Gerald Klerman (1929–1992) and Myrna Weissman

11 INTERPERSONAL PSYCHOTHERAPY

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OVERVIEW

Basic Concepts

Interpersonal psychotherapy (IPT) is a time-limited, symptom-focused therapy that was originally developed by Gerald Klerman and Myrna Weissman in the 1970s to treat unipolar, nonpsychotic depression in adults (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman, Markowitz, & Klerman 2000; Weissman, Markowitz, & Klerman, 2007). The fundamental principle of IPT is that depression occurs in an interpersonal context. Regardless of the *causes* of depression, the *triggers* of depressive episodes involve disruptions of significant attachments and social roles. Four interpersonal problem areas have been defined as depressogenic triggers and become the focus of IPT: grief, interpersonal disputes, role transitions, and interpersonal deficits. While recognizing the genetic, personality, and early childhood factors that contribute to depression, the IPT therapist focuses on the recovery from the current depressive episode by (1) clarifying the relationship between the onset of patient's current depressive symptoms and interpersonal problems and (2) building interpersonal skills to resolve or manage more effectively these interpersonal problems.

The foundation of IPT as an operationalized and manual-based approach has facilitated extensive testing against other psychotherapeutic and pharmacological interventions

(Weissman et al., 2007). In the last 30 years, randomized controlled clinical trials (RCTs) have established IPT as a major evidence-based psychotherapy for a number of mood disorders (major depression, bipolar disorder, postpartum depression, etc.) as well as other conditions (bulimia, binge-eating disorder, PTSD, etc.); populations (adolescents, adults); settings (hospital clinics—inpatient and outpatient, school-based clinics, primary care, prisons); modalities (individual, group, conjoint, via telephone); for various stages of disorder (prevention, acute treatment, maintenance); and cultural contexts (Western countries, sub-Saharan Africa, Asia, and Latin America). Each adaptation adheres to the fundamental elements of the original treatment manual for depression, while emphasizing, adding, and modifying techniques to address the unique needs of the patient population served. The description of the theoretical and empirical basis and principals of IPT can be found in the original manual (Klerman et al., 1984). Current data on efficacy can be found in Weissman and her colleagues (2000), and a simplified clinical manual has been published by Weissman and her co-authors (2007).

Theory of Depression/Psychopathology

In IPT, depression is conceptualized as having three components:

1. Symptom formation
2. Social functioning
3. Personality factors

Historically, IPT has focused on the first two components. Although IPT recognizes the contribution of personality factors in the etiology and maintenance of mental disorders, due to its short-term nature, it has not focused on entrenched aspects of personality that typically take longer to change. Instead, IPT has addressed current symptoms and interpersonal problems that can be improved. Social functioning, symptom formation, and personality factors are all linked, and improvements in interpersonal relations help assuage problems in the other areas of functioning (Weissman et al., 2000). Recently, however, Markowitz and colleagues have adapted IPT to address the more chronic mood disturbances in borderline personality disorder by extending the duration of treatment while preserving its fundamental strategies and techniques (Markowitz, Skodol, & Bleiberg, 2006).

Phases of Treatment

IPT has a "phasic" structure in that it is conducted in three distinct phases (the initial, middle, and termination phases; the specific content of each phase is described in the Process of Psychotherapy section). In that sense, IPT is different from a modular approach to treatment, which characterizes cognitive behavior therapy or dialectical behavior therapy where, for example, cognitive or mindfulness strategies can be conducted before but also after behavioral ones.

Medical Model

Following a medical model of conceptualizing depression, the patient is diagnosed and prescribed the "sick role" in the very beginning of the treatment. The therapist educates the patient about depression, emphasizing that it is a treatable medical problem similar to other illness such as pneumonia, receptive to treatment and not the patient's fault or failure (Klerman et al., 1984). Giving patients' symptoms a name, allowing them to take on the sick role and instilling hope about recovery is in itself a powerful therapeutic

strategy that (1) demystifies the patients' symptoms by grouping them as part of a known syndrome; (2) excuses patients from blame for the illness and what it makes them do or renders them incapable of doing; (3) separates patients' disorder from their personality and identifies it as a treatable condition; and (4) gives patients permission to experiment with implementation of new interpersonal strategies.

Interpersonal Problem Areas

IPT identifies four classes of interpersonal problem that may trigger depression: grief, interpersonal disputes, role transitions, and interpersonal deficits. Identifying and addressing these problem areas becomes the central axis of the IPT clinical focus. Right at the outset of the treatment, the therapist and patient review current relationship problems that could be associated with the onset and maintenance of depression symptoms. Together they select and focus on the interpersonal problem area associated with the current episode.

The four interpersonal problem areas of IPT-A are:

- **Grief** (actual death of a significant other or pet)
- **Interpersonal disputes** (overt or covert disagreements with family members, friends and peers, neighbors, etc.)
- **Role transitions** (difficulty making transitions between stages in life and/or changes in life circumstances such as divorce, moving to a new home, promotion, birth of a child, illness in the family, transition to college, etc.)
- **Interpersonal deficits** (social isolation and/or significant communication problems that lead to difficulty in starting or maintaining relationships)

Although many patients present with a variety of problems, in order to organize therapy and maintain focus, one or at most two areas should be identified as initial targets for therapy. It is not necessary to address all the interpersonal problems occurring in a patient's life to reduce depressive symptoms and alleviate the current episode. Developing a sense of mastery in one interpersonal context can transfer over into other areas of a patient's life.

Transcultural adaptations of IPT have shown that the interpersonal problem areas are found across cultures and are universal elements of the human condition. For some disorders (e.g. depression, bulimia nervosa), they are seen as triggers for an episode; in others (e.g. PTSD), they are seen as consequences of the illness that contribute to its maintenance. More generally, the interpersonal context is a paradigm that people universally recognize, unlike intrapsychic or cognitive behavioral perspectives that are much more informed by our Western and Anglophone cultural background, values, and assumptions. Likewise, in parts of the world where there may be a stigma against psychological problems and their treatment, the focus in IPT on resolutions to interpersonal and often group conflict may be more acceptable and less threatening than other approaches.

Time-Limited Duration

The length of treatment is also established in the initial phase and typically ranges between 12 and 16 consecutive weekly sessions. This structure presents a clear, positive expectation of rapid relief from symptoms and improvement in interpersonal functioning and generates mobilization and optimism. It helps establish patient–therapist rapport by promoting confidence in the patient's ability to change. By focusing on the here and now, it also protects against potential risks of long-term treatment such as patient dependency on the therapist, regression, and the reinforcement of avoidance behaviors (Weissman et al., 2000).

Testability

IPT was originally developed as part of a clinical drug trial to be directly comparable to the other treatment arms. This influenced the character and structure of the therapy in two fundamental ways: (1) It is manualized to ensure consistency of treatment delivery and, from a research perspective, to limit threats to internal reliability and validity (although there is considerable flexibility in the therapeutic techniques used, particularly in the middle phase of treatment); (2) regular assessment of the patients' depressive symptoms and functioning is built into the structure of the therapy. These elements are not simply byproducts of the context in which the therapy was developed but may also have important therapeutic effects; for example, tracking patients' illness during treatment (using the Hamilton Rating Scale or some other established measure) gives them and their therapists a clear and objective sense of change in their clinical picture and so can be used to promote a sense of movement in therapy.

Evidence-Based

The development of IPT was also informed heavily by the scientific ethos of Klerman and colleagues and their conviction that all approaches should be tested empirically and that the strongest source of evidence for a treatment's efficacy derives from RCTs (Klerman et al., 1984). The testability of IPT has facilitated its comparison with other forms of psychotherapeutic and psychopharmacological intervention in a long series of clinical trials. The results of these studies have greatly influenced the evolution of IPT: its adaptation for a range of disorders in different populations, its modification for use in a variety of treatment modalities, and its employment in many different cultures around the world.

Other Systems

Klerman and Weissman's goal in developing IPT was to make explicit and operational a systematic psychotherapeutic approach to depression based on theory, clinical observation, and empirical evidence. Given the genesis of IPT, it is not surprising that its procedures and techniques have much in common with those used in other schools of psychotherapy: Clarification of mood states and linking them to interpersonal events, communication analysis and decision making, interpersonal skill building, and homework are hardly exclusive to IPT. Likewise, IPT shares many common goals with other schools of psychotherapy: helping patients gain a sense of mastery of current social roles, combating social isolation, restoring a sense of group belonging, and assisting patients in finding new meaning in their lives (Klerman et al., 1984).

The focus on reduction of depressive symptoms and interpersonal issues in the here and now distinguishes IPT from more traditional psychoanalytic and dynamic psychotherapies. While psychodynamic psychotherapy focuses heavily on early childhood experiences as determinants of unconscious mental processes and intrapsychic conflict, IPT does not attempt to explore the patient's behavior as a manifestation of internal conflict but rather in terms of current interpersonal relations. Although the influence of early childhood experiences is recognized as significant, it is not emphasized in IPT. Instead, therapy focuses on patients' current disputes, frustrations, anxieties, and wishes as defined in the interpersonal context. While psychodynamic therapies emphasize unconscious thoughts, IPT works largely at the conscious and preconscious levels. Psychodynamic therapies intervene at the level of personality organization, whereas IPT seeks to improve symptom formation and social adjustment. Psychodynamic therapies are concerned with internalized object relations, whereas IPT looks at interpersonal

relations. A psychodynamic therapist listens for a patient's intrapsychic wishes, whereas the IPT therapist listens for the patient's role expectations and interpersonal disputes (Klerman et al., 1984).

These differences between IPT and psychodynamic approaches are not necessarily due to fundamental theoretical differences. In exploring current interpersonal problems with the patient, an IPT therapist may recognize intrapsychic defense mechanisms such as projection, denial, isolation, undoing, or repression but does so without making internal conflict a focus of treatment. Nor do the techniques used in the two forms of therapy necessarily differ greatly: many dynamically trained and psychoanalytically oriented psychotherapists report that they already routinely use many of the concepts and techniques of IPT in their practice.

The interpersonal focus of IPT is quite different from that of another time-limited treatment, cognitive–behavioral therapy (CBT). Aaron Beck's work in defining and describing the procedures of cognitive therapy (CT), from which CBT developed, provided a model for the development of IPT by Klerman and Weissman. In common with CBT, IPT focuses on the here and now, is structured, shares techniques, and addresses patients' limited sense of options available to them. Unlike CBT, IPT does not attempt to uncover distorted thoughts systematically through homework, nor does it attempt to help the patient develop alternative thought patterns through prescribed practice. Instead, the IPT therapist draws attention to patients' exploration and modification of maladaptive communication patterns that trigger and maintain their depressive symptoms. Unlike CBT, negative cognitions and behaviors such as guilt, lack of assertiveness, and negative bias are focused on only through the examination of their impact on the person's relationships and social roles.

Like REBT, IPT views the therapist's role as active and directive. Unlike REBT, IPT does not focus on uncovering irrational thoughts and beliefs through direct confrontation but uses as a point of departure the functional impact of discordant interpersonal and role expectations between the patient and the other parties involved in the interpersonal problem.

Finally, a number of principles of the Rogerian psychotherapy, such as the importance of creating a genuine, accepting, validating, and safe therapeutic environment to promote desire for exploration and growth in the patient, is shared by IPT. However, unlike the Rogerian tradition, IPT therapists believe that making the patient feel safe is a necessary but not sufficient condition for good therapy. Patients need to develop a thorough understanding of how they affect and are affected by their interpersonal problems and then learn and practice concrete skills to manage these problems more effectively.

HISTORY

Precursors

The formative work by Klerman, Weissman, and colleagues was informed by contemporary theories and empirical findings from three different areas.

Interpersonal Context of Depression

The creators of IPT believed that depression was essentially a biological illness but that the onset and recurrence of symptoms were triggered by stress, particularly the loss or threat of an important interpersonal attachment. This idea has its theoretical origins in Adolph Meyer's psychobiological framework of mental illnesses (Meyer, 1957) and the work of Harry Stack Sullivan (Sullivan, 1955).

Meyer was perhaps the most influential figure in American psychiatry during the first decades of the 20th century. Strongly influenced by evolution theory, his concept of

psychobiology modified the Darwinian principle of biological adaptation to include the adaptation of the organism to its social environment. Within this model, Meyer viewed mental illness as the result of an individual's *maladaptive* attempt to adjust to the changing environment. Although he considered patients' response to environmental stress and change in adulthood to be determined by early experiences in the family and other important social groups, Meyer put great emphasis on patients' current experience, social relations, and relationship to their environments. He noted that a variety of common life events could be important etiological factors in the development of a disorder and created the "life chart" to track the relationship between life history, illness (physical and psychiatric), and stressful events (Meyer, 1951).

Although the interpersonal approach has its basis in Meyer's ideas, it was Sullivan who developed and fully articulated the interpersonal paradigm. Sullivan went so far as to describe psychiatry as the field of interpersonal relations and defined the discipline as the study of people and the processes between them rather than focusing exclusively on the brain, the individual, or society. Along with his associates, he developed a comprehensive theory of the relationship between psychiatric disorders and interpersonal relations, rooted for the developing child in the family and for the adult in life's many interactions. He maintained that one can only understand and address mental illness by making sense of the person's interpersonal matrix (Sullivan, 1955).

Attachment Theory

If the work of Meyer and then Sullivan established the interpersonal approach to psychiatric practice formalized in IPT, it is John Bowlby's *attachment theory* that provides the theoretical basis for the interpersonal context of depression and the mechanisms underpinning the therapy. Bowlby (1969) proposed that humans have an innate tendency to make strong *affectional bonds* (attachments) and that separation or threat of separation of these bonds causes emotional distress, sadness, and in some cases more severe depression. The underlying premise is that there is a universal human need to develop lasting affectional bonds with primary caregivers. These attachments make it possible for the individual to develop the ability to construct and maintain mental representations of the self and others, namely "internal working models," which organize cognition, affect, and behavior (Bowlby, 1980).

Loss or threat of disruption to these affectional bonds causes emotional distress, sadness, and anxiety. In her famous "Strange Situation" study, Ainsworth (1978) was able to identify three major *attachment styles*: secure attachment, ambivalent–insecure attachment, and avoidant–insecure attachment. A fourth attachment style known as disorganized–insecure attachment was added later (Main & Solomon, 1986). Anxious/ambivalent, avoidant, and disorganized styles are insecure attachment patterns and are considered to be secondary behavioral strategies in response to an insensitive or unavailable caregiver. Although somewhat adaptive, they are considered to be pathogenic because they signify important self-deficits (Peluso, Peluso, White, & Kern, 2004).

Based on these observations, Bowlby proposed that psychotherapy should help patients examine current interpersonal relationships and consider how these relationships developed from experiences with attachment figures earlier in life. In addition, therapeutic strategies should seek to correct the distortions produced by faulty earlier attachments and teach patients how to develop more adaptive and salutary interpersonal relationships. This in turn makes patients less vulnerable to the threats to attachment that might trigger future mental health problems. Contemporary theories and studies of attachment have continued to inform IPT; this research is reviewed in the Theories of Personality section.

Life Events

IPT has also been influenced heavily by the psychosocial and life events literature of depression. Since IPT was first developed, the use of systematic life events interviews within long-term epidemiological studies has begun to clarify the role of life events in the complex matrix of factors that contribute to the development of psychiatric disorders. Eugene Paykel has been an important figure in the development of this research. In an influential 1978 study, he used the measure of relative risk—the ratio of the disease rate among those exposed to a putative causal factor versus the disease rate among people not exposed—to examine the impact of stressful life events on depression. He found the relative risk of developing depression after the most stressful category of events to be a striking 6:1 (Paykel, 1978). Since then, evidence corroborating the role of life stress in the genesis of depression has accumulated from large-scale epidemiological and genetic studies (see Theories of Personality section).

Beginnings

IPT was not originally developed with the intention of creating a new psychotherapy for depression. The motivation was to formulize a psychotherapy for a clinical trial testing the efficacy of antidepressant medication as a maintenance treatment for unipolar depression. Tricyclic antidepressants had shown promise in reducing the acute symptoms of depression, but there were no data on the efficacy of medication in maintaining long-term symptom reduction for depression. Klerman and Weissman felt that as far as possible, clinical trials should mimic clinical practice (Klerman et al., 1984). As the majority of patients at that time received both medication and therapy, they felt a therapy arm should be included, if only to create a milieu effect. Thus an 8-month-long clinical trial was designed for subjects who had shown symptom reduction while on antidepressant medication during their acute phase of depression. Patients were randomly assigned to conditions in which they received amitriptyline, placebo, or no medication with or without weekly psychotherapy sessions.

Prior to conducting the study, the team first needed to define the psychotherapy they would use and the techniques it would incorporate. Psychotherapists could then be trained in this standardized approach and the quality and consistency of the treatment could be tested. A cornerstone of the new therapy was its *time-specific* nature, focus on current problems, and the use of a manual to standardize the procedure. The psychotherapy, initially called "high contact," differed markedly from the open-ended structure of psychodynamic psychotherapy, the predominant treatment method of the time. Another novel feature of the treatment, again reflecting the psychopharmacologic trial of which it was a part, was the use of *standardized assessments* to diagnose patients and follow their clinical course.

The development of the psychotherapy was governed by several guiding principles (Weissman, 2006):

1. It was important to test and establish the efficacy of all treatments, including psychotherapy, in RCTs. (There had been no positive randomized trials of psychotherapy.)
2. Outcomes should be measured across a broad range of standardized measures, including assessments of social functioning and quality of life.
3. Treatment results needed to be replicated before widespread dissemination.

The preliminary step in creating the therapy involved determining its dose, frequency, and diagnostic process. The latter evolved into the first phase of IPT and involved what have become many of IPT's most important and distinctive

features: conducting an *interpersonal inventory* of important people currently in the patient's life; giving the patient the "*sick role*"; linking symptoms to *interpersonal situations*; and selecting *problem areas* associated with the onset of the current depressive episode. The four problem areas were chosen to cover the range of problems that lead to disrupted attachment and trigger depression and arose from Klerman and Paykel's ongoing work developing measures to assess the role of life events in depression onset and relapse. The "high contact" treatment manual was developed and revised by reviewing cases and developing scripts based on real practice. In this way, the treatment sequence and procedures were formalized so that therapists could be trained to deliver the therapy in a consistent manner.

The one-year follow-up results from the maintenance study found that medication prevented relapse and that psychotherapy improved social functioning (Klerman, Dimascio, Weissman, Prusoff, & Paykel, 1974). The positive findings for the therapy sparked the team to elaborate the principles of the therapy. It was first termed *interpersonal psychotherapy* at this time. An acute treatment trial involving IPT alone and in combination with medication was also positive, with the combination of IPT and medication proving the most efficacious intervention. This was followed by the NIMH Multisite Collaborative Study testing IPT, cognitive therapy, and drugs as treatments for depression (Elkin et al., 1989). In 1984, the efficacy of IPT was documented by another team, and Klerman, Weissman, and colleagues (1984) published the first IPT manual, *Interpersonal Psychotherapy of Depression*. Since that time, numerous studies and adaptations of IPT for different patient populations have been conducted across a variety of settings and in many different countries.

Current Status

Since it was first developed in the 1970s, clinical and research interest in IPT has grown steadily. IPT has been adapted, tested, and shown to be efficacious as a treatment for a variety of mood and other disorders. Adaptations for mood disorders include IPT as a maintenance treatment of depression, IPT for pregnancy, miscarriage, and postpartum depression, IPT for depression in adolescents and children, IPT for depression in older adults, IPT for depression in medical patients, IPT for dysthymic disorder, and IPT for bipolar disorder. IPT has also been adapted for eating disorders, substance abuse, anxiety disorders, borderline personality disorder (BPD), and posttraumatic stress disorder. The evidence for the efficacy of IPT is strongest for mood disorders (where the most trials have taken place), varies for other adaptations, and remains untested for some of the newest ones.

Although it was developed as an individual psychotherapy, IPT has also been adapted and tested across a variety of treatment modalities: in group, conjoint couple, and telephone formats. These adaptations have been made both for practical reasons (to address barriers to care such as limited funding, poor transportation, and time constraints) and based on a clinical rationale (e.g. to foster a sense of constructive collaboration between patients and destigmatize their problems). Positive evidence has been found for each adaptation, with group therapy in particular supported by a number of RCTs for a variety of disorders, cultures, and patient populations (e.g. Bolton et al., 2003; Wilfley et al., 1993). An abbreviated form of IPT called *interpersonal counseling* (IPC) has also been developed and tested (Weissman & Klerman, 1986) to address the practical restraints of treating patients in certain settings (e.g. patients with depression as a secondary diagnosis being treated for a medical problem in a general hospital setting). A new adaptation, *IPT-EST* (evaluation, support, and triage), developed by Weissman and Verdeli, provides a three-session intervention based on the first phase of the standard IPT (diagnosis, identification of the interpersonal problem area, and management of

depression). IPT-EST is designed to be followed by an assessment of the need for ongoing treatment. IPT-EST is currently being refined and tested.

Not only has IPT been tested and used for a range of disorders in a number of different modalities, increasingly it is being used across a variety of cultures, both within and outside the United States. There have been IPT training programs in Australia, Austria, Brazil, the Czech Republic, Ethiopia, Finland, France, Germany, Greece, Hungary, Iceland, India, Italy, Ireland, Japan, Kenya, the Netherlands, New Zealand, Norway, Portugal, Romania, South Korea, Spain, Sweden, Switzerland, Thailand, Turkey, Uganda, and the United Kingdom. In many of these countries, clinical trials have established the efficacy of important new adaptations such as trials of group IPT (IPT-G) with depressed adults in rural southwest Uganda and depressed adolescents in internally displaced persons (IDP) camps in northern Uganda. In the United States, IPT has shown efficacy in clinical trials with black and Hispanic (mainly Puerto Rican and Dominican) minorities. IPT manuals have been translated into French, Spanish, Italian, German, and Japanese, and Portuguese and Danish translations are currently developed.

Ease of training was a priority in the development of IPT, and learning the psychotherapy should be straightforward for anyone with a basic knowledge of clinical psychiatric diagnosis and prior training in standard psychotherapeutic techniques: how to show empathy and warmth, formulate a problem, develop a therapeutic alliance, maintain professional boundaries, and so forth (Weissman, 2006). Within its prescribed, goal-oriented, and three-phased structure, IPT nevertheless affords the therapist considerable autonomy and flexibility to employ a variety of therapeutic techniques common to other forms of therapy.

Despite its widespread dissemination and proven efficacy, few professional training programs for mental health workers—psychiatrists, psychologists, social workers, or psychiatric nurses—teach IPT as part of a program in evidence-based psychotherapy. Among those that do, typically only a didactic course is offered without the very important training component of hands-on clinical supervision (Weissman et al., 2006).

For students and professionals who are interested in being trained, many of the professional organizational meetings (e.g. the American Psychiatric Associations's annual meetings) offer continuing education courses in IPT. These short half- or full-day courses are primarily didactic. The 2- to 4-day workshops offered by academic centers around the world are much more intensive and include practical, hands-on training. Clinicians interested in becoming trained in IPT should obtain supervision with an experienced IPT therapist. Three supervised IPT cases following didactic training usually suffice for experienced psychotherapists to learn to perform IPT competently (Weissman, 2006). Guidelines for becoming an IPT therapist or trainer can be found at www.interpersonalpsychotherapy.org, the Web site of the International Society for Interpersonal Psychotherapy. Every other year, the organization holds an international meeting at which IPT researchers, students, and clinicians come together to discuss developments in the field and take part in workshops. The 2009 meeting at Columbia University in New York included more than 300 presenters and attendees from Africa, Asia, Australasia, Europe, and North and South America. For clinicians wanting a glimpse of IPT procedures with scripts, the 2007 manual is recommended (Weissman et al., 2007).

PERSONALITY

Theory of Personality

A theory of personality is not relevant to IPT. Within the theoretical framework of IPT, pathology is considered to have three component processes (symptom function, social and interpersonal relations, and personality and character problems). IPT research and

practice have historically focused on the first two. IPT investigators were reluctant to focus on personality traits and disorders for a number of reasons. One is the difficulty in reliably diagnosing personality pathology while in a depressive episode: for example, research by Fava and colleagues (2002) has shown that although Axis II diagnoses are common among acutely depressed patients, they drop significantly following successful antidepressant treatment. Therefore, IPT does not make definitive Axis II diagnostic assessment during the acute phase of the depression. Another reason is that a significant number of patients do not want or cannot be in long-term psychotherapy. Even if a personality disorder emerges, brief treatment focuses on acute symptom relief and not on personality restructuring, which has not been shown empirically to be possible to change in a short time. However, there is some evidence that the skills learned in IPT may have an effect on behavior, which is a reflection of personality. IPT aims for specific, measurable changes in how the person feels, relates, and communicates. As Markowitz and colleagues noted:

> . . . although IPT makes no claims to change personality, imparting interpersonal skills such as self-assertion, confrontation, and effective expression of anger is almost as good as effecting personality change. These skills frequently open up new possibilities for interpersonal functioning that patients may never have dared imagine and that can feel enormously empowering. (Markowitz et al., 2006; p. 442)

The terrain of personality traits as determinants and outcomes of the impact of IPT has changed over the last 10 years. One body of evidence comes from attachment research; another comes from a new line of investigation by Markowitz and colleagues on IPT for borderline personality disorder (2006).

Personality Variables and Environment: Contemporary Research on Attachment

As discussed in the Precursors section, Bowlby's attachment theory and its evolution provide an important theoretical basis for IPT. The attachment framework offers a set of organizing principles for the understanding of the various aspects of normal and pathological interpersonal relations and the consequent psychological fitness across the life cycle.

Attachment patterns remain pertinent throughout the human lifespan. Based on Ainsworth's infant–caretaker attachment paradigm, contemporary research has identified similar attachment patterns in adults. According to Bartholomew's four-category model (Bartholomew & Horowitz, 1991), adult attachment is conceptualized as combinations of the internal working models of the self and others. The internal working model of the self constitutes the dimension of *anxiety* and refers to whether the individual has the inner resources for security and self-soothing vis-à-vis an important relationship, whereas the internal working model of others yields the dimension of *avoidance*—that is, whether security is maintained through proximity or, alternatively, self-reliance and emotional distance (Bartholomew & Horowitz, 1991). The combination of these two dimensions results in *four possible attachment styles:* (1) secure anxiety, (2), dismissing, (3) preoccupied, and (4) fearful.

Secure individuals (those with low scores on measures of anxiety and avoidance attachment) are relatively more protected against psychological distress in general (Hammen et al., 1995) and depression in particular (Mickelson, Kessler, & Shaver, 1997). In contrast, insecurely attached individuals tend to have lower self-esteem (Collins & Read, 1990); poorer affect regulation strategies (Brennan & Shaver, 1995); and marked problems with emotional support (Simpson, Rholes, & Nelligan, 1992), and they tend to have a higher number of depressive symptoms (Murphy & Bates, 1997). Moreover, there is evidence that the fearful attachment pattern is correlated with depression. In a

maintenance study of 162 female participants with major depression who received IPT, Cyranowski and colleagues (2002) identified 43% as fearfully attached compared to only 22% who were securely attached.

There is evidence that attachment style is associated with treatment response in IPT. Cyranowski and colleagues (2002) found a temporal effect of attachment style on depression remission: Although the proportion of subjects who remitted did not differ by attachment profile, among the patients who did remit, those with secure attachment had significantly more rapid remission compared to subjects with fearful–avoidant attachment. The finding indicates that IPT's brief course may not allow enough time for fearful–avoidant patients to develop a trusting relationship with the therapist.

At the same time, there is emerging evidence that IPT can help improve patients' attachment styles as opposed simply to resolving the interpersonal crises to which insecure attachment may predispose them. In a new line of research, Ravitz (2009) has hypothesized that IPT may ameliorate the anxious and avoidant behaviors of insecurely attached depressed patients. In a recent study of IPT with depressed adults, subjects whose symptoms fully remitted also showed significant decreases in measures of attachment avoidance and anxiety (Ravitz, 2009). Although these results need to be corroborated in future trials, they present an intriguing possibility: IPT may intervene at the level of attachment style as well as influence the current interpersonal environment and in this way reduce vulnerability to future psychopathology.

IPT and Treatment of Borderline Personality Disorder

Although IPT explicitly addresses only Axis I disorders, Markowitz and colleagues (2006) note that there is a strong rationale for treating BPD with IPT. First, BPD is frequently comorbid with mood disorders. Second, BPD is largely about maladaptive social interactions. Markowitz's team at Columbia is currently investigating the effectiveness of IPT in an open trial of an 8-month (34 sessions) adaptation for BPD patients. According to the investigators, BPD is a "mood-inflected chronic illness," interspersed with explosive outbursts of anger, despair, and impulsivity. Due to the chronicity of the disorder, patients find it particularly difficult to link their mood symptoms with current life events and erroneously regard those symptoms as part of their personality.

Markowitz has outlined the therapeutic elements in IPT for BPD: IPT provides the patient *success experiences*, whereby patients learn new skills in order to deal effectively with their life crises. Overcoming the crisis is experienced as an interpersonal victory and results in significant improvement of their self-image and a sense of competence and control. The medical model of IPT allows patients to conceptualize BPD as a chronic yet treatable illness. Also, IPT aims at solving patients' problems in the relationships *outside the office*, which is thought to minimize the possibility of therapeutic rupture (in a clinical population in which rupture poses serious threat to therapeutic relationship). Finally, although IPT does not implement "direct" changes in personality, the patient is given tools to deal with those triggers of mood dysregulation characteristic of BPD (intense episodes of depression and anger) that result in *correction of interpersonal dysfunction*. The latter heralds new possibilities for interpersonal functioning that deeply alter the way patients see the world and themselves (Markowitz et al., 2006).

Variety of Concepts

The development and practice of IPT have been informed by several fields of research that variously place emphasis on the impact of life events, biology, social interaction, and personality in the development of psychopathology. Together they suggest that

the etiology of psychiatric disorders is complex and multidetermined, with the various genetic, personality, and environmental factors interacting with one another.

Methodological advances over the years, in particular the use of systematic life events interviews within long-term epidemiological studies, have helped to clarify the role of life events in the complex matrix of factors that coincide in the development of psychiatric disorders. As the isolation of genes related to specific psychiatric disorders becomes a reality, important new advances are being made in our understanding of gene x environment interactions in the development of pathology.

In a landmark study, Caspi and colleagues (2003) examined how genetic differences in the 5-HTT (serotonin transporter) gene moderated the influence of stressful life events on depression. They found that people with one or two copies of the short allele were more likely to become depressed in response to stressful life events than people with a double long allele. In other words, the study showed a *gene x environment interaction* in which the 5-HTT genotype moderated the depressogenic influence of adverse life events. These findings show that psychiatric disorders are genetically complex illnesses in which, like diabetes or hypertension, a genetic predisposition may interact with the environment to produce pathology; the *phenotype* (clinical picture) results from the interaction of the *genotype* and the environment (Weissman et al., 2007). These genetic findings highlight the importance of addressing the pathology of genetically susceptible individuals with treatment that emphasizes current life events.

While the replication of the Caspi findings has recently been called into question, these questions have to do more with the design of the replications than with the original findings of Caspi and colleagues (Risch et al., 2009). Their important findings based on observational epidemiology are being supported by numerous controlled human and animal studies. This work showing the relationship between genes and environmental stress for depression is in its early phase. Most relevant to psychotherapy is the work of Champagne and colleagues showing that attachment stress in mice can be reversed by maternal licking and grooming (Champagne, Francis, Mar, & Meaney, 2003).

There is strong evidence for a relationship between type of life event and the genesis of depression. Kendler, Prescott, Myers and Neale (2003) have found that humiliating events are more strongly associated with depression onset compared to other types of life events. Moreover, personality characteristics influence the impact of life events on the onset of depression (Shahar, Blatt, Zuroff, & Pilkonis, 2003).

While genetic and personality variables that place people at risk for disorders such as depression cannot readily be altered, people's reactions and responses to their social environment can. IPT aims to improve patients' depression by improving interpersonal relations, thus reducing life stress and increasing social support. These improvements in the people's social world are hypothesized to moderate the effects of the genetic, personality, and environmental factors placing the individual at risk for depression.

PSYCHOTHERAPY

Theory of Psychotherapy

IPT aims to improve symptoms and interpersonal functioning by improving the way distressed individuals relate to others. As emphasized earlier, this interpersonal focus is the hallmark of IPT. IPT has not invented new techniques. However, while many of the techniques it uses are common to other time-limited therapies, IPT specifically

applies them to interpersonal issues. Much more than collecting a set of techniques, the developers of IPT codified *strategies* organized around active management of depression and the four problem areas into a cohesive therapeutic system.

The language of affect is used more in IPT than in other time-limited therapies such as CBT or REBT. Commenting on how the affect is communicated (verbally and nonverbally) is the bread and butter of IPT: "Your eyes seem so sad as you are talking about her"; "You say you are mad at him, but I noticed you are smiling"; "How did you let your boss know that you were not happy about his decision?"

IPT is also different from simple interpersonal skills training: Although IPT therapists often work with patients on assertiveness, they put the skills within the much bigger context of patients' expectations of other people. This helps patients mourn what was lost or never given and encourages change and mobilization. The goal is to break patients' social isolation, helplessness, and hopelessness by assisting them in generating new options and enabling them to access sources of interpersonal support.

IPT does not maintain that all relationships need to be maintained at all costs. Some ties are destructive for patients in that they do not foster growth and closeness. In other relationships, one of the parties has moved on and does not wish to continue. Helping patients have a balanced view of the strengths and weaknesses of the relationship and a thorough understanding of their own and the other person's desires would determine the outcome of what is frequently asked by the IPT therapist: "Do you think you would like to try one more time?"

A big challenge in IPT, especially for new therapists, is the difficulty in staying focused on the problem area(s) defined as targets for treatment. Dealing with patients' daily crises without putting them into a larger context of a problem area can diffuse and derail the treatment. What often happens is that a general "antidepressant" method of approaching interpersonal situations is learned systematically through work in one problem area. The learning that was generated is frequently transferred to other interpersonal issues that emerge along the way. There are times, of course, when 16 sessions have not been enough and the person, although better, is still not well. In those cases, therapists renew the contract with the patient, setting as new goals the specific interpersonal aims the patient wants to work on in the next set of sessions.

The Therapeutic Relationship

IPT therapists are active, ask questions, and make comments, especially in the first sessions (see Process of Psychotherapy section below). Although therapists are directive, they are not prescriptive; in other words, they try to let patients generate options, ideas, and resources, as opposed to providing them themselves. They do not work through forms (like the dysfunctional thought records or mood monitoring forms used in CBT). They do not interpret dreams or other material that communicates unconscious desires, and they do not encourage regression (like analytic treatment).

Process of Psychotherapy

The usual course of IPT for acute depression is 16 sessions for adults or 12 for adolescents divided into three phases: the initial phase, middle phase, and termination phase. For a detailed account of clinical practice, see Weissman and colleagues (2007). Here we will briefly illustrate the clinical work through a case vignette with segments from the three phases. The patient, Paul, is a 22-year-old college student

who presented to his university's student health services with symptoms of depression. It should be noted that prior to initiation of IPT, the therapist had already conducted a thorough clinical interview, evaluated suicidality, and assessed the need for medication (in case of melancholic depression, severe neurovegetative symptoms, etc.).

Initial Phase (first 3–4 sessions)

During the initial phase, therapists administer depression rating scales or symptoms checklists (e.g. the Hamilton Rating Scale for Depression, the Beck Depression Inventory). In addition, therapists evaluate patients' idiosyncratic symptoms of depression: For example, when depressed, some patients become particularly jealous or anxious; some drink or smoke more, while others stop smoking and drinking; some may develop somatic symptoms, such as nausea, headaches, and the like. Following an in-depth clinical interview to determine patients' diagnosis and psychosocial functioning, the initial phase is conducted over three to four sessions.

In this phase, therapists aim to (1) educate patients about depression and give them hope that it is a treatable condition; (2) help patients manage the consequences of depression and create space in their lives to heal from the episode; (3) understand how depression affects and is affected by patients' important social ties and roles; and (4) agree with patients to focus during the rest of the treatment on one or two interpersonal problem areas that are associated with the current depressive episode. Therapists complete the following tasks (Weissman et al., 2007):

- confirm diagnosis of depression and give syndrome a name
- give patients hope
- assign the "sick role": explain to patients that they are suffering from a depression that does not let them function at an optimal level; tell them that they may temporarily need to lower expectations for what they are able to accomplish but need to do the therapeutic work to get out of the current episode
- help patients to rationalize and manage the impact of depression on their lives (e.g. lower expectations, suspend major decisions until depression remission, etc.)

The following is a dialogue between Paul and his therapist from the initial phase:

Therapist: Paul, you described today a number of difficulties you've had in the last 2 months . . . trouble concentrating, which led to a low grade in your stats test and your difficulty in finishing your sociology assignment . . . you also have trouble falling asleep, and you've been waking up at 5:30 every day . . . you told me that you have been feeling sad and empty and that your friends noticed it . . . you get tired easily and need to go to bed . . . and since you don't feel like eating, you've also lost 11 pounds in the last 7 weeks. These are symptoms of depression. Depression is . . .

Paul: I'm screwing everything up (on the verge of tears) . . . I should have . . . I'm just failing in everything . . . now I *am* depressed (covers face with hands).

Therapist: It's not your fault that you have depression. It's not your failure, Paul. Depression is common and the good news is that we have a number of great treatments for it. You will get better. Right now it's important for you to take care of yourself and make sure that the circumstances around you allow you to get better.

Paul: But I don't have the time for that. I'm failing at school, I'm in trouble big time . . . (is tearful and panicked)

Therapist: If you had any other illness right now, say if you had pneumonia . . . have you ever had pneumonia, or a really bad flu? (Paul nods in agreement) Would you expect yourself to do well in your classes, "business as usual"?

Paul: Well, that's different, that's a real illness.

Therapist: Depression is also a real illness. It has symptoms, exactly the types of things you mentioned before: sadness, sleep and appetite problems, low energy and motivation, difficulty concentrating and making decisions . . . This is typical depression. The good news is that we have some very effective ways to treat it. Right now, to get your everyday work done you may need a little extra help from family and friends. For the time being, you may not even be able to do all of the things that you need and want to do. As we make progress in the treatment, you'll start improving, but it's going to take a little time.

Paul: I hope so, this can't go on. I feel terrible that I may fail my stats class . . . maybe I don't have what it takes to be in the program any more, it's crushing me, I may have to just drop out . . .

Therapist: Paul, this is not the right time to make decisions about leaving the program. Depression colors everything in your world and you may not see any options available to you. Why don't we discuss the program some more after you recover from your depression? If you still feel the same, it might be something to consider.

Paul: Ok, I guess . . . (seems somewhat less overwhelmed). But what am I going to do about the stats?

Therapist: Well, given that you are in the midst of a depressive episode, it makes sense that you are struggling a lot with stats. It requires good concentration, maybe more than other classes. What are your options right now for that class?

Paul: It's too late to drop it.

Therapist: I see.

Paul: Maybe I can get an incomplete, I don't know.

Therapist: You came up with a really good idea there. How can you find out what you need to do to get an incomplete?

They then discussed ways in which Paul might go about talking to the professor about getting an incomplete grade due to his depression. Paul said that he wanted to talk to his professor about getting some extra time to complete the outstanding assignments before considering asking for an incomplete. When the therapist asked him about people who could help him through the stats course, Paul thought of asking the class RA to go over some recent difficult material with him. At the end of this part of the discussion, Paul seemed somewhat relieved, "lighter," and less anxious.

The therapist then proceeded to explore the interpersonal context of Paul's depression. She did so through the following strategies:

1. By finding out what was happening in Paul's life around the onset of his symptoms
2. By conducting the interpersonal inventory, a detailed exploration of Paul's significant current interpersonal relationships, to understand which contributed to his depression and which were important resources

Therapist: Paul, you said that you started noticing the first depression symptoms at the beginning of the spring semester.

Paul: Yeah, when I came back after I visited home for the holidays.

Therapist: Did anything happen then, during or after the visit?

Here the therapist wanted to explore what problem area had triggered Paul's depression. She asked questions such as: Did anyone important to you die around that time? Or maybe a pet? Did you have a fight with or feel distant from a person who was close to you? Have you felt very lonely or isolated? Were there any big changes in your life around then?

Paul: No big changes, not yet. I have got some big decisions to make about the future, though. I'm not sure what to do after I graduate . . . I have no idea right now . . . I told my parents that during the visit. They asked me, and I told them the truth, I have no idea. I don't know what to do next, I'm not even sure what I want to do.

The therapist started gathering information about an impeding role transition that seemed to be preoccupying Paul. She also wanted to explore the possibility of a dispute (overt or covert) with his parents, since Paul referred emphatically and repeatedly to that interaction.

Therapist: How did they react?

Paul: They didn't say much . . .

Therapist: Do you know how they felt about it?

Paul: I don't know, I don't think they lost sleep over it. We did the usual family stuff. I don't know what happened, it wasn't different from other times, kind of boring . . .

Therapist: Did you expect it to be boring?

Paul: Well, I guess every time I get ready to go home, I have the stupid idea that this time it's going to be different, but nothing ever is.

Therapist: You were disappointed, Paul. You were hoping that this time things would be better, but they were not. (Paul nods) I wonder what you wish was better.

Paul: Well, I know they love me and everything, but . . . I don't know, my sister Sarah was there and . . . Sarah and I are close, she just got engaged and Bill was there as well . . . I guess they didn't have much time for me, so many things to celebrate about Sarah, I guess. She just got accepted into law school, Dad has this ridiculous expression when he looks at her, like she'll continue his practice or something . . . she won't, she's moving to California, where Bill is from, and they're going to school together there. Don't get me wrong, I am really close to Sarah and all, but I don't know, these visits are too much . . .

Therapist: It sounds like this one was especially rough . . .

The therapist had started to form an idea about Paul's problems linked to his depression (a role transition and a covert dispute with his father, who seem to show preference for his successful sister) but felt she needed to get more information. She proceeded to conduct the interpersonal inventory. The therapist elicited examples of interactions and communications to identify strengths and weaknesses in Paul's interpersonal communication patterns.

Therapist: To get a more complete understanding of your life circumstances right now, I think it'd be useful to talk about the important people in your life. Who would you like to start with?

What do you like about ____?

What don't you like about ____?

Have you ever told ____ how you feel?

What stops you? What do you think would happen?

Are there any times that you and ____ enjoy hanging out? What do you guys do?

Are there things that you would like to change in that relationship? What are they?

How would you feel about ______ if those things changed?

Are there things in that relationship that you would like to keep the same? What are they?

Following the inventory, the therapist suspected that Paul's current episode was triggered by two sets of problems: one was his current difficulty in figuring out what to do after he graduated. Paul did not think he would like to pursue graduate studies in sociology (his major). He described being interested in becoming an emergency medical technician (EMT); he had taken and enjoyed an introductory course. However, he was not sure how to investigate this option further. During the inventory, Paul described a strained relationship with his father, a successful attorney, who had always been proud of Paul's older sister's strong personality and academic excellence and who, by contrast, was dismissive and frequently sarcastic toward Paul. Paul reported reacting to his father's comments by leaving the room or "pretending I don't hear him . . . he is full of it . . . I don't care." Paul described being close to his mother and sister, although the latter's success has been hard on him at times ("It's not her fault, but she always gets it right . . . I'm not jealous or anything , that's juvenile, but it's too much, man . . ."). Paul had a few friends, was on "the quiet side," but talked to a couple of friends daily and was particularly close to a female friend, Lisa. He said that he was not dating much this year.

At this point the therapist shared her understanding of Paul's problems, explained the treatment course, and made a treatment contract, also known as the *interpersonal formulation*.

Therapist: From all the information we gathered these 3 weeks, Paul, it seems to me that your depression began shortly after the Christmas vacation. It seems to me like a couple of things were going on for you around that time. Firstly, you started worrying a bit about what you're going to do after you graduate this May, you're not sure what you want to do next. Secondly, the situation isn't helped by the pressure from your father . . . it sounds like he has very high expectations, and can make you feel pretty bad. I think that your anxieties about what to do next, after you finish school, have been made worse by your father's attitude, and that together these two things triggered your depression . . . all the problems you started experiencing about the time you came back to school: your trouble in some of your classes, your difficulty sleeping, the concentration problems, your loss of appetite. Does this sound right to you?

Paul: Sure, I guess.

Therapist: We'll be talking about these important changes that triggered your depression, and we'll try to find ways to help you feel confident to negotiate these problems . . . finishing up with school and thinking about what you want to do next, and how to manage your interactions with your father. I want to remind you that we will be meeting every week for the next 13 weeks. It's important that you come on time and that you reschedule if you need to miss an appointment. Does all that make sense?

Middle Phase

During this phase of treatment, the majority of the interpersonal work takes place: assisting patients in clarifying how they are affected by and affect their interpersonal environments and building antidepressant relational skills to handle interpersonal difficulties better. In Paul's case, the therapist helped clarify his role transition and made him aware of how his father's derogatory remarks affected his depression. Although Paul's difficulties with his father had started a long time previously, the therapist focused on how the dispute manifested itself in the here and now.

The following is an excerpt from session 8:

Therapist: Hi Paul, how have you been since we saw each other last week?

Paul: Kind of mixed.

Therapist: How have your depression symptoms been?

Paul: I don't feel like doing much, I'm sleeping a bit better but still have trouble concentrating

Therapist: How's your appetite? (The therapist asks about whatever depression symptoms the patient has not mentioned.)

Paul: Same.

Therapist: How would you rate your depression on our 1–10 scale (10 being the worst depression you ever felt)?

Paul: I guess a 6.

Therapist: Was it 6 all week?

Paul: No, after I left here on Wednesday it was, I'd say 4, maybe even 3 for a couple of days. Then it kind of went downhill.

Therapist: So you felt really well for a short time. That's wonderful. What happened during those days?

Paul: Lisa called on Wednesday evening, I went over and we watched a couple of movies, Josh and Annie were there too, it was good. Also, I guess what we talked about last time was helpful, how I don't like theoretical stuff and prefer more hands-on work, how happy I felt when I did my EMT work . . . I felt useful, and I was really good at it, Mr. Harris told me so in front of everybody . . . I pulled some info from the Web and made an appointment with the career counselor to see if she can help me find out some more.

Therapist: How did you feel about doing that?

Paul: I felt good, kind of proud, relieved, I guess. I was thinking that things may get better. I also went to speak to the stats professor again. She thinks it makes more sense now to go for the incomplete than trying to finish. She's right, I guess.

Therapist: These were very important steps, Paul. You did a number of things we discussed: you took action and got information to help you decide about your career; you talked with your professor about your stats course; you had a good time with your friends. And look how well you felt after all that. Then things became tough again. When did you start noticing it?

Paul: I'd say on Saturday, I woke up and . . . well, I didn't really feel like getting up.

Therapist: Hmm, that's quite a change. Did something happen on Friday?

Paul: Well, nothing much, I stayed home and watched TV, my parents called, nothing dramatic.

Therapist: Well, as we discussed, subtle things can at times deeply affect people's mood . . . what happened during the call?

Paul: Well, nothing. My mom was telling me about Sarah's new apartment, the furniture they plan to buy and stuff. My father was also on the line, on the other phone. I was yawning, I was tired, they were going on and on about how her in-laws' plan to get them tickets for a trip to Morocco. On and on and on . . . I am failing my stats, I don't know what to do in my life, and I have to hear about Sarah's vacation . . . My dad asked me why I was yawning, and I told him I was tired and wanted to go to bed.

Therapist: What did he say?

Paul: He said, "You're always tired, not quite sure why."

Therapist: How did you feel when he said that?

Paul: I just said, "Oh! Come on, Dad . . . I'm tired, going to bed." Mom said goodnight, he kind of said "alright . . ." or something like that, and we hung up. I went to bed and fell asleep, but woke up at 5 again. I couldn't go back to sleep, so I watched some TV. I was really tired all day, so I cancelled my plans to go out with Annie and Josh.

Therapist: Paul, as you are talking about the event, are you clearer about what affected your mood?

Paul: I guess that discussion with my dad, it didn't sound that bad, but now that I'm talking about it . . .

Therapist: What are you feeling right now?

Paul: I'm pissed . . . he always puts me down, I don't need this shit right now . . .

Therapist: You're right, you sure don't.

Paul: I have so much crap on my plate right now, the least he could do is to leave me alone, just leave me alone . . . (Paul looks tearful but animated).

Therapist: You seem sad and rightfully angry right now, but you don't seem lost. You do have a lot on your plate: you're trying to finish school and decide what your next professional step is, and you are doing this while you're struggling with depression. Have you ever tried to let your father know the effect his remarks have on you?

Paul: I bet he knows.

Therapist: He may know, but I would like now to focus on whether you have tried to make him understand how his comments affect you.

Paul: Not really, we don't get along; I try to stay away from him.

Therapist: From what you said before though, this seems to work only sometimes. Take last week as an example. You were doing a number of things that were making you feel better: you saw your friends, you *were* better, and then after that discussion you felt depressed again, but thankfully not as much as before. As we said in the beginning, you need to make some space for you to heal from your depression and make the changes that will help you move on. Remember what we said about how important it is to have options, not to let yourself be cornered. What are your options right now about contact with your father?

Paul: I can't just stop talking to him, when Mom calls, he says he wants to talk to me, Mom always lets him talk to me. They do the same with Sarah . . . family tradition, I guess.

Therapist: You've said that you feel well after you talk to your mother. Is there any way you can ask her to talk to you without your father present?

Paul: Knowing her, no. She'll be kind of hurt and ask me why, and insist . . . My Mom likes to pretend that everything is fine . . . she won't do that.

Therapist: I wonder if you could have a direct discussion with your father.

Paul: And what would I say?

Therapist: Good question. What would you like to get across?

Paul: (smiles) You asshole, you are ruining my life . . .

Therapist: (laughs) There you go . . .

Paul: (laughing) OK, OK . . . Maybe, I don't know, I could tell him that I'm depressed right now, and listening to him saying things like that isn't really helpful.

Therapist: You know, that was a very clear message. How about we role-play that . . .

Termination Phase (last 2 sessions)

During the initial phase of IPT, the duration of treatment is determined. In IPT, every two to three meetings, therapists explicitly make patients aware of the number of remaining sessions. Having a "deadline" facilitates mobilization and a sense of momentum and keeps patients active. During termination, therapists (1) evaluate patients' depressive symptoms with them to determine if they are full or partial responders; (2) address patients' sadness and/or anxiety about ending treatment (differentiating this from depression); (3) increase patients' competence and independence in continuing therapeutic gains; (4) review what skills were useful; and (5) reduce guilt if IPT has not been successful (e.g., "the treatment failed you, you did not fail the treatment, and we have other options available to you").

One of the therapeutic options after termination is maintenance IPT. The maintenance model consists of monthly therapy sessions for a year after termination of the acute treatment. Therapists emphasize the interpersonal skills learned and practiced during acute treatment while addressing any new interpersonal stressors that could potentially trigger further depressive episodes.

The following is an excerpt from Paul's penultimate therapy session:

Therapist: Paul, you have made some significant gains in the last 4 months. First of all, your depression symptoms have improved: you're sleeping better, you're eating better, you're feeling more motivated and energetic, and your concentration has improved. All these improvements have helped you pass all your courses this semester. You also negotiated the problem with your stats professor by arranging to receive an incomplete. On top of all that, you've found the time to think about what you want to do next, once you graduate. You've looked into a career as an EMT and signed up to take another course to help decide if it's the right job for you. Also, you've done really well in finding a way to communicate effectively with your father. Now that he understands that you've been depressed, he's interfering less. In addition, you've identified people in your life who you can look to for support and encouragement moving forward. I'd like to hear what you think about what I've just said.

Paul: Yeah, I'm happy about the semester. I didn't think I'd make it. But I'm feeling better than I did. But even though Dad has gotten off my back, I don't think he really gets it. He still wants me to be a success, which in his mind doesn't include becoming an EMT.

Therapist: That's one of the things that remain for you to keep working on going forward from here. But what you've done during the last few months has been enough to improve your mood. The work you'll do in the future should help keep you from getting depressed again. We're almost finished for today. Next week is our last session, and I'd like to hear about your feelings about termination, to look at what situations might arise in your future that you think might trigger another depression, and to look at what skills you've developed during our work that you might use to manage those situations.

During the final session, therapists complete the tasks of termination that were not addressed in the penultimate session.

Mechanisms of Psychotherapy

IPT aims to reduce the helplessness and hopelessness inherent in depression. Its therapeutic power involves:

- demystifying depression (it is an illness and can be treated; it does not happen out of the blue but is triggered by interpersonal problems)
- generating options for interpersonal communication and action
- increasing mastery
- realizing the antidepressant effect of healthy expression of anger
- clarifying expectations from individuals and roles
- reducing social isolation

At the beginning of each session, therapists assess patients' depressive symptoms, noting any changes that occurred over the course of the week and linking symptom changes to interpersonal interactions and events. Following the review of symptoms, together they address the tasks specific to each IPT phase. The following are the strategies associated with each problem area used in the middle phase:

GOALS	STRATEGIES
Grief—death of people (or animals) important to the patient	
• Facilitate mourning of the deceased loved one • Re-engage with the world by breaking social isolation and refocusing on relationships and interests	• Start with the sequence of events before, during, and after the death • Help the patient to reconstruct the relationship with the deceased and to view it in a balanced way • Assist the patient in facing the future without the loved one, in developing new skills, and in deepening social support
Interpersonal Disputes—overt or covert disagreements with a significant other	
• Identify the stage of the dispute* • Identify and modify mismatched expectations and/or maladaptive communication between the two parties • Assist the patient in actively resolving the dispute	• Explore interactions between the parties to identify discordant expectations that led to the dispute • Explore patient's wishes about the relationship • Modify maladaptive communication patterns • Support the patient in trying out new communication skills to resolve the dispute (and as a result either improve a relationship or end a destructive one)
Role Transitions—positive or negative life changes	
• Mourn the loss of the old role • Develop new skills and social support to handle the new role	• Elicit feelings about loss of the old role • Identify positive and negative aspects of the old role • Identify positive and negative aspects of the new role • Assist patient in reducing social isolation and in finding resources and skills to handle the new role better
Interpersonal Deficits—difficulty in starting and/or sustaining relationships	
• Reduce social isolation by improving social skills	• Review past and current relationships to identify recurrent patterns • Rehearse new social skills for the formation of new relationships and the deepening of existing relationships

***Stages of Disputes**

Renegotiation:	The two parties are still communicating, and both want to resolve dispute, but have been unsuccessful so far.
Impasse:	The parties have failed in resolving the dispute and have stopped trying. They still want to be together but are "stuck." The therapist helps to move the impasse into either a renegotiation or a dissolution.
Dissolution:	One or both parties want to end the relationship. The therapist explores whether the person wants to try one more time. If this fails, the therapist helps the patient in moving away from the relationship.

APPLICATIONS

Who Can We Help?

IPT was originally developed for the treatment of unipolar, nonpsychotic depression. However, since the development of IPT, the treatment has been adapted to other depressed populations with good results. In all these adaptations, the founding principles of IPT remain the same, with therapy focusing on the interpersonal context. A growing body of literature suggests that no single treatment is appropriate for all patients with the same disorder. Indeed, outcome research has recently begun to focus not on what works in general, but what works for whom and under what circumstances. Thus, through randomized controlled trials, researchers have been trying to identify those characteristics that influence clinical outcome differently, depending on the treatment modality. These characteristics are commonly cited in clinical and epidemiological research as *moderators* or *effect modifiers*.

A moderator suggests for whom or under what conditions a treatment works (Baron & Kenny, 1986). It is a pretreatment or baseline characteristic that is independent of received treatment and has an interactive effect with treatment modalities on therapeutic outcome. Identifying moderators of treatment is central for both researchers and clinicians: Moderators clarify the best choice for exclusion/inclusion criteria and stratification to maximize power in subsequent RCTs, and they help clinicians identify the most appropriate treatment for a patient (Kraemer, Frank, & Kupfer, 2006). Though the literature in the area of moderators of response to IPT is in its infancy, some moderating characteristics have been identified.

Evidence for *baseline depressive severity* as a moderator of treatment outcome is equivocal. Findings from some studies (e.g. Elkin et al., 1989) suggest that the benefits of IPT (particularly in combination with medication) compared to other psychotherapeutic interventions such as CBT may only emerge in relation to more depressed individuals, with patients with less severe baseline depression fairing equally well across different treatments. However, this association has not been found consistently across all trials.

Somatic anxiety (anxiety of a more physiological nature) appears to reduce response to IPT. Feske and colleagues (1998) found that patients whose depression did not remit following IPT experienced significantly higher levels of somatic anxiety and were more likely to meet lifetime criteria for panic disorder compared to those who did remit. Whereas depression with comorbid anxiety disorder is generally responsive to IPT, when that anxiety is more somatic in nature (as in the case of panic disorder), pharmacotherapy may be required as well.

Social functioning has been shown to moderate the relationship between treatment condition and depression outcome, with patients with low baseline social dysfunction responding significantly better to IPT (Sotsky et al., 1991). This led Sotsky and colleagues to hypothesize that for IPT to be effective, a minimum baseline level of social functioning may be required.

Attachment avoidance also seems to moderate treatment outcome in depression, with findings from McBride and colleagues (2006) suggesting that patients with high attachment avoidance do better in CBT than IPT. They proposed that avoidant individuals' tendency to deny the importance of close relationships and to value cognition over emotion as a defense against attachment insecurity may mean they respond better to CBT, which focuses on cognitions and behaviors, than IPT, which focuses on interpersonal relationships (McBride, Atkinson, Quilty, & Bagby, 2006).

Treatment

IPT works in depression by providing understanding of the symptoms and their origin within the current context, changing the context and making the symptoms understandable and manageable, identifying the problem, and providing ways of resolving it to

generate mastery. In the sections above, we outlined the strategies through which the interpersonal goals are realized. We will now present the IPT techniques used to carry out those strategies:

1. Linking mood to the interpersonal event:

Example: "Patient: I am sad." "Therapist: What happened?" or "Patient: I had a terrible fight with my boyfriend." "Therapist: how did it make you feel?"

This is a very important technique, since it provides the interpersonal context in patients' communications and behavior. By understanding that context, patients start realizing which interpersonal interactions contribute to their depression and also which contribute to their recovery.

2. Conducting communication analysis (analyzing frame-by-frame an interpersonal situation to understand where communication strayed):

Example: Justin, you told me how the argument with your boss worsened your mood for the rest of the week. It is important to understand what happened during that argument. How did it start? What did you say? How did he respond? How did you feel when he said that? What did you say in turn? What did you wish you had said? Etc.

The aim of communication analysis is to help patients understand the interpersonal message they wish to convey and clarify what stood in the way of conveying that message or whether the message conveyed was not what they wanted or needed to get across.

Many times, the therapist uses the metaphor of the camera ("I would like to get a sense of what happened with the detail of a video camera"). Communication analysis helps patients to increase their awareness and responsibility for the interpersonal message they need to send.

3. Generating options (e.g., conducting decision analysis): In contrast with analytic work, in IPT therapists always ask patients, "What do you plan to do about this?" Teaching patients to generate options counters the hopelessness and helplessness of depression. Therapists help patients come up with alternative ways of dealing with the situation at hand and support them in thinking how to choose one or a combination of them.

4. Role playing: After a specific option is chosen, therapists and patients play it out (like a dress rehearsal for action). They may take turns playing the roles of the different parties involved. Therapists give feedback on how patients' communications came across; they also instruct patients about interpersonal skills needed to carry out the communication effectively. For example: The need to find an appropriate time for an important discussion, when both parties will be receptive; the importance of focusing on the current issue as opposed to talking about similar issues from the past; characterizing the action but not the person; being direct in what one is asking for; etc.

5. Assigning homework (to implement the options that came out of the session guided by the role play): Homework in IPT is less prescriptive than in CBT. Patients are instructed to try to implement a certain interpersonal interaction before the next session, when they review how the interaction went.

Evidence

The rules of evidence should apply equally to studies of psychotherapy and studies of medication. We believe that a controlled clinical trial with randomization of treatment (RCT) is the highest level of evidence. This phase of research, known as *efficacy testing*, typically tests the treatment within a relatively homogenous group, under optimal clinical circumstances, and with the therapy performed by highly trained experts.

Effectiveness studies, which by contrast include a broad range of participants and are typically conducted in real-life settings by community clinicians, are the next step in the psychotherapy development sequence (Weissman et al., 2007).

This section offers an overview of the evidence for the various adaptations of IPT. For a more complete discussion of the studies that have contributed evidence for the efficacy of IPT, please refer to Weissman et al. (2007).

IPT for Mood Disorders

In the trial of maintenance antidepressant medication for which it was developed, IPT was shown to improve social functioning. This positive clinical trial, the first for any form of psychotherapy, was followed by a series of studies that established IPT as a leading evidence-based treatment for acute adult unipolar depression. These showed the efficacy of IPT both as a monotherapy and in combination with medication (e.g., Elkin et al., 1989).

Since then, IPT has been adapted to a number of depressed populations. In their adaptation of IPT for *depressed adolescents* (IPT-A), Mufson and colleagues (1999) tailored the therapy through several important modifications: (1) reduction of treatment from 16 to 12 sessions, since in general adolescents do not want to be in treatment for a long time; (2) telephone contact, especially during the initial phase, to increase active participation in the treatment; and (3) engaging in a collaborative relationship with the parents and school. The efficacy of IPT-A has been validated through a number of RCTs (e.g. Mufson, Dorta, & Wickramaratne, 2004). In addition, Young and colleagues have used group IPT focused on interpersonal skills training as a preventive intervention for adolescents at risk for depression (Young, Mufson, & Davies, 2006). At the opposite end of the age spectrum, IPT has also shown efficacy as a treatment for *geriatric depression* across a number of studies (see Hinrichsen & Clougherty, 2006).

IPT has been successfully adapted and tested for *pregnancy* and *postpartum depression*, based on the following rationale: (1) given the potentially damaging effects of medication on fetus development, psychotherapeutic alternatives for pregnant, depressed women may be especially important; (2) IPT lends itself to the issues most frequently encountered in pregnancy and childbirth: major role transition, disputes, and grief (e.g., due to miscarriage).

IPT has also been used for *medical patients*, who often suffer from depression comorbid with their primary diagnosis. Serious medical illness frequently results in social and interpersonal distress: role transitions due to the incapacitating effects of the illness, interpersonal disputes with family and medical staff, and in some cases grief in anticipation of one's impending death. IPT has shown efficacy in treating depression in primary care patients, to include patients with medical syndromes such as human immunodeficiency virus (HIV), cancer, and coronary disease.

Although it is widely acknowledged that *bipolar disorder* has a major biological component and that treatment requires pharmacotherapy, there are also aspects of the clinical picture that suggest that psychotherapy—and IPT in particular—may make a useful adjunct to medication. The depressive, manic, and psychotic symptoms of the disorder are often extremely disruptive to interpersonal relationships. IPT treats the depressive phase of the illness much like unipolar depression: focusing on interpersonal disputes, role transitions associated with depressive episodes, and—in a variation on the grief problem area—patients' "grief for the lost healthy self." However, as IPT is not equipped to deal with the manic aspect of the illness, in their adaptation Frank and colleagues integrated a behavioral component, social rhythm therapy (SRT), aimed at helping patients avoid the disruptions to their daily routine that can trigger manic episodes. IPSRT aims not to treat mania once it has arisen, but to prevent its recurrence by regularizing daily social activities and improving interpersonal relationships. In combination with medication, IPSRT has shown efficacy in increasing the length of time between episodes (see Frank, 2005).

Adapting IPT for *dysthymia* has necessitated some important theoretical modifications. The IPT model, which identifies and targets an interpersonal problem as a trigger of the current depressive episode, makes less sense for a disorder characterized by chronically impaired mood and psychosocial functioning. Thus, IPT for dysthymia (IPT-D) has developed the concept of an iatrogenic role transition: Here the doctor makes treatment itself a role transition through which patients start to understand maladaptive interpersonal patterns, explore new options, and realize that dysthymia is a treatable disorder (Markowitz, 1998). The efficacy of IPT as an adjunct to medication has been established as both an individual and group therapy for dysthymia.

IPT for Nonmood Disorders

IPT for *bulimia nervosa* (IPT-BN) focuses on the interpersonal problems that may trigger binge episodes. One significant modification from IPT for depression is the lack of focus on the primary symptoms of the illness. In IPT-BN, the therapist tries to steer discussion away from eating topics and toward their interpersonal context and to explore with the patient the affective and interpersonal problems that may be triggering and maintaining eating symptomatology. In clinical trials comparing IPT-BN to CBT for bulimia nervosa (e.g. Fairburn, Jones, Peveler, Hope, & O'Connor, 1993), IPT patients have taken longer to attain symptom reduction but have caught up over the course of treatment and shown significant and lasting improvement. These findings support IPT-BN's putative mediating mechanism: Rather than addressing eating problems head-on (like CBT), IPT helps patients improve the interpersonal problems driving their illness, which then leads to reduction in disordered eating. IPT has also shown efficacy in trials for *binge eating disorder*. IPT has also been tested as a treatment for *anorexia nervosa*, but failed to demonstrate efficacy.

In the case of *posttraumatic stress disorder* (PTSD), which by definition occurs in response to a traumatic event, it is less appropriate to conceptualize an interpersonal trigger of pathology. Instead, IPT for PTSD focuses on the management of interpersonal relationships that may become difficult as a result of the disorder: Many patients with PTSD become mistrustful, have difficulty expressing their emotions, and retreat from their social environment. Unlike most treatments, IPT for PTSD does not utilize exposure as a means of confronting past trauma. However, as patients improve, often they voluntarily expose themselves to reminders of past traumas. Initial trials (e.g. Bleiberg & Markowitz, 2005) have shown promising results. In addition to improving patients' PTSD symptoms, IPT appears to help alleviate the depression that is commonly comorbid with this disorder. Adaptations of IPT for *social phobia* and *panic disorder* have also shown promise in open trials but require further testing.

Some of the central characteristics of IPT, such as its short time frame and attention to the reduction of acute symptoms, reflect its development as a treatment for Axis I disorders. The adaptation of IPT for borderline personality disorder (BPD) by Markowitz and colleagues (2006) therefore represents a new departure for the treatment and remains under testing. For further discussion of IPT for BPD, see the Theories of Personality section.

The use of IPT to treat *substance abuse* is based on a double rationale: Patients may abuse drugs or alcohol to compensate for poor interpersonal relationships, or substance abuse may damage existing relationships and in turn intensify the disorder in a vicious cycle. The goal of IPT with this population is to help patients resolve current interpersonal problems and interpersonal deficits and in doing so counter the need for further substance use. However, in initial trials IPT has failed to demonstrate efficacy for substance abuse, although Markowitz and colleagues (2008) showed an antidepressant effect for IPT in alcoholics with comorbid depression in a recent open trial.

Other Applications

The adaptation of IPT to a format has a number of potential benefits. In clinical terms, *group IPT* (IPT-G) can help validate the sick role by showing patients that other people suffer from the same illness, reducing patients' social isolation, allowing them to practice interpersonal skills within therapy, and providing gratification for patients who feel they are helping one another. On a practical level, the group format allows therapists to see a larger number of patients, making it a potentially cost-effective alternative to individual treatment. One potential drawback of IPT-G, especially if different members of a group present with different problem areas, is diminished focus on each individual's particular interpersonal difficulty. Wilfley and colleagues (1993) successfully developed IPT-G as an adaptation for nonpurging bulimic women. To counteract some of the potential problems of the group format, their treatment included two individual sessions before starting the group format (during which the interpersonal inventory was conducted and the case formulation presented), the issuing of homework specific to each patient's case throughout therapy, and the assigning of the interpersonal deficits problem area to all group members. Subsequent studies have provided additional support for the efficacy of IPT-G, including an adaptation of IPT-G for depressed adults in Uganda, which will be discussed in detail in the Psychotherapy in a Multicultural World section below.

Interpersonal counseling (IPC) is a form of IPT with fewer, shorter sessions. IPC was developed by for use with medical patients with comorbid depression (Weissman & Klerman, 1986) and is currently being tested as a treatment for use in primary care settings.

Conjoint (couples) IPT has been used to treat couples in which one or both spouses are depressed. Before the conjoint phase of treatment, therapists conduct individual sessions with each spouse during which they make their diagnosis, complete the interpersonal inventory, and propose a case formulation. Interpersonal disputes and role transitions have emerged as common problem areas with this population. A pilot study by Foley and colleagues (1989) found that while conjoint IPT and individual IPT resulted in similar reduction in depressive symptoms, subjects from the conjoint IPT arm reported greater improvements in marital satisfaction.

Telephone IPT has been tested successfully in a number of small pilot studies and open trials for populations to include homebound cancer patients with comorbid depression who were too ill to come to sessions, depressed patients in partial remission, and patients with subsyndromal depression following miscarriage. Following an initial in-person session to determine the patient's diagnosis and level of suicidality, all sessions take place over the phone. However, in other respects the approach is the same as that used in standard IPT.

Psychotherapy in a Multicultural World

IPT has been successfully practiced with patients in many countries and cultures throughout the globe. Often with minimal modifications, IPT has been used effectively with minority populations in the United States and in more than 30 countries on 6 continents. Moreover, even when adapting IPT for use in sub-Saharan Africa, researchers and clinicians have been struck by the similarity in the issues faced by people in rural Uganda and urban America despite the considerable cultural and socioeconomic differences between the two societies.

A number of features illustrated in the work in Sub-Saharan Africa were prerequisites to make IPT *feasible*, *acceptable*, *ecologically valid*, *effective,* and *sustainable* (Verdeli, 2008):

- Understand the mental health issues and needs of the community.
- Validate assessment scales (not just translate and back-translate) to capture local mental health syndromes.

- Intervene when community recognizes the need for assistance and consents to the intervention plans.
- Choose and adapt the therapy for ecological validity by engaging in ongoing dialogue with the trainees and key informants.
- Develop a practical and feasible intervention by choosing as mental health providers educated local laypeople.
- Develop collaborations among domestic and international academic centers, nongovernment organizations (NGOs), and local communities to test and, if found effective, disseminate the treatment.
- Have a strong commitment from the international experts to gradually make themselves redundant by withdrawing and letting the local experts take over.

An Example of IPT Adaptation: Group IPT in Southwest Uganda

The adaptation of IPT for use in Southwest Uganda serves as a model for the psychotherapy adaptation process. Bolton and colleagues tested the efficacy of IPT to treat adults suffering from depression in the Masaka and Rakai districts of southwestern Uganda, with the long-term goal of making IPT sustainable following the end of the project (Bolton et al., 2003).

Qualitative Research to Inform the Adaptation. Epidemiological studies conducted over the last 25 years have indicated an elevated level of depression in Uganda, with prevalence rates as high as 21% (Bolton et al., 2003). Local people cited the HIV epidemic in Uganda, a country with one of the highest rates of HIV infection in the world, as the cause of this depression. In 2000, an ethnographic study was conducted and two local syndromes were found to be particularly prevalent: "*y'okwetchawa*" (self-loathing) and "*okwekubagiza*" (self-pity). The symptoms experienced within these syndromes overlapped considerably with the DSM-IV criteria for depression (e.g. sadness, poor sleep and appetite, low energy, and feelings of worthlessness). However, these local syndromes also included a number of additional symptoms not recognized with the DSM criteria, such as not responding when greeted and not appreciating assistance when it was provided. The lack of physicians and high cost of medication prohibited the use of antidepressants. Psychotherapy was seen as a viable alternative provided that (1) laypeople with no previous experience as therapists could be trained to deliver the intervention (due to the scarcity of mental health professionals); (2) the therapy could be conducted in groups to increase coverage and reduce cost; and (3) its effectiveness could be established.

IPT seemed like a potentially good fit for this population for three principal reasons: the established efficacy of IPT for depression, its compatibility with the importance local Ugandan culture gives to interpersonal relations, and the match between the IPT problem areas and the types of issues the population surveyed seemed to be experiencing (Verdeli et al., 2003). Grief in the local communities was typically associated with the death of a family member or close friend, often due to AIDS or other epidemics. Some sources of interpersonal dispute were disagreements with neighbors about property boundaries, political fights, and wives protesting an HIV-affected husband's demands to have sex without using condoms. Role transitions included becoming sick with AIDS and other illnesses, getting married and moving into the husband's home, and dealing with a husband's decision to marry a second wife. Local workers deemed interpersonal deficits less relevant to the local culture, and as a result this problem area was dropped from the treatment (Verdeli et al., 2003).

Task-shifting. A group of workers from World Vision, the organization sponsoring the project, were selected as group leaders. Despite the fact that the majority had no

background in mental health work, a 2-week training with IPT experts followed by supervision by telephone during the trial itself proved an effective means of instruction. This approach is consistent with the World Health Organization's *task-shifting model*: the delegation of tasks to less specialized local health workers in order to make the most efficient use possible of available resources and thereby improve health care coverage (WHO, 2007).

Adaptations Made for the Local Context. The language used during therapy was informed by the Ugandan cultural context. For example, grief was referred to as "death of a loved one," role disputes were termed "disagreements," and transitions were referred to as "life changes" (Clougherty, Verdeli, & Weissman, 2003). In addition, the strategies employed were adapted to local cultural norms. For instance, in the local context, direct confrontation could be interpreted as inappropriate and disrespectful and, therefore, indirect forms of communication had to be employed. One effective strategy was for women to cook bad meals, which indicated to their husbands that something was amiss. In another cultural modification, group members understandably had difficulty drawing positives from many of the devastating life changes that had brought about role transitions in Uganda—the AIDS epidemic, tyrannical regimes, and civil war. This problem area was therefore adapted such that therapists worked with group members to identify aspects of life that were under their control and worked on identifying options and building skills that would improve their sense of mastery in these areas (Verdeli et al., 2003).

Results of the Clinical Trial in Southwest Uganda. An RCT found modified IPT-G for depression to be significantly more effective than the control condition (Bolton et al., 2003). The treatment was very well received by the local community, with excellent attendance and a dropout rate of only 7.8%. Moreover, the groups continued to meet on their own following the official termination.

IPT in Northern Uganda

Effectiveness. One of the deadliest humanitarian emergencies in the world is the 22-year civil war in Northern Uganda. More than 20,000 children have been abducted and forced to serve and fight for the Lord's Resistance Army rebel movement. In 2005, the Columbia IPT team participated in the adaptation of group IPT for adolescents living in internally displaced persons (IDP) camps in Northern Uganda. Ethnographic studies showed elevated levels of both depression and anxiety in this population (Bolton et al., 2007). Two additional treatment conditions to those used in the adult study in southwest Uganda were included: creative play (CP), which is what NGOs routinely administer in these settings, and wait list. CP was included to control for nonspecific group effects and to discern whether any improvements observed were due to specific elements in IPT over and above generic inclusion in a group. The results of the RCT showed significant improvement of depression in the IPT group compared to the other two conditions (Bolton et al., 2007). Since the study, IDP camp officials have been working with World Vision employees to promote the use of IPT-G among the locally depressed youth, and once again the group leaders have been working extraordinarily hard to cope with the high demand for the treatment.

Sustainability. Since the initial Ugandan study in 2003, the IPT-G project has been expanded to form new groups and provide services in other provinces. To date, more than 2,500 people in southwest Uganda have been treated as well as adolescents in eight IDP camps in northern Uganda. This stands in contrast to many international projects implemented in developing countries that have dissolved after the initial study (Verdeli, 2008).

Dissemination. To facilitate the continued development of the IPT work in Africa, a training of trainers was held in Nairobi in 2007. Twelve of the most experienced trainers from the Ugandan projects spent 2 weeks working on including quality assurance and delineation of training standards for trainers and supervisors, clarification of theoretical and technical issues, and teaching of training skills. As a result of collaborations between World Vision and other partner organizations, there are now plans to use IPT in many East and West African countries and with depressed and traumatized populations, including female combatants in Liberia, HIV-infected adults in shanty towns in Nairobi, and child soldiers in Uganda.

Finally, IPT is currently being tested with distressed primary care patients in Goa, India, and with depressed Hispanic immigrants in the United States. In their adaptation of IPT to Spanish-speaking patients with Major Depressive Disorder (MDD), Blanco and colleagues (Markowitz et al., 2009) identified several cultural issues that emerged from therapy with Hispanic patients: (1) the centrality of the family (*familismo*); (2) conflicts because of migration and acculturation, since migration is a major role transition; (3) gender issues (*machismo*) aimed at constructing a more desirable but also culturally acceptable gender-based sense of self; and (4) the need for culturally acceptable confrontational approaches.

CASE EXAMPLE

This summary refers to the case of Paul, whose treatment was used to illustrate aspects of IPT in the Process of Psychotherapy section. Paul, a 22-year-old college student, presented to his university's student health services complaining of a number of symptoms he had been experiencing over the past couple of months: feeling sad and empty, difficulty concentrating, poor sleep, loss of appetite, and fatigue.

Paul's clinical interview confirmed a diagnosis of major depression, and his score of 18 on the Hamilton Rating Scale for Depression (HAM-D) confirmed that he was suffering from a severe depressive episode. Based on his low scores on measures of suicidality and neurovegetative symptoms, the therapist decided not to recommend medication at this time.

While taking a psychiatric history, the IPT therapist learned that Paul was the second of two children. His father was a partner in a big law firm, while his mother had stayed at home to raise Paul and his sister, Sarah. Paul had been an anxious child, and although he had always had two or three close friends, he struggled to meet new people. He had always been close to Sarah, who was very protective of her younger brother. While on the one hand his relationship with his sister gave him a sense of security, on occasion it left him feeling deficient. Whereas Paul was shy, an average student, and lacked confidence, by contrast Sarah was outgoing and academically gifted. Paul felt close to his mother but had a difficult relationship with his father, who seemed to identify much more with his sister. While he was quick to praise Sarah and celebrate her academic excellence, he was often dismissive and sarcastic toward Paul, whose lack of direction seemed to puzzle and frustrate him.

Paul had always gotten by at college with mediocre grades, despite having suspected attention deficit hyperactivity disorder (ADHD), although a formal assessment was inconclusive. He was not passionate about any particular subject area and had chosen to major in sociology because it "seemed easy and kind of general." However, now that he was in the spring semester of his final year, this choice of major had left Paul unsure what he wanted after he graduated in the summer. He felt like he might do better with a career that was concrete and action oriented: "less academic and, you know, more practical."

Paul's depressive episode started after the winter break. He was finding it hard to concentrate and struggling with his courses; in particular, his anxiety that he might fail stats had led Paul to think that maybe he should "just drop out." Being given the "sick role" at this point in treatment seemed to reduce somewhat Paul's anxiety and to persuade him to hold off making drastic decisions about his college and professional future.

It also helped him to start considering practical solutions to his most pressing current problems, in particular how to handle his failing grade in his stats class.

Having conducted the interpersonal inventory, the IPT therapist hypothesized that Paul's depressive episode had been triggered by his uncertainty about what to do after college (a role transition) and exacerbated by the pressure and high expectations resulting from his tense relationship with his father (an interpersonal dispute). The fact that his sister had recently gotten engaged and been accepted into law school had left Paul feeling even more inadequate and lost. This interpersonal formulation made sense to Paul, and he and the therapist agreed to focus their work together in therapy on his upcoming postcollege role transition and his interpersonal dispute with his father.

In the middle phase of treatment, the therapist worked with Paul to help him clarify his role transition by separating his feelings and views from other people's, coming up with options about his next career step, and identifying individuals who could help him in this transition by providing information or support. The therapist also helped Paul become more aware of how his father's derogatory remarks affected his depression and assisted Paul in learning to set limits with him.

Over the next few weeks, Paul's depressive symptoms began to improve, and increasingly he took an active role in therapy. Paul explained his situation to his stats professor and, based on her advice, decided to take an incomplete grade for the course. He also made an effort to spend more time with his friend Lisa, and in doing so became friends with her roommates. These accomplishments gave Paul a sense of interpersonal mastery and a new sense of confidence. Paul also became more proactive about planning what to do after college. Reflecting on how much he had enjoyed taking an introductory EMT course, he did some Internet research and talked with a career counselor about next steps in exploring this as a potential career. Paul also worked hard at setting limits in his interactions with his father. Although he felt they "weren't any closer," he became better at establishing limits and over the course of therapy their phone conversations began to affect Paul's mood less.

Having declined steadily, four sessions before treatment termination, Paul's HAM-D depression score briefly increased by several points. Reflecting that this was quite normal for a patient nearing the end of treatment, the therapist assuaged Paul's anxiety about ending therapy, reminding him of the considerable progress he had made over the prior few months. In the final phase of treatment, Paul and his therapist took stock of the progress he had made: the improvements in his depression, his increased interpersonal mastery, and the progress he had made in his postcollege role transition and interpersonal dispute with his father. This discussion became a springboard to discuss Paul's ongoing progress after therapy, the problems that might trigger a future depressive episode, and the resources available to Paul to deal with them. Paul reflected that he felt proud of his gains during therapy and pleased about his decision to take a second EMT course after graduating. He was realistic about his relationship with his father, noting that although he was now giving him more space, when it came to his career plans, he still did not really "get it." He felt good about his relationship with his mother, who had been very supportive of his treatment and encouraging with regard to his plans for the future. Now that Paul felt more secure in himself and his future, he was also able to enjoy his sister's success more. When, in the last session, Paul and the therapist discussed treatment termination, Paul reflected that although things "weren't perfect," he felt he would "do all right."

Before the termination of treatment, the therapist made sure to keep the door open by letting Paul know that if ever he needed more help he could recontact her. Eighteen months later, Paul did call. He reported that in general things were going well. He had not had any more depressive episodes, had become a full-time EMT, and was enjoying the work. He had made a few new friends, and although mostly he was focusing on his career, had been dating casually. However, although he was getting on well with his mother and sister, his relationship with his father remained distant. Paul still felt that in his father's eyes he was

"just an EMT" and resented feeling "like I somehow disappointed him, or something." Recently, Paul's father had suffered a heart attack, which had left Paul feeling anxious and as though he should try to "patch things up between us." The therapist congratulated Paul on the gains he had made and reminded him of the importance of separating his own feelings and views from those of others. She helped him accept that his current relationship with his father might be "as good as it gets" and gave him an opportunity to mourn the fact that he might not ever get to be as close to his father as he would have liked. This realization, while sad for Paul, made him feel "less bad, less . . . responsible for how things are between Dad and me" and appeared to reduce his anxiety about their relationship.

SUMMARY

Initially designed to represent the psychotherapy arm of a psychopharmacological trial, in IPT Gerald Klerman, Myrna Weissman, and their colleagues sought to create a therapy that brought together a variety of best psychotherapeutic practices and strategies within a cohesive, systematic structure. What they developed was a logical framework within which therapists from different theoretical approaches and backgrounds could place and use their clinical expertise in a coherent and testable fashion. These characteristics also turned out to be the greatest strength of the approach. IPT is neither doctrinaire nor prescriptive; it allows therapists considerable flexibility to incorporate a broad variety of therapeutic tools within a short-term framework that provides shape to therapy and facilitates patient movement and symptom reduction.

This structure has not only made IPT accessible to clinicians from a variety of professional and cultural backgrounds, it has also allowed for ready adaptation of the treatment to a range of disorders and settings. This flexibility and usability within a uniform, overarching structure has allowed IPT to evolve through continuous testing and adaptation.

The interpersonal context of psychopathology upon which IPT focuses and the problem areas of grief, interpersonal deficits, role transitions, and interpersonal deficits that it identifies as triggers of mental illness appear to hold constant across cultures. Research has established IPT as a feasible and efficacious treatment for a variety of disorders spanning political, economic, and cultural contexts. Currently, it is being used to treat patient populations ranging from depressed American adolescents to sub-Saharan trauma survivors.

Weissman has suggested that psychotherapy in the Western world is in crisis. Rendered prohibitively expensive by the exigencies of insurance companies and the pressures of managed care, psychotherapy is being replaced by pharmacotherapy even where there is evidence to support its use either as monotherapy or in combination with medication. Paradoxically, psychotherapy is beginning to flourish in resource-poor parts of the world, where it is frequently much more cost effective than pharmacological approaches. As the first psychotherapeutic treatment to show efficacy in places such as Africa, IPT is at the forefront of this movement.

ANNOTATED BIBLIOGRAPHY AND WEB RESOURCES

Annotated Bibliography

Frank, E. (2005). *Treating bipolar disorder: A clinician's guide to interpersonal and social rhythm therapy*. New York: Guildford Press.
In this manual, Frank describes the framework and process of IPSRT, an evidence-based treatment for bipolar disorder that incorporates the principles and practice of IPT as part of a broader therapy. This book provides practical guidelines for employing this intervention, outlines efficacy data, and provides clinical vignettes.

Hinrichsen, G. A., & Clougherty, K. F. (2006). *Interpersonal psychotherapy for depressed older adults*. Washington: American Psychological Association.

This manual describes the adaptation of IPT for depressed older adults, addresses issues specific to this population, and discusses the empirical and theoretical basis of the approach.

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression.* New York: Basic Books.
This book was the first IPT manual, published by Klerman, Weissman, and colleagues once efficacy for IPT had been shown outside their research group. The nature and prevalence of depression are discussed, the theoretical basis for IPT is described, and detailed treatment strategies are provided for the four IPT problems areas.

Mufson, L., Dorta, K. P., Moreau, D., & Weissman, M. M. (2004). *Interpersonal psychotherapy for depressed adolescents* (2nd ed.). New York: Guildford Press.
Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) presents readers with developmental adaptations for this age group, including the various presentations of depression in teens and the need for parental involvement in treatment. IPT-A is illustrated through case examples.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York: Basic Books.
This second IPT manual builds upon the first by providing an updated description of IPT for depression, discussing the adaptations of IPT for mood and nonmood disorders, and presenting the efficacy research to support these approaches. Case examples and clinical scripts are included.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's quick guide to interpersonal psychotherapy.* Oxford: Oxford University Press.
Designed for busy clinicians, this condensed manual describes how to conduct IPT for depression and provides adaptations of the approach for a variety of disorders (e.g., mood and nonmood), populations (e.g., older adults, medical patients), and settings (e.g., developing countries). This text provides clinicians with the outline and course of IPT treatment in a concise and practical format.

Web Resource

www.interpersonalpsychotherapy.org

The Web site of the International Society for Interpersonal Psychotherapy provides students, clinicians, and researchers with information about meetings, training, and developments in IPT research and practice.

CASE READINGS

Crowe, M., & Luty, S. (2005). The process of change in interpersonal psychotherapy (IPT) for depression: A case study for the new IPT therapist. *Psychiatry, 68*(1), 43–54. [Reprinted in D. Wedding & R. J. Corsini (2011). *Case studies in psychotherapy.* Belmont, CA: Brooks/Cole.]

This case provides detailed examples of how IPT was used to treat a 42-year-old divorced woman with a major depressive disorder.

Mufson, L., Verdeli, H., Clougherty, K. F., & Shoum, K. (2009). How to use interpersonal psychotherapy for adolescents (IPT-A). In J. M. Rey & B. Birmaher (Eds.), *Treating child and adolescent depression.* Baltimore: Lippincott Williams & Wilkins.

The chapter provides a session-by-session description of Bill, a depressed adolescent who received IPT-A.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy.* New York: Basic Books.

The case of Ellen, a 27-year-old depressed suicidal woman, is described in detail in this book. The case provides a meaningful introduction to key features of IPT.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's quick guide to interpersonal psychotherapy.* Oxford: Oxford University Press.

This book includes a number of case examples illustrating the adaptation of IPT to a variety of disorders.