Interpersonal Psychotherapy for Major Depression
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Description of the Disorder

Major depression is a frequent disorder with high lifetime rates (lifetime prevalence 5–15%). It typically begins early in life (teens and young adulthood) and occurs about 2-3 times more commonly in women than men. It is a disabling condition that impacts school, work, and physical and family functioning. People who are depressed are more likely to abuse drugs and alcohol and to commit or attempt suicide. Symptoms of depression include feeling sad nearly everyday for at least two weeks; losing interest or pleasure in activities; having a decrease or increase in appetite; having problems with sleep; feeling restless or slowed down; losing energy; feeling worthless; not being able to think or concentrate, and/or frequent thoughts of death or suicide.

Treatment Comparisons

Interpersonal Psychotherapy (IPT), over 16-weeks, has been shown to be as effective as medication in two clinical trials with acutely depressed adult patients. It was better in reducing depressive symptoms than non scheduled treatment in one of the trials and placebo plus clinical management in the other. The effects on reducing depressive symptoms were slower than for medication. The effects in one trial were stronger for IPT as compared to cognitive therapy (CBT) in more severely ill depressed patients. The effects were best in one trial in patients who received both medication and IPT.

IPT has been shown to be more effective than CBT or supportive psychotherapy and equal to medication in a 16-week trial with depressed HIV patients. Sixteen weeks of IPT was as effective as medication and both medication and IPT were better than usual care in reducing depressive symptoms in depressed patients coming to a primary care clinic.

IPT for 12 weeks was more effective than waiting list control on reducing depressive symptoms and improving the mother’s interactions with her infant in women with postpartum depression.

IPT has been shown to be more effective on symptom reduction as compared to clinical monitoring in two clinical trials with depressed adolescents.

Three trials have tested IPT as continuation or maintenance treatment to prevent relapse or recurrence of depression. In one trial, weekly eight-month maintenance IPT was less effective than medication for symptom prevention but more effective than medication for improvement in social functioning. Patients on
the combination treatment had the best outcome. Two three-year monthly maintenance studies of IPT in adult and in geriatric depressed patients with severe recurrent depression found monthly IPT better than placebo in prevention of relapse, but not as effective as high-dose medication. In the geriatric patients with severe recurrent depression, patients in the combined medication and IPT groups had the best outcome as compared to either treatment alone or placebo.

**Treatment Description**

IPT is a time-specified treatment for patients with major depression. The length of treatment of acute depression has varied between 12-16 weekly sessions, and maintenance treatment as long as three years on a monthly basis. It can be used alone or with antidepressant medication. IPT makes no assumption about the "cause of depression," but is based on the observation that depression occurs in an interpersonal context. By understanding and solving the current interpersonal problem(s): grief, role disputes, transitions or deficits associated with the onset of symptoms; the patient will both improve their life situation and relieve their symptoms.

As an acute treatment, IPT has three phases. The first, usually 1-3 sessions, includes diagnostic evaluation and psychiatric history and sets the framework for the treatment. The therapist reviews symptoms using a systematic set of questions, diagnoses the patient as depressed by standard criteria, and gives the patient the sick role. The sick role may excuse the patient from overwhelming social obligations, but requires the patient to work in treatment to recover full function. The psychiatric history includes the "interpersonal inventory," a review of the patient's current social functioning and close relationships, their patterns and mutual expectations. Changes in relationships around the onset of symptoms are elucidated: e.g., death of a loved one, children leaving home, worsening marital strife, or isolation from a confidant. This review provides a framework for understanding the social and interpersonal context of the onset of depressive symptoms and defines the focus of treatment. Having assessed the need for medication based on symptom severity, past history and response to treatment and patient preference, the therapist educates the patient about depression by explicitly discussing the diagnosis, including the symptoms that define major depression, and what the patient might expect from treatment. The therapist next links the depressive syndrome to the patient's interpersonal situation in a formulation that uses as a framework one of four interpersonal problem areas: (1) grief; (2) interpersonal role disputes; (3) role transitions; or (4) interpersonal deficits. If the patient explicitly accepts this formulation as a focus for subsequent treatment, therapy enters the middle phase.

In the middle phase, the therapist pursues strategies specific to the chosen interpersonal problem area. For grief, defined as complicated bereavement following the death of a loved one, the therapist facilitates mourning and
gradually helps the patient to find new activities and relationships to compensate for the loss. *Role disputes* are conflicts with a significant other: a spouse or other family members, co-worker, or close friend. The therapist helps the patient explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it. If these fail, therapist and patient may conclude that the relationship has reached an impasse and consider ways to change the impasse or to end the relationship. *Role transition* includes change in life status: e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation, or diagnosis of a medical illness. The patient learns to deal with the change by mourning the loss of the old role while recognizing positive and negative aspects of the new role he or she is assuming, and taking steps to gain mastery over the new role. *Interpersonal Deficits*, the residual fourth IPT problem area, defines the patient as lacking social skills, including having problems in initiating or sustaining relationships, and helps the patient to develop new relationships and skills. Some patients who might seem to fall into the interpersonal deficits category may in fact suffer from dysthymic disorder, for which separate strategies have been developed.

IPT sessions address present "here and now" problems rather than childhood or developmental issues. Sessions open with the question: "How have things been since we last met?" This focuses the patient on recent interpersonal events and recent mood, which the therapist helps the patient to link. Therapists take an active, non-neutral, supportive and hopeful stance to counter the depressed patient's pessimism. They elicit and emphasize the options that exist for change in the patient's life, options that the depression may have kept the patient from seeing or exploring fully. Moreover, therapists stress the need for patients to test these options in order to improve their lives and simultaneously treat their depressive episodes.

The final phase of IPT, occupying the last few weeks of treatment or last months in case of maintenance treatment, supports the patient's sense of independence and competence by recognizing and consolidating therapeutic gains. The therapist also helps the patient to anticipate and develop ways of identifying and countering depressive symptoms should they arise in the future. IPT de-emphasizes termination: it is a graduation from successful treatment. The sadness of parting is distinguished from depressive feelings. If the patient has not improved, the therapist emphasizes that it is the treatment that has failed, not the patient, and stresses the existence of alternative effective treatment options. IPT uses techniques developed in various psychotherapies. For example, IPT employs a medical model consistent with pharmacotherapy; shares role playing and a “here and now” focus with cognitive therapy; and addresses interpersonal issues in a manner familiar to marital therapists. It is not its specific techniques but rather its overall strategies that make it a unique and coherent approach. Although IPT overlaps to some degree with psychodynamic psychotherapies, it also differs from them in significant ways: in its focus on the present, not the past, and on real life change; its medical model, and its avoidance of the transference and of genetic and dream interpretations. While it shares with cognitive therapy a
focus on a syndromal constellation (e.g., major depression), attention to the “here and now,” and techniques like role playing, IPT is considerably less structured, requires no explicit homework, and uses interpersonal problem areas as the major focus.

The techniques of IPT aid the patient’s pursuit of these interpersonal goals. The therapist repeatedly helps the patient to link life events to mood and symptoms. These techniques including an opening question that leads the patient to provide a history of mood and events; communication analysis, a recreation of recent, effectively charged life circumstances; an exploration of the patient’s wishes and options, to achieve those wishes in particular interpersonal situations; decision analysis, to help the patient decide which options to employ; and role playing, to help patients rehearse tactics for real life.

IPT deals with current rather than past interpersonal relationships, focusing on the patient's immediate social context. The IPT therapist attempts to intervene in symptom formation and social dysfunction associated with depression rather than addressing enduring aspects of personality.

IPT has been adapted and tested for adolescent and geriatric depressed patients, depressed HIV positive patients, depressed pregnant and post partum women and depressed patients coming to primary care. It has been adapted for use as acute, as well as maintenance treatment to prevent recurrence of depression; in a group format; as a telephone intervention and in a patient self-help guide.

The full descriptions of the techniques of IPT with case examples have been defined in a manual, which also include the adaptations (Weissman MM, Markowitz JC, Klerman GL. Comprehensive Guide to Psychotherapy. Basic Books, 2000). The early version of the manual has been translated into German, Italian and Japanese. A modification of IPT for Uganda is available. An international society to develop standards of training to provide information on opportunities and new clinical trials and adaptation across the world can be found in www.interpersonalpsychotherapy.org.

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