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Special Issue Article

Interpersonal Psychotherapy: Evaluation, Support, Triage

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Depression is highly prevalent and debilitating among medically ill patients. As high as one third of the primary practise patients screen positive for depression symptoms and over half of the patients diagnosed with major depressive disorder are treated in primary care. However, current primary care service arrangements do not efficiently triage patients who screen positive for depression into appropriate treatments that reflect their individual needs and preferences. In this paper, we describe a tool that aims to fill the gap between screening the patients for depression and triaging them to appropriate care. This is a three-session adaptation of interpersonal psychotherapy: ipt; evaluation, support, triage (IPT-EST). We first outline IPT-EST procedures that aim to provide structure and content to primary care practitioners who identify patients with positive depression symptoms, thus assisting the practitioners to explore the patients' psychosocial triggers of depression, give basic strategies to manage these interpersonal stressors and provide decisions tools about triaging patients with severe/persistent depression into appropriate treatment.

Key Practitioner Message:

- IPT-EST is a brief (2–3 sessions) intervention designed for primary care providers working with patients screened positive for depression.
- It offers practitioners structure and content to 1) support patients during depression evaluation; 2) explore interpersonal triggers of depression symptoms; and 3) triage into appropriate services as needed.

INTRODUCTION

We describe a novel adaptation of interpersonal psychotherapy (IPT). It is designed to fill a gap in primary care and family practise between screening patients for depression and triaging patients to appropriate care. We call this adaptation interpersonal psychotherapy: evaluation, support, triage (IPT-EST). The method uses IPT strategies and is designed to provide comprehensive evaluation and support to patients who screen positive for depression in primary care or its equivalent and who have transient symptoms in relationship to a current stressor and to provide guidelines for support and triage to the minority of the patients with sustained depression who require more intensive or continuing treatment. Its structure enables non-mental health professionals to address the gap between depression screening and triaging patients into appropriate care.

Interpersonal psychotherapy has already demonstrated efficacy for depression in numerous clinical trials including in primary care and medical settings (Mossey, Knott, Higgins, & Talerico, 1996; Schulberg et al., 2007; Weissman, Markowitz, & Klerman, 2007). We are currently testing this IPT adaptation in clinical trials in Israel, Brazil and Haiti. Although we are strong advocates of the need for testing of any new treatment by controlled clinical trials before dissemination, we present IPT-EST at an earlier phase in its development in order to invite collaborators to try it out and share their clinical experience. This feedback will assist us in refining the methods for its further testing and dissemination and ensure its broader applicability.

In this paper, we describe the rationale for IPT-EST, a broad outline of its procedures and a case example from a family practise clinic.

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RATIONALE

Interpersonal psychotherapy: evaluation, support, triage derives from our experience following over 3000 primary care or family practise patients (Das et al., 2005; Vidair et al., 2011). Our systemic follow-up studies of depressed patients in primary care clearly demonstrate that depression complicates the course and treatment of chronic medical illness, contributes to increased utilization of expensive emergency room services and results in increased frequency of patient visits. If untreated, depression contributes to severe and costly long-term medical and psychiatric morbidity (Gross et al., 2005; Weissman et al., 2010).

Depression is highly prevalent among primary care patients. A quarter to one third of family practise patients screen positive for elevated mood symptoms (e.g., Coyne, Fechner-Bates, & Schwenk, 1994; Vidair et al., 2011). Furthermore, for patients seeking treatment for depression, the first point of contact is often their primary care clinic (Coyne et al., 1994), and over half of the patients diagnosed with major depressive disorder are treated in primary care (Rubenstein et al., 2007; Shapiro et al., 1984). In addition, there are significant disparities in depression care among populations defined by race, ethnicity and income (Miranda & Cooper, 2004; U.S. Surgeon General, 2000).

IDENTIFYING DEPRESSION IN PRIMARY CARE

There is an over 40-year history of screening for depression in primary care. Several well-validated depression screening instruments have been developed and have demonstrated utility to detect depression in primary care settings (Mulrow et al., 1995; Pinto-Meza, Serrano-Blanco, Peñarrubia, Blanco, & Haro, 2005; Spitzer, Kroenke, & Williams, 1999). Although primary care providers have been trained to screen for major depression as well as the various subthreshold depressive states (Pincus, Davis, & McQueen, 1999), it is becoming clear that screening alone is unlikely to improve patient outcomes (Campbell, 1987; Gilbody, Sheldon, & House, 2008; Valenstein, Vijan, Zeber, Boehm, & Buttar, 2001; Williams, Pignone, Ramirez, & Perez Stellato, 2002). Current primary care service arrangements do not efficiently triage patients who screen positive for depression into appropriate treatment that reflects their individual needs (Weissman et al., 2010).

Persistent depressive conditions requiring sustained treatment in primary care settings are often more difficult to distinguish from more transient, depressive symptoms that occur in relation to an immediate life stressor (Regier et al., 1993). Based on our primary care follow-up studies, we have found that patients who screen positive for depression usually receive antidepressant medication and little or no attention to their psychosocial circumstances (Weissman et al., 2010). When patients who screened positive for depression were asked what help they would like, over a third said, they wanted to talk to their doctor or a mental health professional about their problems even if they were receiving medication (Vidair et al., 2011). There are often no support and engagement strategies for those patients who need to be referred for longer treatment, resulting in poor adherence to medication, high rates of relapse and a net result of poor and costly outcomes (Sturm & Wells, 1995; Wells, Schoenbaum, Unützer, Lagomasino, & Rubenstein, 1999; Weissman et al., 2010).

Moreover, when minor depression remains unaddressed, a considerable proportion of patients experience recurrent episodes and higher risk for more persistent mood problems such as major depression and dysthymia (Angst & Merikangas, 1997; Cuijpers & Smit, 2004). We now know that with early intervention and targeted clarification and management of the source of stress, the symptoms of minor depression typically resolve promptly (Klerman et al., 1987).

PRECEDENT FOR INTERPERSONAL PSYCHOTHERAPY: EVALUATION, SUPPORT, TRIAGE

In practice, even patients who enter psychotherapy usually do not receive or seek long-term treatment (Olfson & Marcus, 2010). In 1987, Klerman, Weissman and colleagues adapted a brief, six-session variant of IPT, which they called interpersonal counselling (IPC). The authors compared IPC against treatment as usual with distressed patients in primary care. IPC was conducted by nurse practitioners. Results showed more rapid reduction of distress symptoms and functional improvement in the IPC group. Furthermore, although IPC was designed for six sessions in practise, the mean number of sessions attended in IPC condition was three (Klerman et al., 1987). Since then, there have been further clinical trials showing the efficacy of IPC with depressed patients in medical settings (Judd et al., 1998; Mossey et al., 1996; Neugebauer et al., 2006). However, IPC did not have a triage focus and was designed for six sessions.

OTHER PSYCHOSOCIAL APPROACHES IN PRIMARY CARE

In addition to IPC described previously, full IPT has been used in primary care and other medical settings administered by nurses (Mossey et al., 1996) or psychiatrists (Schulberg et al., 2007). A brief version of IPT was used in a stepped-care study of distressed primary care patients in Goa, India. However, logistical issues such as poor transport in the region limited participants' attendance at IPT sessions (Patel et al., 2010). Psychosocial interventions for depression such as cognitive–behavioural

therapy (Unützer et al., 2002) and more recently, guided self-help for mild depression (Cuijpers, Donker, van Straten, Li, & Andersson, 2010) have been used in primary care, either as stand-alone treatments or within a collaborative care paradigm. As defined by Gilbody, Bower, Fletcher, Richards, and Sutton (2006), collaborative care is an empirically supported model for organizing primary care management of depressed patients, emphasizing structured delivery of interventions and mechanisms to foster better communication between primary care clinicians and mental health specialists.

These approaches are complementary and are important sources of triage treatment for depression. The purpose of IPT-EST within such a paradigm is very specific: to bridge the gap between initial screening, when the diagnostic picture and severity of depression may not be clear, and subsequent allocation of treatment needs to match realistically the patient's level of clinical need and life circumstances. As noted previously, distressed primary care patients have been shown to respond quickly to treatment, and such patients may require minimal or no treatment following three sessions.

Interpersonal psychotherapy: evaluation, support, triage may also be helpful in addressing false positive diagnoses of depression in primary care. Overdiagnosis is a common problem in those settings: a recent meta-analysis of 41 studies investigating general practitioners' accuracy of diagnosing depression in primary care patients revealed that false positives were much more common than false negatives or correct diagnoses (Mitchell, Vaze, & Rao, 2009). The remedy that the authors proposed was a second evaluation a few weeks later. IPT-EST addresses this problem by providing guidelines for support and continuing evaluation for a few weeks after initial screening.

INTRODUCTION TO THE INTERPERSONAL PSYCHOTHERAPY: EVALUATION, SUPPORT, TRIAGE MANUAL

This manual describes a three-session evaluation, support and triage for persons with suspected major depression or depressive symptoms, designed to be used by providers of a variety of disciplines, including family practice physicians, physician assistants, social workers, nurse practitioners or nurses. It presents scripts and strategies to identify and help patients manage acute problems, provide support and triage patients into appropriate treatment including mental health referral or watchful waiting. IPT-EST providers do not require previous mental health training. The procedures derive directly from the initial phase of IPT, as described elsewhere (e.g., Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman, Markowitz, & Klerman, 2000), with the language simplified for non-mental health specialists.

Adapted for the time pressures of a primary care visit (e.g., interpersonal inventory has a much briefer and focused format revolving around relationships pertinent to the problem area and to provision of support), IPT-EST is designed for three sessions. The three sessions can be conducted on a flexible schedule: weekly or more or less frequently, e.g., three sessions over 6 weeks, depending on the patient's preferences. A fourth session to complete/follow-up on the triage can be used, if needed.

The sessions are conceived as a supportive evaluation following positive screening that shows elevated depression symptoms. Sessions will involve: (1) clarification of symptoms and diagnosis; (2) delineation of the social and interpersonal context associated with the onset of the symptoms, which in IPT fall into one of the four problem areas; (3) identification of patient resources (e.g., who is there for the patient); and (4) training in strategies for dealing with problems contributing to the patient's depression. Compared with standard IPT, the tempo of IPT-EST is faster: from the very first session, the therapist focuses more on clarifying the problem and providing basic strategies to manage it. For patients who are parents, exploration of problems with their children is included as there are ample data showing that the offspring of depressed parents have high rates of psychiatric and behavioural problems. Inquiry about the children is part of the initial self-report assessment (Weissman & Olfson, 2009).

At the end of the three sessions, the patient and the provider make a decision regarding allocation to further services. Depending on the severity of the patient's symptoms, at the end of these three sessions, the patient's wishes and social supports and the availability of resources, the possible triage allocations are as follows:

1 For those who have minimal or no symptoms and no impairment: No further treatment, use of family and other supports.
2 For those who have improved but still have some minimal symptoms and slight functional impairment: Unscheduled treatment as needed: 'Call me if you need me' or monthly maintenance in person or by telephone.
3 For those who have improved but still have moderate symptoms and impairment, as well as those who are still in an episode, not improving, or worsening: regular treatment alone or in combination, including group, or individual psychotherapy and/or medication.

The manual describes the IPT-EST procedures in detail with scripts and patient handouts to facilitate information gathering and therapeutic discussions. Although it focuses on evaluation and triage, it contains the key elements of IPT, making it more than a diagnostic history

evaluation. These elements encompass the initial phase of IPT. In addition to the clinical and interpersonal history, there is an educational component about depression. The therapist offers the patient an account of how depressive symptoms influence and are influenced by medical illness, in order to help the patient clarify the problem and link it to the depressive episodes. The diagnostic focus is on the interpersonal event(s) triggering the current episode, as well as the exploration of the event and resources for dealing with it.

The therapeutic relationship is supportive and encouraging. For simplicity's sake, the manual uses the term 'therapist' for the health care provider and 'patient' for the recipient, recognizing that the three-session approach is designed to be used by persons of different educational and occupational levels and with persons identified in mental health, health, work, educational and other facilities. We suggest that the term 'therapist' and 'patient' be modified as appropriate to the setting and provider.

OUTLINE OF THE THREE SESSIONS

The manual provides scripts for the procedures outlined in the following text (Weissman & Verdeli, 2010). The suggested scripts are shown in bold, and the novice will likely use them as presented. The experienced provider will undoubtedly elaborate, but the material included should be covered. Handouts are available to help guide the patient's recollections but only as appropriate and are optional (Weissman, 2005). The actual manual provides scripts for these strategies.

Session 1
Review screening form
Review depressive symptoms with patient
Review level of impairment with patient and other co-morbid symptom (e.g., alcohol abuse, anxiety)
Explain how depression impacts and is impacted by any co-morbid medical conditions
Provide education about depression symptoms using the medical mode and reduce guilt: 'It is not your fault'
Give hope: 'Your symptoms will improve'
Problem-solve current role performance difficulties resulting from current depression: 'Who can help you right now?'
Explain the course of evaluation
Explore interpersonal problems associated with onset of current depressive symptoms (using problem area handouts): 'What was happening when you started feeling sad and your headaches worsened?'
Conduct focused interpersonal inventory (cover children's problems if patient is living with children)
Choose one to two problem areas on which to focus, and share plan with patient
Explain procedures for the next two sessions (i.e., duration and frequency), as well as post-IPT-EST triage options
Session 2
Review reactions from previous session
Review symptoms and functioning
Review problem area handout
Briefly present strategies for dealing with problem areas:
Grief
Disputes
Transitions
Deficits, loneliness and isolation
Identify general IPT strategies to help the patient: breaking the social isolation; brainstorming alternative options to deal with the problem; identify others who can help and advocate for patient; improving communication
Session 3
Review symptoms and functioning
Review progress on problems
Discuss patient's clinical needs and triage preference
Discuss options at termination
No further follow-up
As needed 'Call me as you need me'
Maintenance treatment monthly
Referral for medication and/or psychotherapy (individual or group)

(Continues)

Prior to the first session, the provider asks patients to complete an assessment of demographics, symptoms, functioning, treatment history, preferences and obstacles and problems with children. Depending on the goals and setting, the patient diagnosis may be confirmed by an additional diagnostic assessment. The intervention can be used for patients with depressive symptoms regardless of diagnosis.

Case Example

The following is a pilot case using the IPT-EST manual. As the manual was still in its development and testing phase, the therapist was a post-doctoral fellow, observed by one of the IPT-EST co-authors (H.V.).

Lisa (a pseudonym), presented at her local family medicine centre, one of the primary care clinics affiliated with Columbia University, complaining of severe recurrent headaches and insomnia. Noting that her mood seemed low, her family medicine doctor asked her to fill out the Patient Health Questionnaire. Lisa endorsed six of nine depression symptoms over a period of several days. Additionally, in conducting a brief medical history, her doctor found that she had a previous episode of post partum major depressive disorder after the birth of her first child, for which she was prescribed fluoxetine. She reported that she discontinued medication after 3 months because she was feeling better and felt afraid of gaining weight.

Having heard about the IPT-EST pilot study, the doctor referred her to us at that time. The three sessions were conducted in the primary care clinic, which she attends.

Session 1

In the first session, the IPT-EST therapist explained to Lisa that she met the criteria for depression. Lisa readily accepted this diagnosis, stating that 'it felt just like last time, after the baby.' Together, Lisa and the therapist discussed how her depression impacted her medical issues (her debilitating headaches), how her medical issues impacted her depression and how her depression symptoms affected her role as a mother of four young children, aged nine to three. It quickly became apparent that the children were safe and cared for, but that in her current condition, Lisa did not have the energy and motivation to engage with them fully. Lisa acknowledged this and indicated that she was particularly worried about her 9-year-old, Mark. She reported that his school had called about his aggressive behaviour towards other children at school, while at home he oscillated between being irritable and withdrawn, adding, 'it's probably all my fault.' The therapist noted that depression was certainly not her fault or failure and emphasized that despite her emotional pain, she manages the demanding task of caring for her four young children.

In discussing the support available to her while she was struggling with her depression, Lisa reported that her mother enjoyed taking care of her grandchildren. However, she also indicated that her mother was diabetic and assisted by a visiting nurse and that she felt guilty asking her to take on this extra burden, retorting 'she's already got enough going on, and I should be looking after them.' She indicated that her sister, who lived with her parents, was also involved with her children. The therapist encouraged Lisa to let her mother and sister take an active role in looking after the children until she recovered. The therapist also took this opportunity to restate that Lisa's depression was not her fault and that, like any other illness, Lisa needed to accept the support and give herself a chance to improve.

When the therapist asked Lisa what was happening in her life around the onset of her current symptoms, Lisa said 4 months ago, she lost her job and that this coincided with her live-in boyfriend—and father of her three youngest children—losing his job as well. As a result, the family's financial situation deteriorated dramatically, to the point where Lisa was worried that they might not be able to pay the rent, bills or car payments. She also indicated that being around her boyfriend all the time was a considerable source of stress, stating, 'I can't stand him.' She reported that their relationship had been difficult 'for a long time,' and that her boyfriend had been verbally abusive 'for ever.' On one occasion, shortly after losing his job, he had become physically abusive during a fight, and Lisa had called the police. However, she did not press charges; and since then, her boyfriend had not hit her again, although the verbal abuse continued. Lisa indicated that she felt physically safe because 'he is a coward, he won't want to face the cops again'.

While recounting her mounting difficulties since losing her job, Lisa became tearful. Her therapist reflected that she 'had so much on her plate right now' and asked her gently about which was her most pressing concern. When Lisa indicated that losing her apartment was her most immediate fear, together, they brainstormed advocates and sources of support to help with this problem. Lisa mentioned that in the past, she had been able to talk to the landlord about getting an extension on her rent and in the meantime could ask one of her sisters if she could lend her money to help pay it over the next few months. Lisa seemed somewhat relieved following this discussion.

The therapist suggested to Lisa that her current episode of depression appeared to have been triggered by a combination of the role transition of losing her job (and her resulting financial difficulties and fear of losing her home) and her interpersonal disputes, in the form of her increasing arguments with her boyfriend. She explained to Lisa that both these types of problems often trigger depression. Lisa indicated 'Yeah, that seems about right.' Before the end of the session, they set the schedule for the next two sessions, and the therapist explained the different treatment options that might be available afterwards.

Session 2

Lisa called to cancel her second appointment due to a bad headache. However, on presenting for the rescheduled session, she said that she felt a little better. On further inquiry, she showed minor improvements in two symptoms, sleeping a little better and feeling a little more interest. In particular, she had been mobilized to discuss her rent situation with her landlord, something she had been dreading and putting off. Although the landlord did not seem eager to help her out, she had also talked to a friend, who had recommended a housing clinic that offered services to tenants facing eviction.

When the therapist asked how things were going with her boyfriend, Lisa suggested that was an ongoing problem, further explaining that her more immediate, pressing concerns were finding a way to pay the rent, and finding help for her oldest son, whose teacher had called again since the last session complaining about his behaviour. Together, Lisa and the therapist discussed finding another temporary job to make ends meet and brainstormed who could help with this. One idea they came up with was Lisa asking

a friend to accompany her to supermarkets to inquire about supermarket cashier positions. Following from this discussion, Lisa revealed her longer-term goal of returning to community college to complete her studies to become a medical assistant.

Session 3

When Lisa came in for her third session, her symptoms had remained stable. She reported that she had an appointment with the housing clinic for the following week, but that her landlord was putting a lot of pressure on her to pay. As she still met the criteria for current major depression, her therapist suggested triaging her into ongoing depression treatments, clinical services or research protocols. She opted to become part of a treatment study at Columbia, which offered routinely-used medication to all treatment arms and also an assessment for patient's children. Lisa stated that the IPT-EST intervention, as well as the incentive of having her older son assessed in the depression study helped mobilized her to seek treatment at this point.

CONCLUSION

The aforementioned case example illustrated the principles and techniques of IPT-EST, a brief (three sessions), structured integrated model for adult primary care patients who screen positive for depression. The IPT-EST procedures are designed to provide guidance, management and support on triaging the patient into appropriate follow-up care if needed, thus bridging the gap to engagement and successful referral for those patients who need more sustained depression treatment and by providing specific content so that non-mental health professionals would be able to address this gap. The IPT-EST manual has been designed to promote ease of training, dissemination and generalizability to multiple patient contexts and settings. We are currently in the process of developing computer-assisted IPT-EST training and decision making tools to further ensure the effectiveness and feasibility of IPT-EST in the context of primary care.

HOW TO RECEIVE THE MANUAL AND REQUIREMENTS FOR BEING A COLLABORATOR

We are interested in having IPT-trained clinicians try out the manual and provide us with their clinical experience and feedback. If you are interested in participating, please contact M. Weissman at mmw3@columbia.edu.

REFERENCES

Angst, J., & Merikangas, K. (1997). The depressive spectrum: diagnostic classification and course. *Journal of Affective Disorders*, *45*(1–2), 31–39; discussion 39–40.

Campbell, T.L. (1987). Is screening for mental health problems worthwhile in family practice? An opposing view. *Journal of Family Practice*, *25*(2), 184–187.

Coyne, J.C., Fechner-Bates, S., & Schwenk, T.L. (1994). Prevalence, nature, and comorbidity of depressive disorders in primary care. *General Hospital Psychiatry*, *16*(4), 267–276.

Cuijpers, P., & Smit, F. (2004). Subthreshold depression as a risk indicator for major depressive disorder: A systematic review of prospective studies. *Acta Psychiatrica Scandinavica*, *09*(5), 325–331.

Cuijpers, P., Donker, T., van Straten, A., Li, J., & Andersson, G. (2010). Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychological Medicine*, *40*(12), 1943–1957.

Das, A.K., Olfson, M., Gameroff, M.J., et al. (2005). Screening for bipolar disorder in a primary care practice. *JAMA*, *293*(8), 956–963.

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A.J. (2006). Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine*, *66*(21), 2314–2321.

Gilbody, S., Sheldon, T., & House, A. (2008). Screening and case-finding instruments for depression: A meta-analysis. *CMAJ*, *178*(8), 997–1003.

Gross, R., Olfson, M., Gameroff, M.J., et al. (2005). Depression and glycemic control in Hispanic primary care patients with diabetes. *Journal of General Internal Medicine*, *20*(5), 460–466.

Judd, L.L., Akiskal, H.S., Maser, J.D., et al. (1998). A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. *Archives of General Psychiatry*, *55*(8), 694–700.

Klerman, G.L., Weissman, M.M., Rounsaville, B.J., & Chevron, E.S. (1984). Interpersonal psychotherapy for depression. New York: Basic Books.

Klerman, G.L., Budman, S., Berwick, D., et al. (1987). Efficacy of a brief psychosocial intervention for symptoms of stress and distress among patients in primary care. *Medical Care*, *25*(11), 1078–1088.

Miranda, J., & Cooper, L.A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine*, *19*(2), 120–126.

Mitchell, A.J., Vaze, A., & Rao, S. (2009). Clinical diagnosis of depression in primary care: A meta-analysis. *Lancet*, *374*(9690), 609–619.

Mossey, J.M., Knott, K.A., Higgins, M., & Talerico, K. (1996). Effectiveness of a psychosocial intervention, interpersonal counseling, for subdysthymic depression in medically ill elderly. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, *51*(4), M172–M178.

Mulrow, C.D., Williams, J.W., Gerety, M.B., et al. (1995). Case-finding instruments for depression in primary care settings. *Annals of Internal Medicine*, *122*(12), 913–921.

Neugebauer, R., Kline, J., Markowitz, J.C., et al. (2006). Pilot randomized controlled trial of interpersonal counseling for subsyndromal depression following miscarriage. *The Journal of Clinical Psychiatry 67*(8), 1299–1304.

Olfson, M., & Marcus, S.C. (2010). National trends in outpatient psychotherapy. *The American Journal of Psychiatry, 167*(12), 1456–1463.

Patel, V., Weiss, H.A., Chowdhary, N., et al. (2010). Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): A cluster randomised controlled trial. *Lancet*, *376*(9758), 2086–2095.

Pincus, H.A., Davis, W.W., & McQueen, L.E. (1999). 'Subthreshold' mental disorders. A review and synthesis of studies on minor depression and other 'brand names'. *The British Journal of Psychiatry*, *174*, 288–296.

Pinto-Meza, A., Serrano-Blanco, A., Peñarrubia, M.T., Blanco, E., & Haro, J.M. (2005). Assessing depression in primary care with the PHQ-9: Can it be carried out over the telephone? *Journal of General Internal Medicine*, *20*(8), 738–742.

Regier, D.A., Narrow, W.E., Rae, D.S., et al. (1993). The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50*(2), 85–94.

Rubenstein, L.V., Rayburn, N.R., Keeler, E.B., et al. (2007). Predicting outcomes of primary care patients with major depression: Development of a depression prognosis index. *Psychiatric Services*, *58*(8), 1049–1056.

Schulberg, H.C., Post, E.P., Raue, P.J., et al. (2007). Treating late-life depression with interpersonal psychotherapy in the primary care sector. *International Journal of Geriatric Psychiatry, 22*(2), 106–114.

Shapiro, S., Skinner, E.A., Kessler, L.G., et al. (1984). Utilization of health and mental health services. Three epidemiologic catchment area sites. *Archives of General Psychiatry, 41*(10), 971–978.

Spitzer, R.L., Kroenke, K., & Williams, J.B. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. *JAMA*, *282*(18), 1737–1744.

Sturm, R., & Wells, K.B. (1995). How can care for depression become more cost-effective? *JAMA*, *273*(1), 51–58.

U.S. Surgeon General. (2000). Mental health: A report of the surgeon general. Washington D.C.: U.S. Surgeon General's Office.

Unützer, J., Katon, W., Callahan, C.M., Williams, J.W. Jr, Hunkeler, E., Harpole, L., & IMPACT Investigators. (2002). Improving mood-promoting access to collaborative treatment. Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA*, *288*(22), 2836–2845.

Valenstein, M., Vijan, S., Zeber, J.E., Boehm, K., & Buttar, A. (2001). The cost-utility of screening for depression in primary care. *Annals of Internal Medicine*, *134*(5), 345–360.

Vidair, H., Boccia, A.S., Johnson, J.G., Verdeli, H., Wickramaratne, P., Klink, K., Softness, A.M., Dominguez-Rafer, C., Younge, R.G., & Weissman, M.M. (2011). Parental depression: Treatment needs and children's problems in an urban family medicine practice. *Psychiatric Services*, *62*, 317–321.

Weissman, M.M. (2005). Mastering depression through interpersonal psychotherapy. New York. Oxford University Press.

Weissman, M.M., & Olfson, M. (2009). Translating intergenerational research on depression into clinical practice. *JAMA*, *302* (24), 2695–2696.

Weissman, M.M., & Verdeli, H. (2010). Interpersonal psychotherapy: A three session evaluation, support and triage (IPT-EST). Available from mmw@columbia.edu

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

Weissman, M.M., Markowitz, J.C., & Klerman, G.L. (2007). A clinician's quick guide to interpersonal psychotherapy. New York, NY: Oxford University Press.

Weissman, M.M., Neria, Y., Gameroff, M.J., et al. (2010). Positive screens for psychiatric disorders in primary care: A long-term follow-up of patients who were not in treatment. *Psychiatric Services*, *61*(2), 151–159.

Wells, K.B., Schoenbaum, M., Unützer, J., Lagomasino, I.T., & Rubenstein, L.V. (1999). Quality of care for primary care patients with depression in managed care. *Archives of Family Medicine*, *8*(6), 529–536.

Williams, J.W., Pignone, M., Ramirez, G., & Perez Stellato, C. (2002). Identifying depression in primary care: A literature synthesis of case-finding instruments. *General Hospital Psychiatry, 24*(4), 225–237.

