## CHAPTER 3

# The Origins and Development of Interpersonal Psychotherapy for Depression

Interpersonal psychotherapy (IPT) is a brief, time-limited psychotherapy that was initially developed in the late 1960s for the treatment of nonbipolar, nonpsychotic, depressed adult outpatients. The treatment is based on the premise that, regardless of the underlying cause of depression, the depression is inextricably intertwined with the patient's interpersonal relationships. IPT's goals are (1) to decrease depressive symptomatology and (2) to improve interpersonal functioning by enhancing communication skills in significant relationships (Klerman, Weissman, Rounsaville, & Chevron, 1984). IPT is a unique departure from other types of psychotherapeutic interventions because its focus is on current interpersonal conflicts, and it is one of the first therapeutic modalities to be operationalized in a treatment manual. IPT can be administered after appropriate training by experienced psychiatrists, psychologists, and social workers. It can be used alone or with medication. IPT for depressed adolescents (IPT-A) is an innovative adaptation of a psychotherapeutic treatment that already has been shown to be effective in clinical trials. This chapter describes the development, concepts, and evidence for the efficacy of IPT as well as IPT-A. By reviewing IPT's history and development, the reader will gain a greater understanding of

the conceptual framework that serves as the foundation for this adaptation.

## BACKGROUND

### Theoretical and Empirical Sources

IPT does not make any assumptions about the etiology of depression. However, IPT does assume that the development of clinical depression occurs in a social and interpersonal context and that the onset, response to treatment, and outcomes are influenced by the interpersonal relations between the depressed patient and significant others. This assumption is supported by the writings of Adolf Meyer and Harry Stack Sullivan as well as by more recent empirical investigation of the interpersonal model of depression.

The ideas of Adolf Meyer, whose psychobiological approach to understanding psychiatric disorders places great emphasis on the patient's relation to his or her environment (Meyer, 1957), form the theoretical foundation for IPT. Meyer views psychiatric disorders as an expression of the patient's attempt to adapt to his environment. An individual's response to environmental change is determined by prior experiences, particularly early experiences in the family and the individual's affiliation with various social groups. Harry Stack Sullivan, a colleague of Meyer, has written extensively about his own theories on interpersonal relationships (Sullivan, 1953).

According to Sullivan (1953), *psychiatry* is the study of interpersonal relationships under any and all circumstances in which these relationships exist. Sullivan states in his interpersonal theory of emotions that interpersonal behavior of other individuals forms the most significant class of events and objects that trigger emotions in people. He states that a large part of mental disorders results from and is perpetuated by inadequate communication. He emphasizes that a person's actions need to be understood and derive meaning from their historical or present interpersonal context. An appropriate treatment therefore would offer ways to identify interpersonal problems, clarify the conflict, and help the person to experiment with alternative behaviors (Horowitz, 1996).

Kiesler expands on the theory and develops an elaborate model of interpersonal communication and relationships focusing on issues of complementarity in communication and the patient's "evoking messages" (Kiesler, 1979). According to Kiesler, the therapist's job is to identify specific problematic interpersonal issues and how they manifest themselves in the patient's style of interpersonal communication. Then, through metacommunication about his interpersonal style, the therapist

helps to correct his problematic communications both with the therapist and others in the patient's life (Kiesler, 1979). While Klerman and Weissman's original model of IPT does not use the same specific language as Kiesler and Leary, nor the specific techniques of the interpersonal circumplex and impact messages (Kiesler, 1983), the techniques are very consistent and target the same goals of (1) changing communication and (2) solving interpersonal problems in order to change the level of satisfaction to be achieved from interpersonal relationships and thereby improve one's emotional well-being. The interactional perspective of depression addresses the reciprocal influences of a depressed person's communications occurring between the person and his significant others. This is consistent with IPT's goals of helping the patient understand how changing certain communications will change the responses that he elicits in his relationship and thereby change the emotional valence of that relationship, which will, in turn, reduce his feelings of depression.

The interpersonal theory of emotions has roots in early attachment theory, as does interpersonal psychotherapy (Klerman et al., 1984). Bowlby states that people have a propensity and need to make strong affectional bonds to particular others and experiences (e.g., separation or loss of these relationships) and give rise to emotional distress, including depression (Bowlby, 1978). Adolescence is a time when early attachments may lessen and become supplemented by new ones. These attachment transitions can be difficult to traverse and can result in depression. Many conflicts between parents and adolescents may be due to the effects of the adolescent's exploration and extension of relationships with peers on perceived attachment to his parents. IPT recognizes the importance and role of attachment in depression. It focuses on conflicts or transitions as well as grief in relationships that may affect the adolescent's feelings and perceptions of attachment and contribute to depression. IPT is a natural outgrowth of the attachment theorists' emphasis on exploring patterns of interaction with significant others and how these patterns may be repeated in other relationships or be causing difficulties in these relationships, manifested in the patient's response to particular life events. This leads to the same treatment goals of teaching the patient different ways to communicate and interact, changing the affective experience of the relationship.

## The Social Context of Depression

IPT is based not only on theory but also on empirical research, including studies associating stress, life events, and social impairment with the onset and clinical course of depression. Longitudinal studies demonstrating

the social impairment of depressed women during the acute phase of their depressive episode, as well as during their recovery, highlight the need for a treatment intervention that would directly address the persistent social problems of depressed adults (Klerman et al., 1984). Brown, Harris, and Copeland (1977) have demonstrated the role of intimacy and social supports as protection against depression in the face of adverse life stress and have supported the perceived importance of good social relations for emotional well-being.

Brown and Harris (1978), in *The Social Origins of Depression,* focus on the role of social factors in depression. They show that interpersonal factors are crucial in the creation of vulnerability to life stress. The most potent of these factors is the lack of an intimate and confiding relationship. The interactional theorists have sought to extend these findings by demonstrating that depressed persons engage the environment in ways that lose support from significant others and actually elicit depression-supporting feedback (Coyne, 1976), making the person vulnerable to increased depression. Studies demonstrate that experiences such as early parental loss (Brown & Harris, 1978), having a depressed parent (Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997), and poor parenting (Parker, 1979) contribute to the development of depression in adolescence and later in life, supporting the orientation of both the adult manual as well as the adolescent adaptation. Interestingly, another group of researchers has focused on the role of adaptive interpersonal functioning in protecting against depression. They have demonstrated that coping strategies, such as approach instead of avoidance, direct problem solving, and seeking out information from others rather than making assumptions, can buffer people against the depressogenic effects of negative life events (Holahan, Moos, & Bonin, 1999). These protective techniques are the very focus of the middle phase of IPT and are significant strategies used to facilitate recovery from depression as well as to prevent relapse or recurrence.

## ORIGINS IN ADULT WORK

IPT itself has evolved over nearly 25 years of treatment and research experience with ambulatory depressed adult patients. The development began in 1968 as part of a clinical trial for depressed outpatients intended to test approaches to preventing relapse following reduction of acute symptoms of depression with pharmacotherapy (Klerman et al., 1984). By the mid-1960s it was clear that the new antidepressants were effective in reducing acute depressive symptoms. Sleep, appetite, and mood usually improved in 2–4 weeks. However, the relapse rate was high, and it

was unclear how long medication should be continued and whether there was any advantage to adding psychotherapy. The intent of standardizing the psychotherapy in a manual for the first clinical trial was to ensure a consistent approach among therapists. The intent, however, was not to develop a new psychotherapy but to describe what we believed was a treatment that included the best and most important components of good clinical practice with depressed patients.

## Clinical Depression as Conceptualized in IPT

Clinical depression, within the IPT framework, is conceptualized as having three component processes (Klerman et al., 1984; Weissman, Markowitz, & Klerman, 2000):

1. *Symptom formation,* involving the development of the depressive affect, signs, and symptoms that may derive from psychobiological or psychodynamic mechanisms, or both.
2. *Social functioning,* involving social interactions with other persons, which derives from learning based on childhood experiences, concurrent social reinforcement, and current personal efforts at mastery and competence as a result of the depression; and
3. *Personality,* involving more enduring traits and behaviors; the handling of anger and guilt and overall self-esteem that constitute the person's unique reactions and patterns of functioning and that may contribute to a predisposition to symptom development.

IPT, as it was originally developed, intervenes in the first two processes. Due to the brevity of the treatment, low level of psychotherapeutic intensity, and focus on the current depressive episode, IPT does not purport to have an impact on the enduring aspects of personality.

In fact, in IPT, there is the intentional avoidance, during the treatment of the acute symptomatic episode, of issues related to personality functioning and character pathology. The reluctance to focus on personality traits is most pronounced in work with adolescents. Our clinical experience has shown us that very often behaviors demonstrated by the adolescents during the acute illness that appear to be personality traits (e.g., dependency, splitting and viewing people as all bad or all good, instability of relationships) tend to resolve with the alleviation of symptoms. This suggests that these characteristics are more secondary as symptoms of the Axis I depression and its effect on relationships at this stage of life rather than any enduring personality pathology.

We define IPT at three levels: (1) strategies for approaching specific tasks, (2) techniques used to accomplish these tasks, and (3) therapeutic stance. IPT resembles other therapies in techniques and stance, but not in strategies as they are applied to specific tasks. The therapeutic strategies of IPT are to help the patient master the interpersonal context of the depression. Strategies include (1) education; (2) clarification of feelings and expectations; (3) clarification of roles in family, peer group, and community; and (4) facilitation of social competence. Techniques can include communication analysis, interpersonal problem solving, and modeling as well as role playing.

IPT has been evaluated in a number of studies for depression both as an acute and a maintenance treatment. These controlled clinical trials provide the foundation for clinical practice utilizing IPT and for efforts to modify IPT for application to other clinical conditions. IPT has been tested alone, in comparison, and in combination with tricyclics in six clinical trials with depressed patients, three of acute treatment (Elkin et al., 1989; Sloane, Stapes, & Schneider, 1985; Weissman et al., 1979) and three of maintenance treatment (Frank et al., 1990; Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974; Reynolds & Imber, 1988; Weissman et al., 1974). Five completed studies have included a drug comparison group (Elkin et al., 1989; Frank et al., 1990; Klerman et al., 1974; Reynolds & Imber, 1988; Sloane et al., 1985; Weissman et al., 1979), and four have included a combination of IPT and drugs (Klerman et al., 1974; Kupfer, Frank, & Perel, 1989; Reynolds & Imber, 1988; Weissman et al., 1979). For a comprehensive review of the past studies and current adaptations of IPT, see *A Comprehensive Guide to Interpersonal Psychotherapy* (Weissman et al., 2000).

There are similarities and differences between IPT and the other major psychosocial treatments along several dimensions, including duration of treatment; whether the patient's problem is defined as lying in the distant past, the immediate past, or the present; explicit attention to the interpersonal context; and the use of specific therapeutic techniques. In brief, IPT deals with current, not past, interpersonal relationships, focusing on the patient's immediate social context just before and following the onset of the current depressive episode. Past depressive episodes, early family relationships, previous significant relationships, and friendship patterns are assessed in order to understand overall patterns in the patient's interpersonal relations. The psychotherapist does not frame the patient's current situation as a manifestation of internal conflict or as a recurrence of prior intrafamilial maladaptive patterns but rather explores the patient's current disorder in terms of interpersonal relations. In contrast to CBT, the IPT-A therapist focuses on changing relationship patterns rather than distorted cognitions, and there is less focus on sys-

tematic homework assignments targeting the cognitive distortions. They are similar in their goals of improving interpersonal problem-solving skills and assisting the adolescent in gaining a sense of social and emotional competence.

## Rationale for Use with Adolescents

The rationale for the adaptation of IPT for adolescents lies in research evidence, the developmental relevance of the treatment, and the clinical need in the community. As stated above, clinical research conducted in the 1970s and 1980s had clearly established the efficacy of IPT for the treatment of depression in adults (DiMascio et al., 1979; Elkin et al., 1989; Weissman et al., 1979). At the same time, other research has demonstrated the similarities between adolescent and adult depressive symptoms (Ryan et al., 1987). Chronic and significant psychosocial impairment and interpersonal difficulties are associated with adolescent depression (Hammen, 1999; Marx & Schulze, 1991; Puig-Antich et al., 1993; Stader & Hokason, 1998). They occur in acute stages, continue after recovery, and persist into adulthood. There is little question that major depression has an adverse effect on a child's academic performance, family and peer relationships, and overall functioning. Depression may increase alcohol and drug use and may lead to suicide attempts. In a study of prepubertal depressives, Garber and colleagues (1988) find that depressed adolescents have significant adjustment difficulties in social activities, family relationships, and significant partner relationships, while another study states that depressed children view themselves as less socially competent (Altmann & Gotlib, 1988). In a study of prepubertal children, after they had sustained recovery from their index episode, Puig-Antich and colleagues (1985a, 1985b) show that, while the children's school functioning improves, they still suffer impairment in familial and peer relationships. Thus, while their depression has resolved, they are left with interpersonal deficits.

IPT-A is an intervention that is specifically aimed at treating the interpersonal problems that are associated with adolescent depression. IPT-A focuses largely on current interpersonal issues that are likely to be areas of the greatest concern and importance to adolescents. Discussing interpersonal events is something adolescents can relate to and are accustomed to doing in their daily lives. The current adaptation, IPT-A, has modified the treatment goals and strategies of the specified problem areas to address the developmental tasks and abilities of adolescents. IPT-A focuses on damaged interpersonal relationships, particularly those occurring within the family. Parents and siblings are encouraged to become involved in the treatment either for support of the adolescent, for

direct intervention to change patterns in familial relations, or to affect intrafamilial communications. Thus, it effectively addresses the psychological context associated with depression: familial conflict, social competence, affective expression, and effective communication. Familial relationships are models for extrafamilial intimate relationships. Strategies for changing the adolescent's interpersonal relationships with family members can be extrapolated by the adolescent to relationships outside of the family system. IPT-A attempts to address these associated symptoms and impairments and to provide the adolescent with skills that will be helpful in the future as well as present interpersonal context.

## OVERVIEW OF BASIC PRINCIPLES OF IPT-A

IPT-A is designed as a once-a-week, 12-week-long treatment. The goals of the treatment are to reduce depressive symptoms and to address the interpersonal problems associated with the onset of the depression. The two main approaches for achieving these goals are to identify one or two problem areas as the focus of treatment and to emphasize the interpersonal nature of the problem as it occurs in current relationships. The treatment is divided into three phases: (1) the initial phase, (2) the middle phase, and (3) the termination phase. The initial phase focuses on confirmation of depression diagnosis, psychoeducation about the illness, exploration of the patient's significant interpersonal relationships, and identification of the problem area that will be the focus of the remainder of the treatment. Symptom relief begins with helping the patient understand that the vague and uncomfortable symptoms are part of a known syndrome that responds to various treatments and has a good prognosis. The major problem associated with the onset of the depression is identified, and an explicit treatment contract to work on this problem area is made with the patient. The topical content of the sessions is, therefore, not open-ended. The identified problem areas of IPT-A include grief reactions, parent–child disputes, peer conflicts, difficulty making transitions between stages in life, coping with stresses associated with changes in family structure, and communication problems.

During the middle phase of treatment, the therapist focuses on identifying specific strategies that can help the adolescents negotiate their interpersonal difficulties, within one or two problem areas, more successfully. For example, adolescents are taught communication skills to express their feelings regarding conflicts or disappointments in their relationships and life circumstances such as an absent father, an inconsistent father, or conflict about dating rules. Techniques include expression of

affect, clarification of expectations for relationships, communication analysis, interpersonal problem solving, and role playing new methods of interaction.

The goal of the termination phase is to clarify warning symptoms of future depressive episodes, identify successful strategies used in the middle phase, foster generalization of skills to future situations, emphasize mastery of new interpersonal skills, and to discuss the need for further treatment.

## MODIFICATIONS MADE FOR ADOLESCENTS

IPT has been selected for use with adolescents due to its developmental relevance to the adolescent population. However, several alterations have been made to the IPT manual to increase the model's appropriateness for the treatment of adolescent depression. Although the overall goals and problem areas of IPT are employed in IPT-A, the latter also includes a discussion, within the problem area of role transitions, of a specific type of role transition for adolescents that is due to family structural change. This separate discussion of a specific transition is included given the frequency with which it occurs for adolescents, its empirically demonstrated connection to depressive symptoms, and the interpersonal challenges and difficulties that are associated with this situation. A second adaptation is the addition of a parent component to the treatment protocol. Although IPT-A is an individual treatment, for many adolescents some degree of involvement on the part of the parent or guardian is often advisable and critical in promoting the well-being of the adolescent and in encouraging the success of the treatment. Parent involvement in IPT-A is flexible and can range from no involvement to attendance at several sessions. Recommendations typically include, in the least, involvement at the initial phase in order to be educated about the disorder and the treatment. The role of the parent or guardian in treatment is presented for each phase of the treatment, as described later in this volume.

The objectives of treatment have been altered slightly to take into account developmental tasks, including individuation, establishment of autonomy, development of interpersonal relations with members of the opposite sex and with potential romantic partners, coping with initial experiences amid death and loss, and managing peer pressure. Second, the techniques employed in the treatment for working toward the goals of decreasing depressive symptoms and improving interpersonal functioning have been geared toward adolescents. Techniques employed

specifically with adolescents include giving them a rating scale of 1–10 to rate their mood, which is concrete and makes it easier for them to monitor improvement; doing more basic social skills work; conducting explicit work on perspective-taking skills to counteract adolescent black-and-white thinking about solutions to problems; and learning how to negotiate, specifically, parent–child tensions. Strategies have been developed to include family members in various phases of the treatment as needed and to address special issues that arise in the treatment of adolescents, such as school refusal, physical or sexual abuse, suicidality, aggression, and involvement of a child protective service agency. These strategies are more fully discussed in the chapter on special issues in working with adolescents.

## OVERVIEW OF EFFICACY

The efficacy of IPT-A has been demonstrated in three randomized controlled clinical trials (Mufson et al., 1999, in press-a; Rosselló & Bernal, 1999). In the clinical trial conducted by Mufson and colleagues, IPT-A is superior to clinical monitoring with respect to decreasing depressive symptoms and increasing rates of recovery from depression and rates of retention in treatment. In addition, adolescents who received IPT-A demonstrate significant improvement in certain areas of social functioning and interpersonal problem-solving skills as compared to adolescents who received clinical monitoring. These findings, together with the results of Rosselló and Bernal (1999), demonstrate the effectiveness of IPT with depressed adolescents.

Current empirical investigations of IPT-A aim to reach a broader range of depressed adolescents by providing treatment in community-based practice settings. Adaptations are being made to make treatment delivery accessible to more teens. In the third clinical trial, Mufson and colleagues conducted an effectiveness trial comparing IPT-A to treatment as it is usually delivered in school-based health clinics located in impoverished urban communities. The study demonstrates the ability to train community clinicians to conduct IPT-A effectively as well as shows that IPT-A is significantly more effective compared to treatment as usual (TAU) in decreasing depression symptoms and improving global and social functioning in depressed adolescents (Mufson et al., in press-a). Mufson and colleagues also have a small-scale, randomized trial of the group version of IPT-A under way. If effective, the group version of IPT-A (Mufson et al., in press-b) possibly could be a more cost-effective treatment. A more complete discussion of IPT-A research can be found in

Chapter 19 on current and future research. Preliminary feedback suggests that the group model is at least acceptable and feasible. Findings from these studies will hopefully be part of the solution to the public health need to provide more empirically based, efficacious treatments for depressed adolescents.

## CONCLUSION

IPT has arisen out of the tradition of the interpersonal theorists and their emphasis on the importance of good interpersonal relationships for mental health. The significant evidence for the efficacy of IPT with depressed adults both as an acute and maintenance treatment served as the impetus for the adaptation of IPT for depressed adolescents. Importantly, there is increasing evidence for the efficacy of IPT-A. The development of psychotherapies specifically designed for depression that are time-limited and of brief duration is a significant advance in psychotherapy research.

The chapters that follow present the detailed treatment manual for IPT-A. This edition of the manual has been modified based on over a decade of experience treating adolescents both in hospital-based clinics as well as in the community, specifically in school-based health clinics. We hope to share the knowledge that we have gained from training diverse types of clinicians and participating in their experiences in applying IPT-A to a variety of adolescents suffering from depression. These experiences have culminated in this revised and expanded version of the IPT-A treatment manual, characterized by a more detailed delineation of our treatment principles, techniques, and therapeutic processes.



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