

Special Issue Article

Interpersonal Psychotherapy: Past, Present and Future

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The authors briefly describe the origins, theory, and development of interpersonal psychotherapy: its roots in clinical outcome research, its spread from major depression to other psychiatric disorders and its increasing dissemination as an empirically validated clinical intervention included in treatment guidelines. They attempt to forecast research, organizational and training issues the growing interpersonal psychotherapy community may face in the future. Copyright © 2012 John Wiley & Sons, Ltd.

Key Practitioner Message:

- Multiple randomized controlled trials have shown that IPT effectively treats mood disorders, bulimia, and possibly other disorders in multiple randomized controlled trials.
- Time-limited treatment.
- Focuses on the relationship between mood and social circumstance.
- Improves social functioning while relieving symptoms.
- Builds social support, a crucial factor in many psychiatric disorders.

Keywords: Interpersonal, Psychotherapy, Diagnosis, Social Support, Life Events, Social Functioning

It began as an experiment, in a research setting. What became interpersonal psychotherapy (IPT) was developed and tested in New England in a study designed in 1969, when the late Gerald L. Klerman, M.D., Myrna M. Weissman, Ph.D., and their colleagues added a psychotherapy condition to an 8-month randomized controlled trial for patients with major depressive disorder (Weissman, 2006). IPT thus became part of the first clinical efficacy study of pharmacotherapy and psychotherapy for depression (Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974). The study yielded a manualized, time-limited psychotherapy, initially called 'high contact' and then renamed IPT. IPT was based on the principles of a medical model, defining major depression as a diagnosable and treatable psychiatric illness, and on empirically derived interpersonal factors related to depression (Klerman, Weissman, Rounsaville, & Chevron, 1984). Study results indicated that this therapy relieved depressive symptoms, improved social functioning and had additive effects to pharmacotherapy (Klerman et al., 1974; Weissman, Klerman, Prusoff, Sholomskas, & Padian, 1981; Weissman et al., 1979).

In 1969, Gerald L. Klerman, M.D., invited Dr Eugene Paykel from London to design a randomized trial of a

tricyclic antidepressant alone and with psychotherapy as a maintenance treatment for outpatients with unipolar depression. At that juncture, the optimal duration of maintenance pharmacotherapy and the role of psychotherapy in relapse prevention were not clear. At the time, many clinicians had an ideological belief in either medication or psychotherapy, disparaging the alternative (Weissman, 2006).

Klerman felt that a clinical trial of maintenance tricyclic antidepressants should mimic community practice: inasmuch as many depressed patients received both medication and psychotherapy in clinical practice, he wanted to include psychotherapy. If only as a milieu effect: as no firm evidence for psychotherapeutic efficacy existed, he was unsure whether psychotherapy would benefit patients. The first task in planning the study was to define the psychotherapy and specify the protocol. Klerman felt that the study psychotherapy should make sense in the context of time-limited treatment of depression. What emerged, initially called 'high contact' in contrast to a low therapist contact alternative, became IPT (Weissman, 2006).

Three principles guided this initial work: the use of a randomized controlled trial, using a broad range of standardized assessments, and recognition of the need to replicate study treatment findings before disseminating the treatment. The assessments included measures not only of symptoms but of social functioning and quality of life. Gerald Klerman entrusted Myrna Weissman, a

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newly graduated social worker, with the design of the psychotherapy. She used Aaron Beck's hundred-page, typed cognitive therapy manual as a guide, following Gerry's dictum that they needed to similarly manualize supportive psychotherapy. Although Klerman, a psychiatrist, saw depression as basically a biological illness, he was impressed by how social and interpersonal stress exacerbated onset and relapse. Noting that 'one of the great features of the brain is that it responds to its environment', he felt that the interpersonal context of the onset of a depressive episode might be a target for psychotherapy. The basic assumption was that the onset or recurrence of a depressive episode was related to the patient's social and interpersonal relationships at the time. The research group met weekly to develop the manual, reviewing cases and developing scripts from actual practice in order to define the treatment structure and content (Weissman, 2006).

This initial trial set the pattern for the history of IPT, which has progressed in a series of randomized outcome trials to test empirically the diagnoses and patient populations for which IPT works and does not work. In addition to its efflorescence as a research enterprise, IPT has been incorporated into national and international treatment guidelines, is practiced by growing numbers of clinicians, and has developed an international organization. This article describes the largely research-focused past of IPT, its current situation at what may be a crossroad and its potential future in a climate now—at least in the USA—more ambivalent than in the past about the value of psychotherapy.

THE PAST

The 1960s were a watershed for sex, politics, rock and roll, and psychotherapy. Before then, there had been essentially no clinical trials of psychotherapy. Not only were psychiatric diagnoses unreliable and often largely in the eye of the clinician, but psychotherapies were considered more art than science, and essentially untestable. This situation began to change with the development, manualization (Beck et al., 1979) and testing (Rush, Beck, Kovacs, & Hollon, 1977) of cognitive behavioural therapy (CBT) for depression in the late 1960s and early 1970s. Aaron Beck and Gerald Klerman were in contact during the development of the CBT and IPT manuals (Weissman, 2006). At this same crucial moment, diagnosticians were developing the Research Diagnostic Criteria (Spitzer, Endicott, & Robins, 1978) and eventually the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (American Psychiatric Association, 1980), which made it possible to reliably define groups of patients with relatively homogeneous disorders. In this environmental setting, IPT arose.

Although this was an early moment in psychotherapy outcome research, the first IPT study (Klerman et al., 1974) contained forward-looking features. This randomized controlled trial assessed not only depressive symptoms

but psychosocial functioning. The psychotherapy was manualized (Klerman et al., 1984). IPT defined major depression as a treatable medical condition that was not the patient's fault—a fairly radical idea at the time, although it has since been assimilated into general clinical practice. The psychotherapy itself was as empirically derived as was possible, on the basis of what was known about psychosocial aspects of depression:

- that social supports protect against psychopathology;
- that whatever the 'cause' of a depressive episode, it occurs in an interpersonal context and usually involves disruption of significant attachments and social roles;
- that the death of a significant other (grief), antagonistic relationships (role disputes), life disruptions or losses (role transitions), and isolative lack of social support (interpersonal deficits) are negative life events or circumstances that place vulnerable individuals at risk for a depressive episode; and
- that it is useful to work on change in social functioning in the 'here and now' to improve symptoms.

The underlying interpersonal theory of IPT incorporated Harry Stack Sullivan's and Adolf Meyer's observations of the importance of interpersonal context and environment in the course of psychiatric illness (Lidz, 1966; Sullivan, 1953) and Bowlby's crucial understanding of emotional attachment and the consequences of interpersonal loss and separation (Bowlby, 1973, 1998). From this outlook, Klerman's clinical research group constructed a time-limited, supportive, patient-friendly intervention that helped depressed patients to link affects to life circumstances (Figure 1): to name their feelings, to understand them as social cues, and to learn to express them effectively in order to improve their social situations. The hope was that this intervention would not only improve patients' social functioning but thereby relieve their depressive symptoms.

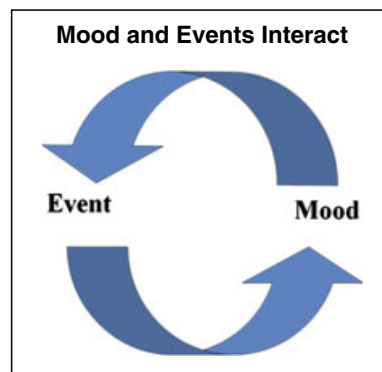


Figure 1. The IPT paradigm: mood and events interact

The first treatment trial compared the tricyclic antidepressant amitriptyline, pill placebo, IPT, a 'low contact' alternative to IPT, and combined IPT and amitriptyline. At the time many clinicians had strong ideological beliefs in either medication or psychotherapy that led them to favour one and to disparage the other (Rounsaville, Klerman, & Weissman, 1981). It was not known whether combining psychotherapy and antidepressant medication was tolerable or efficacious. And, of course, it was not known whether the psychotherapy that became IPT would work at all. It did. Treating 150 depressed women who had shown some response to 4–6 weeks of amitriptyline alone, Klerman and colleagues found that random assignment to 8 months of what became known as IPT was associated not only with improved symptoms but with better social functioning.

The same research team next compared 16 weeks of IPT with amitriptyline, combined amitriptyline/IPT, and a low contact condition for acutely depressed patients. Amitriptyline and IPT were each more efficacious than the control condition, and the combination of medication and IPT had greater benefit than either monotherapy alone (Weissman et al., 1979). Moreover, on follow-up a year later, patients who had received IPT reported improved social functioning, whereas patients treated with the tricyclic antidepressant alone did not (Weissman et al., 1981). Given the focus of IPT on improving social functioning, this outcome now hardly seems surprising.

Although these study results were exciting, Klerman, Weissman and their colleagues proceeded with caution, awaiting replication of their findings by other research groups before disseminating their manual in 1984 (Klerman et al., 1984). After their group had shown the benefit of IPT as both an acute and a continuation form of psychotherapy for depression, IPT was tested in the landmark NIMH Treatment of Depression Collaborative Research Program, the first direct comparison of IPT and CBT, which were each compared with imipramine and pill placebo, with the medications delivered by pharmacotherapists who provided some warmth and support (Elkin, Parloff, Hadley, & Atry, 1985). Two hundred fifty patients with major depressive disorder at three sites across the USA were randomly assigned to treatment.

Results indicated that patients with milder depression responded equally well to all four treatments (including the placebo), whereas *post hoc* analyses showed that for sicker patients, both imipramine and IPT were superior to placebo, but CBT was intermediate, neither significantly worse than medication or IPT nor significantly better than placebo (Elkin et al., 1989). The NIMH Treatment of Depression Collaborative Research Program increased the visibility of IPT around the country. It allowed the examination of differential therapeutics, analyses of which treatments worked best for which subsets of depressed patients. For example, it indicated that patients with

interpersonal deficits fared worst across all treatments, but particularly in IPT (Sotsky et al., 1991).

At this juncture, IPT had repeatedly demonstrated efficacy for major depression and might have begun to spread into clinical practice. Klerman, Weissman and their colleagues were more researchers than popularizers, however, and the death of Gerald Klerman in April 1992 further delayed the dissemination of IPT (Weissman, 2006). Thus, well into the 1990s, there were probably more published papers on IPT than IPT therapists. Most such therapists worked in a research rather than a purely clinical setting.

Nonetheless, research on IPT continued to grow. IPT was adapted for depressed patients with differing characteristics and depressive subtypes, such as adolescent (Mufson, Pollack Dorta, Moreau, & Weissman, 2004), post-partum (O'Hara, Stuart, Gorman, & Wenzel, 2000), geriatric (Reynolds et al., 1999), and medically ill (Markowitz et al., 1998; Schulberg et al., 1996) patients with major depression; patients with dysthymic disorder (Browne et al., 2002; Markowitz, 1998) and subthreshold depression (Klerman et al., 1987; Mossey, Knott, Higgins, & Talerico, 1996), and as an adjunctive treatment to pharmacotherapy for bipolar disorder (Frank et al., 2005; Swartz, Frank, Frankel, Novick, & Houck, 2009). Researchers began to test IPT for patients with diagnoses other than mood disorders: for example, bulimia (e.g., Fairburn et al., 1995) and substance abuse (Carroll, Rounsaville, & Gawin, 1991; Rounsaville, Glazer, Wilber, Weissman, & Kleber, 1983). Other research explored IPT formats: briefer (Swartz et al., 2004) and maintenance treatment (Frank, Kupfer, Wagner, McEachran, & Cornes, 1991), couples IPT (Foley, Rounsaville, Weissman, Sholomskas, & Chevron, 1989), group IPT (Wilfley et al., 2000) and IPT by telephone (Neugebauer et al., 2006; Ransom et al., 2008). IPT began to spread geographically, from the northeast USA to other parts of the country and to Europe and South America. Several groups, working from the IPT manual (Klerman et al., 1984) and with minimal input from outside IPT researchers, taught themselves IPT and used it to conduct important research (e.g., Blom et al., 2007; Browne et al., 2002; de Mello et al., 2001). In its most novel application, IPT was tested as a treatment for depression in Uganda in communities that had suffered from war, HIV and poverty as well as high rates of depression. Two controlled trials demonstrated the efficacy of group IPT for adults (Bolton et al., 2003) and adolescents (Bolton et al., 2007) in this setting.

THE PRESENT

The growth of IPT has continued to the present. Research has continued to expand in treating patients from different cultures (e.g., Bolton et al., 2003; Markowitz et al., 2009) and with different diagnoses: social anxiety disorder, PTSD and borderline personality disorder, among others. Not

all studies have been positive, of course: IPT alone had no spectacular success in treating patients with dysthymic disorder (Browne et al., 2002; Markowitz, 1998) but may add benefit to pharmacotherapy; it has had little benefit for anorexia nervosa (McIntosh, Bulik, McKenzie, Luty, & Jordan, 2000) nor in five studies for patients with substance abuse (which again, sadly, puts IPT in good company with other psychotherapies). The demonstrated efficacy of IPT in treating major depression (Cuijpers et al., 2011) and bulimia has led to its incorporation into professional and national treatment guidelines (American Psychiatric Association 2006, 2010; <http://guidance.nice.org.uk/CG90>).

These guidelines, economic pressures to conduct empirically established treatments, growing interest in time-limited therapies, along with published research and clinical reports, treatment manuals (Weissman, Markowitz, & Klerman, 2007), and IPT courses at psychiatric and psychological conferences, have fanned clinical interest in IPT. The last decade saw the formation of the International Society of Interpersonal Psychotherapy (ISIPT; <http://www.interpersonalpsychotherapy.org>), which has held increasingly well attended meetings in Pittsburgh (2004), Toronto (2006), New York (2009), and Amsterdam (2011). Each meeting has not only had larger attendance but presented a mushrooming growth in IPT research around the world.

Treatment manuals have been translated into multiple languages (including Danish, French, German, Italian, Japanese, Portuguese and Spanish), and IPT is increasingly widely practiced in North and South America, Europe, Australia, New Zealand and elsewhere. IPT was used in the first psychotherapy research studies ever conducted in Africa (Bolton et al., 2003). So IPT would appear to be in good shape.

THE FUTURE

Success not only engenders further success but breeds potential problems. Some of the issues we see arising for IPT in the present and foreseeable future concern its science, dissemination, standards, and governance and organization.

Science

We have learned a good deal about diagnostic indications for IPT but much remains unexplored. IPT research should continue to address its efficacy and effectiveness for untested diagnoses, indications for when to combine it with pharmacotherapy, and evaluation of optimal dosing and administration. Head to head studies with other psychotherapies may further develop differential therapeutics, the science of when to prescribe which empirically validated psychotherapy for a patient with a given

disorder. Moreover, IPT research to this point has focused nearly exclusively on outcome research. As it is now clear that IPT has efficacy for mood, eating, and possibly other disorders, it makes sense to further explore why and how it works. What factors mediate and moderate the efficacy of IPT? Are there environmental moderators or biomarkers that might distinguish when IPT is likely to benefit a depressed or bulimic individual? What aspects of IPT are 'active' ingredients, and what might prove to be inert? How can we bolster IPT to work more effectively for particularly difficult patients, for example, those who fit the 'interpersonal deficits' category?

Repeated clinical trials of IPT have indicated that life events can provide a plausible focus for depressed and otherwise dysphoric patients. The degree to which a patient resolves the interpersonal crisis on which IPT focuses seems to correlate with symptomatic improvement (Markowitz, Bleiberg, Christos, & Levitan, 2006). Therapist fidelity to IPT matters (Frank et al., 1991), as likely do the basic empathic skills of being a good psychotherapist, such as tolerating negative affect (Markowitz, & Milrod, 2011). Several clinical factors may also influence the efficacy of IPT (e.g., Thase, & Friedman, 1999).

Dissemination and Standards

Interpersonal psychotherapy is now spreading into clinical practice. It is taught in some psychiatric residency programmes (Lichtmacher, Eisendrath, & Haller, 2006; Markowitz, 1995) and graduate schools of psychology and social work, although not most US programmes (Weissman et al., 2006), and in continuing education courses at various professional meetings. Certain universities, such as the University of Toronto, have emerged as IPT educational centres. The growth of IPT into clinical practice has increased the need for clinical training materials. There is a paucity of demonstration videotapes of IPT cases. A *Casebook of Interpersonal Psychotherapy* (Markowitz & Weissman, 2012) will provide clinical background to supplement the available IPT treatment manuals.

As IPT spreads through clinical practice, there is the inevitable danger of its dilution and fragmentation. Like psychoanalysis and CBT, IPT risks becoming a catchphrase that different psychotherapists appropriate but assign very different meanings. Appropriate training and supervision is therefore obviously important. IPT trainees regularly ask about certification, but no certifying body exists. IPT initially spread from one research group to another, and the relatively small number of research clinicians and intensive training and supervision (including at least two closely supervised pilot cases) served to keep the treatment relatively homogeneous and pure. This process no longer applies in the non-research setting.

Different training groups have sprung up, but there is no single standard for what constitutes adequate training or competence in the clinical practice of IPT, and there is no official 'diploma' for training. The UK IPT group has proposed rigorous guidelines for certification of IPT therapists and supervisors (www.interpersonalpsychotherapy.org/onlineDocuments/isipt_accreditation_standards.pdf), but it is not clear that these will be universally or even widely adopted. Needs differ from locale to locale, as professional standards for psychotherapies differ greatly from country to country. The time and effort that would be required to monitor the quality of IPT training around the world is massive, and no one has yet found the time or initiative to undertake it. The ISIPT thus far left training standards to the discretion of individual IPT societies in different regions, but the potential for problems is clear. Until IPT becomes a required training in psychiatric, graduate psychology, social work and psychiatric nursing training programmes, dissemination will be compromised. In the USA, graduate accreditation mandates recently have led to markedly increased training in CBT, but these same requirements have dictated training in supportive psychotherapy rather than IPT.

Governance and Organization

Among the purposes of the nascent ISIPT will be maintaining gross uniformity of standards of IPT and maintaining communication among researchers and clinicians interested in IPT. This loose-knit organization has always been a collegial group. We should take pains to keep it this way: the history of psychotherapy has repeatedly involved fragmentation of movements as theorists and their followers split off from an original approach. Certainly, the loose governance of IPT has not resembled the authoritarian hierarchy that caused such difficulties in psychoanalysis (Makari, 2008, p. 5). Cognitive behavioural therapy has also struggled with diffusion in its theory and practice.

CONCLUSIONS

Interpersonal psychotherapy is a growing treatment, and despite the vagaries of grant funding and the economic pressures that generally oppress psychotherapy, it should continue to flourish. Never intended as a treatment for all patients and all diagnoses (as what treatment is?), IPT has proven its worth to many clinicians and patients. The treatment has proven impressively adaptable over time. There remains much room for expansion both in research and clinical practice. Whereas in the past the question was 'Does psychotherapy work?', we know that some psychotherapies clearly do work, IPT among them. Nevertheless, as Klerman and his colleagues noted in the very

first IPT publication, 'There remain many unanswered questions about the value of psychotherapy' (Klerman et al., 1974, p. 190). He went on to say that the answers to these questions should be empirically determined. IPT should remain empirically based, as it began.

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