment completers, approximately 70% receiving either drug or IPT, but only 20% receiving usual care, were judged as recovered at 8 months. IPT is designed to include attention to the behavioral management of daily schedule and sleep patterns. This modification is being tested as a 3-year maintenance treatment in an ongoing study of lithium-stabilized bipolar patients, comparing IPT-BP to medication.

Depressed primary care patients

A clinical trial comparing IPT to pharmacotherapy for depressed ambulatory medical patients in a primary care setting has been completed. IPT is designed to conform with the practices of the primary care center, e.g. nurses take vital signs and blood pressure prior to each session. IPT continues if a patient is medically hospitalized. Two hundred and seventy-six patients with current major depression who were assigned to either IPT administered by a psychiatrist or clinical psychologist; nortriptyline treatment; or primary care physicians' usual care were seen weekly for 16 weeks and monthly thereafter for four months in IPT. Severity of depression was reduced more rapidly by either the drug or psychotherapy than by usual care. Among treatment completers, approximately 70% receiving either drug or IPT, but only 20% receiving usual care, were judged as recovered at 8 months.

Bipolar disorder: Frank, in Pittsburgh, has modified IPT to include attention to the behavioral management of delay schedule and sleep patterns. This modification is being tested as a 3-year maintenance treatment in an ongoing study of lithium-stabilized bipolar patients, comparing IPT-BP to medication.

Conjoint IPT for depressed patients with marital disputes: Since marital disputes, separation, and divorce have been associated with onset and course of depressive episodes, and individual psychotherapy for depressed patients in marital disputes may lead to premature termination of some marriages, IPT was adopted for conjoint therapy in depressed patients with marital disputes. IPT focuses on the current marital dispute, and involves the spouse in all sessions. Eighteen patients with major depression linked to the onset or exacerbation of marital disputes were randomly assigned to 16 weeks of individual IPT or conjoint IPT. Patients undergoing both treatments showed the same reduction in depressive symptoms. However, patients in conjoint IPT had significantly better marital adjustment, greater marital affection, and better sexual relations than did IPT-alone patients.

Antepartum/postpartum depression: IPT is being used in women with antepartum depression by Spinelli at Columbia University. Role transition focuses on the pregnant woman's evaluation of herself as a parent, as well as the physiologic changes of pregnancy and altered relationship with spouse and significant others. Women with unplanned pregnancies are concerned about the loss of freedom to work, or finish school, or with marital disputes. Timing and duration of sessions require flexibility around issues of bedrest, delivery, obstetrical complications, and child care. Young children may be brought to sessions and, if postpartum, mothers may breastfeed during sessions. Telephone sessions at visit and the hospital may be necessary. Spinelli is undertaking a controlled clinical trial comparing IPT and a didactic parent education group in depressed pregnant women weekly over 16 weeks of acute treatment and monthly for 6 months.

IPT for Other Disorders

IPT has been modified for a variety of other disorders and a number of studies are in progress. IPT has not been shown to be effective in two clinical trials with substance abusers. Fairburn in Toronto has made little change in IPT for two studies of bulimics. By design, reference is not made to the patient's eating disorder during the course of the treatment. The initial study included 24 patients randomized to either CBT or IPT, for 19 sessions over 18 weeks and demonstrated the comparability of the treatments. In the second study, 75 patients with bulimia nervosa were randomly assigned to CBT, IPT or a behavioral treatment (BT) study for 19 sessions over 18 weeks with a 12-month follow-up. Few patients in BT ceased binge eating and purging. Patients in CBT and IPT made equivalent and substantial changes across all areas of symptoms, with IPT taking longer to achieve these effects. A modification of IPT in a 16-week session group format is being tested in comparison to group CBT and a waiting list control (WL) in 56 women with nonpurging bulimia. Both IPT-G and CBT significantly reduced binge eating, but the WL did not. These results were sustained at the one-year follow-up.

IPT is now being modified for a host of other disorders including social phobia, panic, body dysmorphic disorder, somatizations in primary care patients, borderline personality disorder, metastatic breast cancer, patients with distress, subdysthymic hospitalized elderly patients, and mothers of children with cancer. It is being tried over the telephone, with a patient guide. A simple version of IPT called interpersonal counseling has been modified for non-psychiatric professionals treating patients with distress attending medical clinics.

Conclusion

Evidence from controlled clinical trials suggests that IPT is a reasonable alternative or adjunct to medication as an acute, continuation, and/or maintenance treatment for patients with major depression, patients who are HIV positive, or who have bulimia. It is a promising, but still not fully tested, treatment for depressed adolescents and for geriatric patients, for patients with dysthymia, patients with mild depression seen in pri-
mary care and as treatment for depressed couples with marital disputes. More efficacy data are needed in these areas before substantial claims can be made. IPT is not effective, as compared to a standard drug program, for opiate and cocaine addicted patients.

It is unclear how efficacy data for psychotherapies like IPT will be used in the new health care systems. Will standardization of treatment be required? What type of education, credentials and training will be required? What type of evidence of effectiveness and/or cost offsetting will be required? Will untested psychotherapies be reimbursed? Will limits be placed on the amount, length or duration of treatment? We feel that strict limitations on psychotherapy reimbursement for certain patients will not be in the patients' best interest, e.g. for recurrent depressives who cannot take or fail to respond to medication, or for depressed women during pregnancy and nursing. The efficacy of antidepressant pharmacotherapy is unequivocal. Yet mediating depressed patients without psychological management or monitoring may lead to poor compliance or missed suicide risk. At a minimum, clinical management of depression entails the tasks defined by the initial phase of IPT: explaining the diagnosis and its spectrum of symptoms, the expected clinical course, side effects, range of treatment alternatives, and linkage between the onset of symptoms and social and interpersonal problems. The role of evidence (i.e. controlled clinical trials) in shaping policy on reimbursement needs to be evaluated. Time limits on treatment such as IPT are a necessary part of research protocols. However, clinical trials usually exclude the complicated patients with comorbidity seen in clinical practice. Reimbursement policy when based on data extracted from clinical trials should allow for these contingencies. We need to know how the efficacy of IPT in clinical research translates into effectiveness when used by general clinicians for ordinary cases.

The best interests of all psychiatric patients are ensured by the availability of a range of treatment modalities whose efficacy has been established in controlled clinical trials. However, psychotherapy research is a cottage industry. The Food and Drug Administration in the United States approves new drugs. There is no analogy for psychotherapy to evaluate claims of efficacy, and no corporate industry to develop new treatments and take these treatments through the phases of testing. It is no surprise that there are considerable gaps in empirically based guides for the use of psychotherapy.

The work of Gerald L Klerman, MD on IPT was ahead of his time. He developed a treatment which could be adapted to the new treatment guidelines. These guidelines were published after his death. His words about a scientific basis for treatment in 1990 are still true today.

“In current psychiatric practice, where there are large areas of ignorance, it behooves individual practitioners and institutions to avoid relying on single treatment approaches or theoretical paradigms... Treatment programs based only on psychotherapy or only on drugs are subject to criticism. Professionalism requires balancing available knowledge, clinical experience and promoting the advancement of scientific knowledge. In the case of treatment practices such knowledge comes best from controlled trials.”

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