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Interpersonal Psychotherapy for Depression

Depressive Disorders

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Interpersonal Psychotherapy for Depression¹

This chapter will describe Interpersonal Psychotherapy (IPT) for depression, including the theoretical and empirical bases, efficacy studies, and derivative forms, and will also make recommendations for its use in clinical practice.

Interpersonal Psychotherapy (IPT) is based on the observation that major depression—regardless of symptom patterns, severity, presumed biological or genetic vulnerability, or the patients' personality traits— usually occurs in an interpersonal context, often an interpersonal loss or dispute. By clarifying, refocusing, and renegotiating the interpersonal context associated with the onset of the depression, the depressed patient's symptomatic recovery may be accelerated and the social morbidity reduced.

IPT is a brief, weekly psychotherapy that is usually conducted for 12 to 16 weeks, although it has been used for longer periods of time with less frequency as maintenance treatment for recovered depressed patients. It has been developed for ambulatory, nonbipolar, nonpsychotic patients with major depression. The focus is on improving the quality of the depressed patients' current interpersonal functioning and the problems associated with the onset of depression. It is suitable for use, following appropriate training, by experienced psychiatrists, psychologists, and social workers. Derivative forms have been developed for nonpsychiatric nurse practitioners. It can be used alone or in combination with drugs.

IPT has evolved over 20 years' experience in the treatment and research of ambulatory depressed patients. It has been tested alone, in comparison with, and in combination with tricyclics in six clinical trials with depressed patients—three of maintenance (Frank, Kupfer, & Perel, 1989; Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974; Reynold & Imber, 1988) and three of acute treatment (Elkin et al., 1986; Sloane, Staples, & Schneider, 1985; Weissman et al., 1979). Two derivative forms of IPT (Conjoint Marital (IPT-CM); Foley, Rounsaville, Weissman, Sholomskas, & Chevron, 1990), and Interpersonal Counseling (IPC; Klerman et al., 1987), have been developed and tested in pilot studies. Six studies have included a drug comparison group (Elkin et al., 1986; Frank et al., 1989; Klerman et al., 1974; Reynold & Imber, 1988; Sloane et al., 1985; Weissman et al., 1979), and four have included a combination of IPT and drugs (Elkin et al., 1986; Klerman et al., 1974; Sloane et al., 1985; Weissman et al., 1979). Two studies (Reynold & Imber, 1988; Sloane et al., 1985) have modified the treatment to deal with special issues of elderly depressed patients.

The concept, techniques, and methods of IPT have been operationally described in a manual that has undergone a number of revisions. This manual, now in book form (Klerman, Weissman, Rounsaville, & Chevron, 1984), was developed to standardize the treatment so that clinical trails could be undertaken. A training program developed (Weissman, Rounsaville, & Chevron, 1982) for experienced psychotherapists of different disciplines provides the treatment for these clinical trials. To our knowledge, there is no ongoing training program for

practitioners, although workshops are available from time to time, and the book can serve as a guide for the experienced clinician who wants to learn IPT.

It is our experience that a variety of treatments are suitable for major depression and that the depressed patients' interests are best served by the availability and scientific testing of different psychological as well as pharmacological treatments, to be used alone or in combination. Clinical testing and experience should determine which is the best treatment for a particular patient.

THEORETICAL AND EMPIRICAL BACKGROUND

The ideas of Adolph Meyer (1957), whose psychobiological approach to understanding psychiatric disorders placed great emphasis on the patient's environment, comprise the most prominent theoretical sources for IPT. Meyer viewed psychiatric disorders as an expression of the patient's attempt to adapt to the environment. An individual's response to environmental change and stress was mostly determined by prior experiences, including early experiences in the family, and by affiliation with various social groups. Among Meyer's associates, Harry Stack Sullivan (1953) stands out for his emphasis on the patient's current psychosocial and interpersonal experience as a basis for treatment.

The empirical basis for IPT includes studies associating stress and life events with the onset of depression; longitudinal studies demonstrating the social impairment of depressed women during the acute depressive phase and the following symptomatic recovery; studies by Brown, Harris, and Copeland (1977) which demonstrated the role of intimacy and social supports as protection against depression in the face of adverse life stress; and studies by Pearlin and Lieberman (1979) and Ilfield (1977) which showed the impact of chronic social and interpersonal stress, particularly marital stress, on the onset of depression. The works of Bowlby (1969) and Henderson and associates (1978) emphasized the importance of attachment bonds, or, conversely, showed that the loss of social attachments can be associated with the onset of major depression; and recent

epidemiologic data showed an association between marital dispute and major depression (Weissman, 1987). The sequence of causation between depression and interpersonal dispute is not clear from any of this research.

Components of Depression

Within the framework of IPT, major depression is seen as involving three components:

1. *Symptom formation*, which includes the depressive affect and vegetative signs and symptoms, such as sleep and appetite disturbance, loss of interest and pleasure;
2. *Social functioning*, which includes social interactions with other persons, particularly in the family, derived from learning based on childhood experiences, concurrent social reinforcement, and/or current problems in personal mastery of social situations;
3. *Personality*, which includes more enduring traits and behaviors, such as the handling of anger and guilt, and overall self-esteem. These constitute the person's unique reactions and patterns of functioning and may contribute to a predisposition to depression, although this is not clear.

IPT attempts to intervene in the first two processes. Because of the brevity of the treatment, the low level of psychotherapeutic intensity, the focus on the context of the current depressive episode, and the lack of evidence that any psychotherapy changes personality, no claim is made that IPT will have an impact on the

enduring aspects of personality, although personality functioning is assessed. While some longer-term psychotherapies have been designed to achieve personality change using the interpersonal approach (Arieti & Bemporad, 1979), these treatments have not been assessed in controlled trials.

THE CHARACTERISTICS OF INTERPERSONAL PSYCHOTHERAPY

Goals of IPT with Depression

A goal of IPT is to relieve acute depressive symptoms by helping the patient to become more effective in dealing with those current interpersonal problems that are associated with the onset of symptoms. Symptom relief begins with educating the patient about depression—its nature, course, and prognosis, and the various treatment alternatives. Following a complete diagnostic evaluation, the patient is told that the vague and uncomfortable symptoms are part of a known syndrome that has been well described, is understood, is relatively common, responds to a variety of treatments, and has a good prognosis. Psychopharmacological approaches may be used in conjunction with IPT to alleviate symptoms more rapidly. Table 19.1 describes the stages and tasks in the conduct of IPT.

Treating the depressed patient's problems in interpersonal relations begins with exploring which of four problem areas commonly associated with the onset of depression is related to the individual patient's depression: grief, role disputes, role transition, or interpersonal deficit. IPT then focuses on the particular interpersonal problem as it relates to the onset of depression.

TABLE 19.1. Stages and Tasks in the Conduct of IPT

Stages	Tasks
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Early Treatment of depressive symptoms

- Review of symptoms
- Confirmation of diagnosis
- Communication of diagnosis to patient
- Evaluation of medication need
- Education of patient about depression (epidemiology, symptoms, clinical course, treatment prognosis)

Assessment of interpersonal relations

- Inventory of current relationships
- Choice of interpersonal problem area

Therapeutic contract

- Statement of goals, diagnosis, problem area
- Medication plan
- Agreement on time frame and focus

Middle Treatment focusing on one or more problem areas

- Unresolved grief
- Interpersonal disputes
- Role transition
- Interpersonal deficits

Termination Discussion of termination

- Assessment of need for alternate treatment

IPT Compared with Other Psychotherapies

The procedures and techniques in many of the different psychotherapies

have much in common. Many of the therapies have as their goals helping the patient develop a sense of mastery, combating social isolation, and restoring the patient's feeling of group belonging.

The psychotherapies differ, however, as to whether the patient's problems are defined as originating in the distant or immediate past, or in the present. IPT focuses primarily on the patient's present. It differs from other psychotherapies in its limited duration and in its attention to the current depression and the related interpersonal context. Given this frame of reference, IPT includes a systematic review of the patient's current relations with significant others.

Another distinguishing feature of IPT is its time-limited nature. Even when used as maintenance treatment, there is a definite time course (Frank et al., 1989; Klerman et al., 1974; Reynold & Imber, 1988). Research has demonstrated the value of time-limited psychotherapies (usually once a week for less than nine to 12 months) for many depressed outpatients (Klerman et al., 1987). While long-term treatment may still be required for changing chronic personality disorders, particularly those with maladaptive interpersonal and cognitive patterns, and for ameliorating or replacing dysfunctional social skills, evidence for the efficacy of long-term, open-ended psychotherapy is limited. Moreover, long-term, open-ended treatment has the potential disadvantage of promoting dependency and reinforcing avoidance behavior.

In common with other brief psychotherapies, IPT focuses on one or two problem areas in the patient's current interpersonal functioning. Because the focus is agreed upon by the patient and the psychotherapist after initial evaluation sessions, the topical content of sessions is focused and not open-ended.

IPT deals with current, not past, interpersonal relationships; it focuses on the patient's immediate social context just before and since the onset of the current depressive episode. Past depressive episodes, early family relationships, and previous significant relationships and friendship patterns are, however, assessed in order to understand overall patterns in the patient's interpersonal relationships.

IPT is concerned with interpersonal, not intrapsychic phenomena. In exploring current interpersonal problems with the patient, the psychotherapist may observe the operation of intrapsychic mechanisms such as projection, denial, isolation, or repression. In IPT, however, the psychotherapist does not work on helping the patient see the current situation as a manifestation of internal conflict. Rather, the psychotherapist explores the patient's current psychiatric behavior in terms of interpersonal relations.

EFFICACY OF IPT

The efficacy of IPT has been tested in several randomized clinical trials. Table 19.2 describes the efficacy data on IPT and its derivatives— alone, in comparison with, or in combination with drugs (Weissman, Jarrett, & Rush, 1987).

TABLE 19.2. Efficacy Studies of IPT and Its Derivatives

Study No.	Treatment Condition	Diagnosis (No. of patients)	Time weeks/ (years)	Reference
<i>Acute Treatment Studies</i>				
1	IPT + amitriptyline/ami/IPT/nonscheduled treatment	MDD (N=96)	16	Weissman et al. (1979)
2	IPT/nortriptyline/placebo	MDD or dysthymia, age 60+ (N =30)	6	Sloane, Staples, & Schneider (1985)
3	IPT/CB/imipramine +management/placebo + management	MDD (N= 250)	16	Elkin, et al. (1986)
<i>Maintenance Treatment Studies</i>				
4	IPT/low contact +	Recovered	32	Klerman,

	amitriptyline/placebo/ no pill	MDD (N=150)		Weissman, Rounsaville, & Chevron (1974)
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5	IPT/IPT +placebo/ IPT + imipramine/ management + imipramine management + placebo	Recovered recurrent MDD (N =125)	(3)	Frank, Kupfer, & Perel (1989)
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6	Same design as #5	Recovered recurrent MDD, geriatric (N= 120)	(3)	Reynold & Imber (1988)
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Derivative IPT

7	Conjoint IPT-CM/individual IPT for marital disputes	MDD+ marital disputes (N=18)	16	Foley, Rounsaville, Weissman, Sholomskas, & Chevron (1990)
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8	Interpersonal Counseling (IPC) for distress/treatment as usual	High score GHQ (N=64)	6	Klerman et al. (1987)
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IPT as Maintenance Treatment

The first study of IPT began in 1967 and was on maintenance treatment

(study 4 in Table 19.2). At that time, it was clear that the tricyclic antidepressants were efficacious in the treatment of acute depression. The length of treatment and the role of psychotherapy in maintenance treatment were unclear. Our study was designed to answer those questions.

One hundred and fifty acutely depressed outpatients who had responded to a tricyclic antidepressant (amitriptyline) with symptom reduction were studied. Each patient received eight months of maintenance treatment with drugs alone, psychotherapy (IPT) alone, or a combination. We found that maintenance drug treatment prevented relapse and that psychotherapy alone improved social functioning and interpersonal relations, but had no effect on symptomatic relapse. Because of the differential effects of the treatments, the combination of the drugs and psychotherapy was the most efficacious (Klerman et al., 1974) and no negative interaction between drugs and psychotherapy was found.

In the course of that project, we realized the need for greater specification of the psychotherapeutic techniques involved and for the careful training of psychotherapists for research. The psychotherapy had been described in terms of conceptual framework, goals, frequency of contacts, and criteria for therapist suitability. However, the techniques, strategies, and actual procedures had not been set out in a procedure manual, and there was no training program.

IPT as Acute Treatment

In 1973 we initiated a 16-week study of the acute treatment of 81 ambulatory depressed patients, both men and women, using IPT and amitriptyline, each alone and in combination, against a nonscheduled psychotherapy treatment (DiMascio et al., 1979) (study 1 in Table 19.2). IPT was administered weekly by experienced psychiatrists. A much more specified procedural manual for IPT was developed. By 1973, the Schedule for Affective Disorders and Schizophrenia (SADS) and Research Diagnostic Criteria (RDC) were available for making more precise diagnostic judgments, thereby assuring the selection of a more homogeneous sample of depressed patients.

Patients were assigned randomly to IPT or the control treatment at the beginning of treatment, which was limited to 16 weeks since this was an acute and not a maintenance treatment trial (Weissman, Klerman, Prusoff, Sholomskas, & Padian, 1981). Patients were assessed up to one year after treatment had ended to determine any long-term treatment effects. The assessment of outcome was made by a clinical evaluator who was independent of and blind to the treatment the patient was receiving.

In the latter part of the 1970s, we reported the results of IPT compared to tricyclic antidepressants alone and in combination for acute depressions. We demonstrated that both active treatments, IPT and the tricyclic, were more effective than the control treatment and that combined treatment was superior to either treatment (DiMascio et al., 1979; Weissman et al., 1979).

In addition, we conducted a one-year follow-up study which indicated that the therapeutic benefit of treatment was sustained for a majority of patients. Patients who had received IPT either alone or in combination with drugs were functioning better than patients who had received either drugs alone or the control treatment (Weissman et al., 1981). There remained a fraction of patients in all treatments who relapsed and for whom additional treatment was required.

Other Studies of IPT for Depression

Other researchers have now extended IPT to other aspects of depression. A long-term period of maintenance of IPT is underway at the University of Pittsburgh, conducted by Frank, Kupfer, and Perel (1989) to assess the value of drugs and psychotherapy in maintenance treatment of chronic recurrent depressions (study 5 in Table 19.2). Preliminary results recently published on the first 74 patients, studied over 18 months, showed that maintenance IPT as compared to maintenance imipramine in remitted patients with recurrent major depression (three or more episodes) significantly reduced recurrence of new episodes. Fifty percent of the patients receiving maintenance medication had experienced a recurrence by 21 weeks, while those assigned to IPT did not reach the 50 percent recurrence rate until 61 weeks. The presence of a pill or no pill did not significantly relate to patient recurrence. A similar study in a depressed geriatric patient population is also underway at the University of Pittsburgh (study 6 in Table 19.2).

Sloane (study 2 in Table 19.2) completed a pilot six-week trial of IPT as compared to nortriptyline and placebo for depressed elderly patients. He found partial evidence for the efficacy of IPT over nortriptyline for elderly patients, primarily due to the elderly not tolerating the medication. The problem of medication in the elderly, particularly the anticholinergic effect, had led to the interest in psychotherapy for this age group.

The NIMH Collaborative Study of the Treatment of Depression

Given the availability of efficacy data on two specified psychotherapies for ambulatory depressives, in the late 1970s, the NIMH, under the leadership of Drs. Parloff and Elkin, designed and initiated a multicenter, controlled, clinical trial of drugs and psychotherapy in the treatment of depression (study 3 in Table 19.2). Two hundred and fifty outpatients were randomly assigned to four treatment conditions: (a) cognitive therapy; (b) interpersonal psychotherapy; (c) imipramine; and (d) a placebo-clinical management combination. Each patient was treated for 16 weeks. Extensive efforts were made in the selection and training of psychotherapists. Outcome was assessed by a battery of scales which measured symptoms, social functioning, and cognition. The initial entry criteria were a score of at least 14 on the 17-item Hamilton Rating Scale for Depression. Of the 250 patients who entered treatment, 68 percent completed at least 15 weeks and 12 sessions of treatment. The preliminary findings from three Centers (Oklahoma City, Washington, DC, and Pittsburgh) were reported at the American

Psychiatric Association Annual Meeting, May 13,1986, in Washington, DC (Elkin et al., 1986). The full data have not yet been published. Overall, the findings showed that all active treatments were superior to placebo in the reduction of depressive symptoms over a 16-week period.

1. The overall degree of improvement was highly significant clinically. Over two-thirds of the patients were symptom-free at the end of treatment.
2. More patients in the placebo-clinical management condition dropped out or were withdrawn—twice as many as for interpersonal psychotherapy, which had the lowest attrition rate.
3. At the end of 12 weeks of treatment, the two psychotherapies and imipramine were equivalent in the reduction of depressive symptoms and in overall functioning.
4. The pharmacotherapy, imipramine, had rapid initial onset of action, but by 12 weeks, the two psychotherapies had produced equivalent results.
5. Although many of the patients who were less severely depressed at intake improved with all treatment conditions—including the placebo group—more severely depressed patients in the placebo group did poorly.
6. For the less severely depressed group, there were no differences among the treatments.

7. Forty-four percent of the sample were severely depressed at intake. The criteria of severity used was a score of 20 or more on the Hamilton Rating Scale for Depression at entrance to the study. Patients in IPT and in the imipramine groups consistently and significantly had better scores than the placebo group on the Hamilton Rating Scale. Only one of the psychotherapies, IPT, was significantly superior to placebo for the severely depressed group. For the severely depressed patient, interpersonal psychotherapy did as well as imipramine.

8. Surprisingly, one of the more important predictors of patient response for IPT was the presence of an endogenous depressive symptom picture measured by RDC following an interview with the SADS. This was also true for imipramine; however, this finding for drugs would have been expected from previous research.

DERIVATIVES OF IPT

IPT in a Conjoint Marital Context

Although the causal direction is unknown, clinical and epidemiologic studies have shown that marital disputes, separation, and divorce are strongly associated with the onset of depression (Weissman, 1987). Moreover, depressed patients in ambulatory treatment frequently present marital problems as their chief complaint (Rounsaville, Prusoff, & Weissman, 1980; Rounsaville, Weissman, Prusoff, & Herceg-Baron, 1979). Yet, when psychotherapy is prescribed, it is unclear whether the patient, the couple, or the entire family should be involved. Some evidence suggests that individual psychotherapy for depressed patients involved in marital disputes may promote premature separation or divorce (Gurman & Kniskern, 1978; Locke & Wallace, 1976). There have been no published clinical trials comparing the efficacy of individual versus conjoint psychotherapy for depressed patients with marital problems.

We found that marital disputes often remained a complaint of the depressed patient despite the patient's symptomatic improvement with drugs or psychotherapy (Rounsaville et al., 1980). Because IPT presents strategies for managing the social and interpersonal problems associated with the onset of depressive symptoms, we speculated that a conjoint version of IPT, which focused intensively on problems in the marital relationship, would be useful in alleviating those problems (study 7 in Table 19.2).

Individual IPT was adapted to the treatment of depression in the context of marital disputes by concentrating its focus on a subset of one of the four problem areas associated with depression for which IPT was developed—interpersonal marital disputes. IPT-CM (Conjoint Marital) extends individual IPT techniques for use with the identified patient and his or her spouse. The treatment incorporates aspects of currently available marital therapies, particularly those that emphasize dysfunctional communication as the focus on interventions. In IPT-CM, functioning of the couple is assessed in five general areas: communication, intimacy, boundary management, leadership, and attainment of socially appropriate goals. Dysfunctional behavior in these areas is noted, and treatment is focused on bringing about improvement in a small number of target problem areas. A treatment manual and a training program like those used in IPT were developed for IPT-CM.

Only patients who identified marital disputes as the major problem associated with the onset or exacerbation of a major depression were admitted into a pilot study. Patients were randomly assigned to IPT or IPT-CM, and received 16 weekly therapy sessions. In IPT-CM the spouse was required to participate in all psychotherapy sessions, while in IPT the spouse did not meet with the therapist. Patients and spouses in both treatment conditions were asked to refrain from taking psychotropic medication during the study without first discussing it with their therapists; therapists were discouraged from prescribing any psychotropic medication.

Three therapists (a psychiatrist, a psychologist, and a social worker) administered individual IPT to depressed married subjects. Three therapists (social workers) administered conjoint marital IPT. All therapists had extensive prior experience in the treatment of depressed patients. At the end of treatment, patients in both groups expressed satisfaction with the treatment, felt that they had improved, and attributed improvement to their therapy (Table 19.3). Patients in both groups exhibited a significant reduction in symptoms of depression and social impairment from intake to termination of therapy. There was no significant difference between treatment groups in the degree of improvement in depressive symptoms and social functioning by endpoint (Foley et al., 1990).

TABLE 19.3. Symptom and Social Functioning at End of Treatment in Depressed Patients with Marital Disputes Receiving IPT vs. IPT-CM

Outcome of Termination	Treatment Condition	
	IPT (N=9)	IPT-CM (N=9)
Depressive symptoms (Hamilton Rating Scale)	12.4	13.0
Overall social functioning	2.8	3.0
Marital adjustment* (Locke-Wallace)	4.7	5.8**

Affectional expression * (Spanier Dyadic)	6.5	8.6#
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*Higher score —better marital adjustment

**p< .05

#p< .10

The Locke-Wallace Marital Adjustment Test Scores at session 16 were significantly higher (indicative of better marital adjustment) for patients receiving IPT-CM than for patients receiving IPT (Locke & Wallace, 1976). Scores of the Spanier Dyadic Adjustment Scale (Spanier, 1976) also indicated greater improvement in marital functioning for patients receiving IPT-CM, as compared to IPT, and reported significantly higher levels of improvement in affectional expression (i.e., demonstrations of affection and sexual relations in the marriage).

The results must be interpreted with caution because of the pilot nature of the study—the small size of the pilot sample, the lack of a no-treatment control group, and the absence of a pharmacotherapy or combined pharmacotherapy-psychotherapy comparison group. If the study were repeated, we would recommend that medication be freely allowed or used as a comparison condition and that there be more effort to reduce the symptoms of depression before proceeding to undertake the marital issues.

Interpersonal Counseling (IPC) for Stress/Distress

Previous investigations have documented high frequencies of anxiety, depression, and functional bodily complaints in patients in primary care settings (Brodaty & Andrews, 1983; Goldberg, 1972; Hoepfer, Nycz, Cleary, Regier, & Goldberg 1979). Although some of these patients have diagnosable psychiatric disorders, a large percentage have symptoms that do not meet established criteria for psychiatric disorders. A mental health research program, part of a large health maintenance organization (HMO) in the greater Boston area, found that “problems of living” and symptoms of anxiety and depression were among the main reasons for individual primary care visits. These clinical problems contribute heavily to high utilization of ambulatory services.

We developed a brief psychosocial intervention, Interpersonal Counseling (IPC), to deal with patients’ symptoms of distress. IPC is a brief, focused, psychosocial intervention for administration by nurse practitioners working in a primary care setting (Weissman & Klerman, 1988). It was modified from interpersonal psychotherapy (IPT) over a six-month period, through an interactive and iterative process in which the research team met on a weekly basis with the nurse practitioners to review previous clinical experience, discuss case examples, observe video tapes, and listen to tape recordings.

IPC comprises a maximum of six half-hour counseling sessions in the primary care office, focused on the patient’s current functioning. Particular attention is given to recent changes in the person’s life events; sources of stress in

the family, home, and workplace; friendship patterns; and ongoing difficulties in interpersonal relations. IPC assumes that such events provide the interpersonal context in which bodily and emotional symptoms related to anxiety, depression, and distress occur. The treatment manual describes session-by-session instructions as to the purpose and methods for the IPC, including “scripts” to ensure comparability of procedures among the nurse counselors.

Subjects with scores of 6 or higher were selected for assignment to an experimental group that was offered interpersonal counseling (IPC), or to a comparison group that was followed naturalistically (study 8 in Table 2). Subjects selected for IPC treatment were contacted by telephone and invited to make an appointment promptly with one of the study’s nurse practitioners. During this telephone contact, reference was made to items of concern raised by the patient’s response to the General Health Questionnaire (GHQ), and the patient was offered an appointment to address these and other health issues of concern. Sixty-four patients were compared with a subgroup of 64 untreated subjects with similar elevations in GHQ scores during June 1984, matched to treated subjects on gender.

IPC proved feasible in the primary care environment (Klerman et al., 1987). It was easily learned by experienced nurse practitioners during a short training program of from eight to 12 hours. The brevity of the sessions and short duration of the treatment rendered IPC compatible with usual professional practices in a

primary care unit. No significantly negative effects of treatment were observed, and with weekly supervision, nurses were able to counsel several patients whose levels of psychiatric distress would normally have resulted in direct referral to specialty mental health care. In comparison with a group of untreated subjects with initial elevations in GHQ scores, those patients receiving the IPC intervention showed a significantly greater reduction in symptoms and improvement in social functioning over an average interval of three months. Many IPC treated patients reported significant relief of symptoms after only one or two sessions. Many of the patients had substantial depressive symptoms when they entered into the study.

This pilot study provided preliminary evidence that early detection and outreach to distressed adults, followed by brief treatment with IPC, can, in the short term, reduce symptoms of distress as measured by the GHQ. The main effects seem to occur in symptoms related to mood, especially in those forms of mild and moderate depression that are commonly seen in medical patients.

Although definitive evaluation of IPC awaits further study, this report of short-term symptom reduction suggests that this approach to outreach and early intervention may be an effective alternative to current practices. If so, then IPC may be a useful addition to the repertoire of psychosocial intervention skills that can be incorporated into routine primary care.

CONCLUSIONS

The Current Role of IPT in the Psychotherapy of Depression

While the positive findings of the clinical trials of IPT in the NIMH Collaborative Study and other studies described are encouraging and have received considerable attention in the popular press (Boffey, 1986), we wish to emphasize a number of limitations in the possible conclusion regarding the place of psychotherapy in the treatment of depression. All the studies, including those by our group and by the NIMH, were conducted on ambulatory depressed patients or patients experiencing distress. There are no systematic studies evaluating the efficacy of psychotherapy for hospitalized depressed patients or bipolar patients who are usually more severely disabled and often suicidal.

It is also important to recognize that these results should not be interpreted as implying *all* forms of psychotherapy are effective for depression. One significant feature of recent advances in psychotherapy research is in the development of psychotherapies specifically designed for depression—time-limited and of brief duration. Just as there are specific forms of medication, there are specific forms of psychotherapy. (See Weissman et al., 1987 for a review of other brief psychotherapies, particularly cognitive therapy for depression.) It would be an error to conclude that all forms of medication are useful for all types of depression; it would be an equal error to conclude that all forms of psychotherapy are efficacious for all forms of depression.

These investigations indicated that for outpatient ambulatory depression there is a range of effective treatments, including a number of forms of brief psychotherapy, as well as various medications, notably monoamine oxidase inhibitors and tricyclic antidepressants. These therapeutic advances have contributed to our understanding of the complex interplay of psychosocial and biological factors in the etiology and pathogenesis of depression, particularly ambulatory depression.

IPT and Drug Therapy Combined

A number of studies in the program described above compared IPT with medication and also evaluated the combination of IPT plus medication. Unlike other forms of psychotherapy, we have no ideological hesitation in prescribing medication. The decision to use medication in the treatment of depression should be based upon the patient's severity of symptoms, quality of depression, duration of disability, and response to previous treatment. It should not be based on the loyalties or training of the professional, as is too often the case in common clinical practice.

In our studies, IPT and medication, usually tricyclic antidepressants, have had independent additive effects. We have not found any negative interactions; in fact, patients treated with the combination of medication and psychotherapy have a lower dropout rate, a greater acceptance of the treatment program, and more

rapid and pervasive symptom improvement. Contrary to many theoretical discussions, the prescription of medication does not interfere with the patient's capacity to participate in psychotherapy. In fact, the opposite occurs. A reduction of symptoms facilitates the patient's capacity to make use of social learning.

A variety of treatments may be suitable for depression. The depressed patient's interests are best served by the availability and scientific testing of different psychological as well as pharmacological treatments, which can be used alone or in combination. The ultimate aim of these studies is to determine which treatments are best for specific subgroups of depressed patients.

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Notes

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