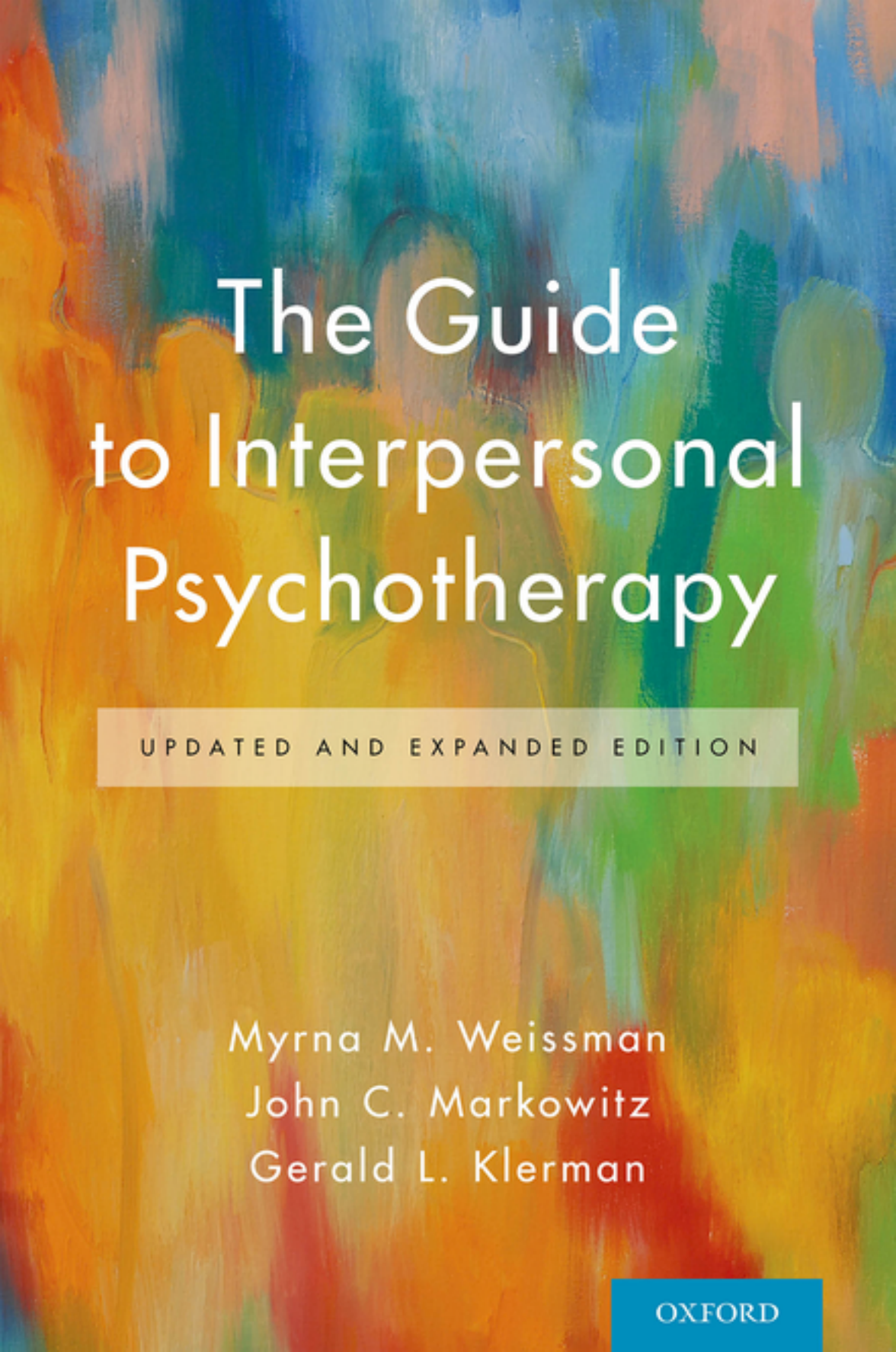
The Guide to Interpersonal Psychotherapy
UPDATED AND EXPANDED EDITION
Myrna M. Weissman
John C. Markowitz
Gerald L. Klerman
OXFORD

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CONTENTS

PREFACE: ABOUT THIS BOOK

Interpersonal psychotherapy (IPT) is one of the best-researched of the evidence-based psychotherapies. This book is designed as the "go to" manual for learning IPT for depression and its various adaptations for other disorders. It is also intended for clinicians who have had some exposure to IPT in workshops or supervision and want a reference book and a treatment manual for their practice. Researchers and clinicians who want to adapt IPT for a new diagnosis, age group, format, or culture may use this book as a foundation. We describe the elements, strategies, and techniques that define IPT. A range of mental health professionals may benefit from this book: psychiatrists, psychologists, social workers, nurses, school counselors, as well as workers in impoverished areas where few mental health treatment options may exist.

In the early 1970s, at the dawn of evidence-based psychotherapy research, Gerald L. Klerman, M.D., and Myrna M. Weissman, Ph.D., developed and, with colleagues, tested a short-term treatment for depression (Weissman, 2006). The success of their studies led to this treatment becoming known as IPT. The treatment was described in the original study manual, *Interpersonal Psychotherapy for Depression* (1984), and subsequently in the *Comprehensive Guide to Interpersonal Psychotherapy* (2000), the slimmed-down *Clinicians' Quick Guide for Interpersonal Psychotherapy* (2007), and the *Casebook of Interpersonal Psychotherapy* (2012). The current book, the descendent and update of those volumes, is the definitive IPT manual.

IPT has been repeatedly studied in randomized controlled trials. IPT studies have been published in major journals. These successes have led to its inclusion in treatment guidelines in Australia, Canada, Germany, Japan, the Netherlands, New Zealand, Norway, Scotland, Sweden, the United Kingdom, and the United States, and to its recognition and recommendation by the World Health Organization. Increasing numbers of practitioners have begun to learn the approach. In this context, several other IPT manuals have appeared. Some have been specialty manuals—elaborated adaptations of IPT for specific formats or treatment populations. Examples include a group treatment manual that the World Health Organization has adapted for dissemination worldwide (WHO, 2016) and manuals

outlining IPT for depressed adolescents (Mufson et al., 2011), bipolar disorder (Frank, 2005), and posttraumatic stress disorder (Markowitz, 2016) (Sections III through V of this book review these and other adaptations). Other manuals have imitated the book you are holding, sometimes departing from the evidence-based approach on which IPT was built. This book contains the material that provided the basis for the very earliest and subsequent IPT research and training, and is the platform on which to build future IPT research and practice.

Many clinicians have heard or read about IPT, but are not quite sure what it is or how to do it. Because programs in psychiatry, psychology, social work, and other mental health professions have been slow to incorporate evidence-based psychotherapy into their required training (Weissman et al., 2006), most mental health clinicians have not received formal training in IPT. Only in the past decade have many begun to learn IPT, primarily through postgraduate workshops or courses or by reading the Weissman et al. 2000 or 2007 manuals. This book now updates those.

We present a distillation of IPT in an easily accessible guide. This book contains a modicum of background theory—we have restored some of the material cut from the 2007 edition—but is designed to be, like IPT itself, practical and pragmatic. The book describes how to approach clinical encounters with patients, how to focus the treatment, and how to handle therapeutic difficulties. We provide clinical examples and sample therapist scripts throughout.

Section I (Chapters 1 and 2) sets a framework for IPT in the modern psychotherapeutic world and briefly outlines the approach. Section II (Chapters 3–11) describes in detail how to conduct IPT for major depressive disorder. You will need to read this section to know the basics of IPT. If you are interested in learning some of the adaptations of IPT for mood disorders with special populations or circumstances, proceed to Section III (Chapters 12–18) and, for non-mood disorders, to Section IV (Chapters 19–23). Although most of the IPT research was based on DSM-III or DSM-IV diagnoses, we have rearranged the grouping of diagnoses to follow the DSM-5 taxonomy. Section V (Chapters 24–26) deals with structured adaptations of IPT (cross-cultural adaptation and group, conjoint, telephone, and online formats), some of which are also covered in earlier chapters that describe the use of these modifications. Section V also addresses further training and finding IPT resources.

We have kept the chapters relatively brief so that you can quickly turn to topics of interest. Each chapter on an IPT adaptation for a particular diagnosis briefly relates the symptoms of the disorder, the specific modifications of IPT for that disorder, and the degree to which outcome data support this application. Rather than clutter the clinical text with descriptions of studies, we refer interested readers to the International Society of Interpersonal Psychotherapy website (http://ipt-international.org/), which maintains a periodically updated bibliography of research. The busy clinician may read the flow chart in Chapter 2 (Table 2.1) and proceed directly to Chapter 4, "Beginning IPT."

There are limits to what a book can provide. At best, it can offer guidelines to enhance practitioners' existing skills. If this is a "how to" book, it presupposes that the clinicians who use it understand the basics of psychotherapy and have experience with the target diagnoses or specific population of patients they are planning to treat. This book does not obviate the need for clinical training in IPT, including courses and expert supervision (see Chapter 26). On the other hand, trainers in resource-poor countries in humanitarian crisis have done quick trainings for health workers of necessity (Verdeli et al., 2008).

We dedicate the book to the late Gerald L. Klerman, M.D., a gifted clinical scientist who developed IPT with Dr. Weissman, his wife. As lead author of the original 1984 manual, he developed IPT but unfortunately did not live to see its current research advances and clinical dissemination. We thank many colleagues throughout the years who pushed the boundaries of IPT by developing and testing adaptations, and whose work is cited throughout.

This book has been updated for 2017, but the field is rapidly changing. Updates on studies may be obtained through the International Society of Interpersonal Psychotherapy (https://www.interpersonalpsychotherapy.org/).

All patient material has been altered to preserve confidentiality.

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We thank our partners, Jim and Barbara, for their patience and support through the lengthy review process. We thank Myrna's late husband, Gerry Klerman, for his brilliant and enduring ideas and drive, which provide the bedrock of this book and which are now spreading around the world. We thank the numerous far-flung members of the International Society of Interpersonal Psychotherapy who contributed updates on their work. Thanks also to Rachel Floyd and Lindsay Casal Roscum, who provided technical support on the text revision in New York. This book would not exist had not our editors at Oxford University Press, Sarah Harrington and Andrea Zekus, met with us on an icily rainy afternoon in early February 2016 and urged us to revise the 2007 book. They have provided invaluable support along the way.

Myrna Weissman and John Markowitz

SECTION I

Introduction

1

The Interpersonal Psychotherapy Platform

Since the publication of the 2007 version of this book, enormous changes have occurred in psychotherapy and in IPT. While overall psychotherapy use has declined slightly in the United States (Marcus et al., 2010), there has been a marked increase in the use of evidence-based psychotherapy and of IPT. This growth is reflected in IPT's inclusion in national and international treatment guidelines, the proliferating training programs (Stewart et al., 2014; IAPT, www.iapt.nhs.uk; http://www.iapt.nhs.uk/workforce/high-intensity/interpersonal-psychotherapy-for-depression/), an explosion of international interest, and the evolution of the International Society of Interpersonal Psychotherapy (ISIPT; http://ipt-international.org/).

For example, in 2016 the World Health Organization, in collaboration with the World Bank, declared the need to emphasize mental health treatment in health care; their mhGAP program[1] sponsored dissemination of IPT for depression all over the world. Other programs sponsoring IPT training and use are Grand Challenges Canada;[2] the international Strong Minds program in Uganda and elsewhere in Africa;[3] the use of IPT for refugees and national disasters in Haiti, Jordan, and Lebanon; and more recently for primary care in Muslim countries (see Chapter 24). These projects have highlighted the universality of interpersonal problems and of the wish to heal them. It has been relatively easy to adapt IPT for different cultures and settings, as human attachments and the response to the trigger of their breakage are conserved across cultures and countries. Communication in relationships varies with culture, but the fundamental issues and emotional responses to them remain the same. Rituals of death may vary by religion and culture, but the experience of grief following the death of a loved one

1. http://www.who.int/mental_health/mhgap/en/

2. http://www.grandchallenges.ca/

3. http://strongminds.org/

is nearly universal. Thus the elements of IPT, the problem areas and interventions, transfer readily across cultures, ages, and situations.

Yet the vast increase in IPT training at many levels, and the range of cultures and situations for which IPT has been adapted, raise questions about its elasticity and authenticity: How far can one alter the model and still call it IPT?

We call this book the *platform* for IPT. By platform, we mean both a manifesto or "formal declaration of principles" (www.thefreedictionary.com/platform) and the technical definition of "a standard for the hardware of a computer system, determining what kinds of software it can run" (http://www.oxforddictionaries.com/us/definition/american_english/platform). This book provides the platform for the clinical and research use of IPT, defining its essential elements. Any adaptation must have these elements to be considered IPT. The book also defines incompatibilities with IPT: absence of defined time limits or an interpersonal focus, jettisoning of the medical model, therapist passivity, focus on personality or on transference or cognitions, and so forth.

We are pleased that so many investigators and clinicians find the elements of IPT useful and have adapted them for differing treatment populations, diagnostic groups, and treatment formats. We encourage such exploration and adaptation. But to call what they do IPT, adaptors must employ the basic elements or describe why a particular one may not be suitable. To depart from the model we describe, which has been the basis for the research that put IPT on the international map, is to depart from the evidence base that gives IPT clinical validity.

ELEMENTS OF PSYCHOTHERAPY

In an effort to develop evidence-based standards for psychotherapy, the Institute of Medicine (IOM) in 2015 called for research on a common terminology of the elements of individual psychotherapy across psychotherapies and across diagnoses. The term "elements" has entered the evidence-based psychotherapy literature to denote the core components of treatment methods. The IOM defined "elements" as therapeutic activities, techniques or strategies that are either nonspecific or specific (IOM, 2015). Nonspecific elements, often described as "common factors" (Frank, 1971; Wampold, 2001), are common across psychotherapies. These techniques help to build a trusting therapeutic alliance, enable the patient to express intimate material, and account for a great, shared portion of the therapeutic benefit of all talking therapies (Wampold, 2001). These nonspecific elements, such as establishing confidentiality, engaging the patient, warmth, empathy, nonjudgmental listening, trust, and encouragement of affect, are all part of IPT (see Chapter 3). Common factors may be a necessary component of any therapy and account for a significant proportion of treatment outcome. These techniques, which IPT (and ideally all) therapists use to facilitate more specific IPT strategies, are neither unique nor new.

We describe more specific elements in Chapter 10. Specific IPT strategies include (1) using the medical model, in which the therapist defines and describes

the onset of symptoms and diagnosis, and gives the patient the "sick role"; (2) eliciting an interpersonal inventory; (3) specifying a time limit for treatment; and (4) presenting early in treatment a formulation linking an interpersonal problem area (grief, role dispute, role transition, or interpersonal deficits) to the psychiatric diagnosis. IPT also uses strategies such as helping patients to connect mood fluctuations to daily interpersonal events, communication analysis, and exploring interpersonal options, as well as techniques shared with cognitive-behavioral therapy (CBT) and other treatments, such as role play.

Some of these "specific" IPT elements arise in other psychotherapies, sometimes under other names. Nonetheless, the goals, the sequence, the emphases, and the explicit description of these elements to the patient as part of the therapeutic strategy are unique to IPT. These elements hold across the numerous IPT adaptations for different diagnoses, age groups, formats, and cultures. Many are captured by therapist adherence measures used in research studies (e.g., Hollon, 1984). Most importantly, the research evidence based on nearly 100 clinical trials derives from these specific elements. As health care (at least in the United States) moves toward measurement-based practice, fidelity measures may become used to ensure that clinicians in general practice do in fact use these elements of IPT appropriately as the basis for reimbursement.

Proponents of the "elements" approach, who apparently consider all psychotherapies fundamentally similar, have largely been cognitive-behavioral therapists who are comfortable with dismantling CBT into component parts. IPT, like other affect-based therapies (Milrod, 2015; Swartz, 2015), takes a more holistic approach. IPT may amount to more than the sum of its parts, and subtracting crucial elements may damage the treatment as well as depart from its evidence base. Hence we encourage researchers and clinicians to use IPT as an integrated whole and as a complete package, as defined in this book, making necessary adaptations defined for a specific patient population.

BOUNDARIES OF ADAPTATION

The adaptation of IPT for different disorders, symptoms, situations, and cultures has rapidly grown. Questions may arise about how much adaptation is reasonable while still retaining the title of IPT.

The basic specific elements of IPT we describe constitute the core of IPT. Researchers can modify these by adjusting time length, as in brief IPT, interpersonal counseling, or maintenance treatment. As for psychotherapy more generally, it remains unclear what the optimal length of IPT may be. Nonetheless, it is crucial to **define the time frame at the outset of treatment**: a fixed number of weekly sessions (or for maintenance, perhaps monthly) for a delineated duration. The pressure of the time limit helps drive IPT forward. IPT ingredients can be adapted for different ages (for example, adolescent, prepubescent, and geriatric), and the researcher may tweak the approach for the target population. An adaption may change the format (e.g., group or couples IPT) or the target

diagnosis (e.g., posttraumatic stress disorder [PTSD] or bipolar disorder). If the researcher shifts the diagnosis, the IPT focus on the relationship between syndrome and interpersonal context remains. Another basic principle and historical aspect of IPT is that such adaptations deserve testing to evaluate whether they work.

IPT adaptations for different cultures necessarily incorporate cultural sensitivities and customs. Examples include family participation in therapy sessions; disputes regarding the moving of a second wife into the home; concepts of death and ways of showing reverence to the dead; dealing with assertiveness; and avoiding direct criticism that might threaten the stability of *familismo* (Markowitz, 2009). Incorporating these differences as special issues again does not fundamentally change the clinical IPT paradigm linking mood to life circumstance. We thank the many IPT investigators who have contributed their adaptations to the field, many but hardly all of whom we cite in this book. Our overview is necessarily selective rather than exhaustive: too many IPT adaptations already exist to cover in this book, and we hope researchers will test many more.

More than one therapeutic approach may benefit patients with a particular diagnosis, and no one treatment works all the time. The availability of a range of evidence-based psychotherapies and somatic treatments (such as pharmacotherapy) that can benefit patients serves the public health interest. A therapeutic problem is how to respond to some clinicians' eagerness to combine different treatment approaches they like without violating the integrity of IPT as validated in clinical trials. We caution against casual therapeutic eclecticism, for two reasons:

1. Research evidence shows that thematic adherence—good therapist fidelity—is associated with better outcomes (Frank et al., 1991).
2. A patient in a time-limited therapy should leave treatment with a coherent understanding of how to respond to symptoms.

A therapist who mixes too many methods may look brilliant to the patient, seemingly having a (different) answer to every situation, but will leave the patient confused about how to handle life stressors after therapy ends (Markowitz & Milrod, 2015). Therapist adherence to a single, clear approach is more likely to communicate a useful model for responding to symptoms.

Nonetheless, it may be helpful on occasion to augment IPT with other treatment elements. When doing so, the clearest and likely most helpful way to proceed is to explicitly add a separate module to the IPT core. For example, motivational interviewing may help to encourage patients to engage in therapy or to diminish substance use (Swartz et al., 2008). Perhaps the best example of this is Ellen Frank's adding to IPT (for depression) a behavioral component to regulate levels of arousal and to preserve sleep for bipolar patients, an amalgam she terms Interpersonal and Social Rhythm Therapy (IPSRT; Frank, 2005). The innovator will need to consider whether mixing elements from different psychotherapies creates potential theoretical or practical treatment contradictions, and if so how

to address them. The modular approach keeps IPT and the added module distinct in their indications and potentially in the evaluation of their efficacy.

We fully support referring IPT patients to other evidence-based therapies, medication (which shares the medical model and hence can be easily combined with IPT), and/or an alternative psychotherapy, if IPT has not produced clinical progress or it becomes clear to patient and therapist that IPT is not the most appropriate treatment. The goal of therapy is that the patient achieve remission.

A final boundary issue is that other evidence-based psychotherapies might add IPT elements as modules, for example the interpersonal inventory or an interpersonal problem area. Developers of such approaches should not tinker with IPT and market it under a different name, which would only blur the field of psychotherapeutic evidence.

TRANSDIAGNOSTIC ISSUES

Another term that has arisen since 2007 is "transdiagnostic," describing psychotherapies and their elements that work across diagnoses. To some degree the rise of this term reflects the divergent adaptations of CBT, some of which are more cognitive and some more behavioral, for a range of differing disorders. Many of these specific CBT adaptations—for example, exposure and response prevention for obsessive-compulsive disorder—have shown impressive efficacy. The problem is that the approaches can so differ that therapists who are expert in one manualized CBT approach may be unskilled in a second one; this has led to a yearning for a single, unified approach that treats multiple diagnoses. IPT, by contrast, has always been "transdiagnostic." The core elements of IPT were developed to treat adults with major depressive disorder (MDD), but they all fundamentally apply wherever they have been tested, for example to bipolar disorder, social anxiety disorder, dysthymic disorder, and bulimia, across age groups and cultures. IPT for primary substance use does not appear efficacious (see Chapter 19).

There seems to be a near universality across cultures to attachment, interpersonal issues, social support, and their relation to psychopathology. A clinician should have familiarity with the target diagnosis when moving from treating MDD to using IPT for another disorder, but the basic IPT approach should fundamentally remain. In using IPT, regardless of diagnosis, the therapist needs to define the target disorder (or symptoms) and its onset, and to identify the focal interpersonal problem area in the patient's current life. The relationship between onset of diagnosis and interpersonal problem area should be maintained.

While we have emphasized diagnosis in treatment studies, IPT in primary care has targeted symptoms, and in resource-poor countries has targeted distress, successfully using the same linkage between focal interpersonal problem area and symptomatology. "Distress" usually includes symptoms of depression and/or anxiety, although other symptomatology is possible.

HOW DOES IPT WORK?

Exactly how any psychotherapy works is unknown. A therapeutic alliance is necessary; the "common factors" (Frank, 1971) play an important role; and specific factors may add to those. We describe below the theoretical (Bowlby, Sullivan, attachment theory) and the empirical (life events research) framework underlying IPT. Here we describe how the elements of IPT link to the framework (Fig. 1.1) and explain the mechanisms of change or how IPT may work.

The genetics underlying depression and all psychiatric disorders remains unknown, although considerable research has provided glimpses of understanding. Most psychiatric disorders run in families with moderate heritability (Guffanti et al., 2016), their expression moderated by the environment or families in which the individual lives. The recognition that the environment influences gene expression—the field of epigenetics—is growing in importance. Situations of environmental stress that threaten attachment, such as the death of a loved one, may be considered the proximal triggers (what IPT classifies as interpersonal problem areas) that can lead to phenotypic change, or symptom onset. IPT attempts to clarify the relationship between symptom onset (change in phenotype) and its trigger (the interpersonal problem area), propelled by the pressure of time-limited treatment. Much of the work in IPT involves helping patients to see the relationship between their environmental triggers and the changed phenotype, then encouraging them to find interpersonal responses to ameliorate the crisis (which is why we have made the arrows in Fig. 1.1 bidirectional).

Sometimes symptoms arise without dramatic environmental triggers and lead to interpersonal difficulties (role disputes or transitions). IPT is ultimately less interested in causality than in the connection between the two.

The nonspecific elements facilitate the relationship, establish trust, and provide some of the therapeutic effects of IPT. IPT uses "common factors" like affective arousal and success experiences (Frank, 1971) particularly effectively, helping patients to tolerate affect and use it as information to create interpersonal successes. The techniques include standardized methods for facilitating dialogue and evoking affect. The interpersonal inventory helps identify both the problem area (trigger) and potential social supports and dangers in the environment that the patient can manage to reduce symptoms.

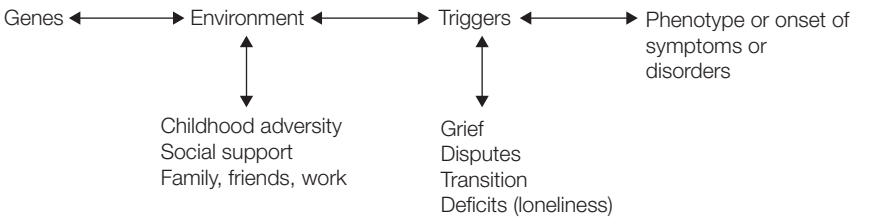

Figure 1.1. A Stress-Diathesis Model.

The diagnostic review, medical model, and psychoeducation in IPT help to clarify symptoms and their onset and to comfort patients about their prognosis and the range of available treatments. The time limit focuses the treatment, sets goals, pressures the work forward without formally assigning homework, and ensures that the therapist and patient consider alternative treatment options if the symptoms do not improve within a reasonable interval. The early work in acute treatment helps patients make the crucial recognition that their interpersonal encounters evoke strong feelings that, rather than being "bad" or "dangerous," provide interpersonal information (e.g., anger means someone is bothering you) they can reflect upon and use to handle their environment. The middle phase of IPT focuses on helping patients to do so. The focus is on the current "here and now" environment, not on the reconstruction of the patient's remote past to understand the current problem. Treatment focuses on the interpersonal meaning of the patient's emotions and how the patient can translate them into action to improve her life. The termination phase summarizes understanding of the process and what the patient has achieved, bolsters autonomy, and concludes acute treatment.

HISTORICAL, THEORETICAL, AND EMPIRICAL BASIS OF IPT

> One of the greatest features of the brain is that it responds to the environment.
>
> —*Klerman, circa 1973*

IPT was developed before the explosion in neuroscience and genetics research in psychiatry and before the notion of epigenetics gained prominence. It was developed in the context of refining assessment of new medications for psychiatric disorders and the development of tools to study the environment.

IPT grew from Gerald L. Klerman's belief that vulnerability to depression and other major psychiatric disorders had a biological basis. This was not a mainstream idea in the 1960s, when psychoanalytic thinking and theory dominated psychiatry. Klerman and other rising psychiatric leaders in those days were trained in psychoanalysis. While Klerman received analytic training, he began his research career at the National Institute of Mental Health (NIMH). He was a psychopharmacologist when he began the first large-scale study testing the efficacy of medication (in this case, amitriptyline) and psychotherapy for maintenance treatment of depression (Klerman et al., 1974; Weissman et al., 1981).

The psychotherapy, first called "high contact" in this trial (in contrast to a "low contact condition"), became IPT (Klerman et al., 1984; Markowitz and Weissman, 2012). It was added to the medication trial as a treatment arm in order to mimic clinical practice, as psychotherapy was widely used but had not been defined in manuals suitable for clinical trial testing. We defined high contact/IPT in a manual for the study to ensure reliable training of therapists. The need to test the new

psychiatric medications led to the development of rating scales and other tests on which Klerman capitalized for the study of psychotherapy.

The effect of the environment on the brain was a basic tenet of Klerman's thinking. During medical school, he had also studied sociology. As a resident in psychiatry he wrote about the effect of the ward atmosphere and family visits on patients' symptoms. Klerman saw that the brain responded to the environment. Therefore, psychotherapy could work through understanding both the toxic and supportive aspects of the environment in the patient's current life and close interpersonal relations, and relating these to the onset of symptoms. When Weissman joined Klerman in this work, she had just completed social work training, well before earning a Ph.D. in epidemiology. Her training in addressing current, practical social and interpersonal problems and functioning in the "here and now" fit naturally into the development of IPT.

The writings of Adolf Meyer and Harry Stack Sullivan, founders of the interpersonal school, which emphasized the effect of the patient's current psychosocial and interpersonal experience on symptom development, provided compatible theories for this practical therapy. By applying these ideas to depression, three component processes were identified (Klerman et al., 1984):

1. Symptom formation involving the development of depressive affect and the neurovegetative signs and symptoms. This component was hypothesized to be the primary target of medications.
2. Social and interpersonal relations involving interaction with others in social roles. Such relationships may be based on learning from childhood and other experiences, as well as current social reinforcement. This component led to the classification of the IPT focal problem areas. It was hypothesized that the prime target of psychotherapy would be reflected in social functioning.
3. Personality, involving enduring traits such as expression of anger, guilt, self-esteem, interpersonal sensitivity, and communication. These traits may predispose to depression, but it was hypothesized that neither psychotherapy nor medication would greatly affect them. However, successful symptom reduction and social functioning may reduce negative personality traits.

For a more comprehensive historical discussion of the evolution in psychiatric thinking from Freud and the interpersonal school, see Klerman et al. (1984).

Attachment Theory

Bowlby's work on attachment (1969) influenced IPT. Sadness and depressed mood are part of the human condition and a nearly universal response to disruption of close interpersonal relations. Bowlby argued that attachment bonds are necessary to survival: the attachment of the helpless infant to the mother helps to preserve

the offspring's biological survival. The continued presence of secure attachment figures helps a child to explore her physical environment and make social and group contacts, and to feel safe and supported in it. Many psychiatric disorders result from inability to make and keep affectional bonds. Disorders often have an onset with the disruption of an attachment bond (Milrod et al., 2014).

Bowlby used these observations to develop a general approach to psychotherapy that included examining current interpersonal relations and how they developed over the life span based on experience with various attachment figures. These ideas appear in IPT problem areas: grief, role disputes, role transitions, and interpersonal deficits of attachment, with the focus mainly on current relationships, not necessarily their past origins. IPT makes explicit the relationship between the symptoms/diagnosis onset and the proximal attachment disruptions. Attachment theory has stimulated a body of empirical research especially on mother–infant attachments (e.g., Fearon et al., 2006), as well as on offspring of depressed parents, attachment disruption of adults (Lipsitz & Markowitz, 2013), and epidemiological studies of social support, social stress, and life events. Related research addressed the importance of social supports as a compensation for loss and conflict (Brown & Harris, 1978). As more sophisticated rating scales were developed, this field became more empirically based.

Studies showing the onset of symptoms and disorders in association with stress, life events, and the long-term consequences of childhood maltreatment (Brown & Harris, 1978; Caspi et al., 2003) have emerged. Accelerating this work, the psychiatric epidemiology revolution beginning in the 1980s provided data on rates, risks, and onset of psychiatric disorders in large community samples (e.g., Kessler et al., 2005). Tools for examining the brain, such as the electroencephalogram (EEG) and magnetic resonance imaging (MRI), have been widely used in psychiatry for studying possible mechanisms. Few studies, however, have yet used such assessments to study IPT outcome (Brody et al., 2001; Martin et al., 2001; Thase et al., 1997).

Psychopharmacology Revolution

The development of IPT was influenced by the availability of new psychopharmacological agents and the need to systematically assess their efficacy in clinical trials. The use of the medical model; taking a medical history; making a diagnosis using systematic, serial assessments; and educating the patient had not been a psychotherapy tradition through the 1960s but developed as an essential part of medication trials. At that time, many practitioners considered medication and psychotherapy antithetical (Armor & Klerman, 1968; Klerman, 1991; Rounsaville et al.,1981), but these medicalized elements have now become more routine in psychiatry. The medical model was incorporated into the IPT initial phase assessment of symptoms—then a radical idea for psychotherapy—and social functioning assessments were encouraged, with flexibility as to which rating scales were used.

Testing IPT in controlled clinical trials, as one would test medication, was essential from the treatment's inception. The first IPT manual (Klerman et al., 1984) was not written until two further clinical trials showed efficacy, comparable to requirements for establishing the efficacy of medication. Clinical trials for adaptations were also required. This proved important when two early clinical trials showed that IPT was not efficacious for treating substance abuse (Carroll et al., 1991; Rounsaville et al., 1983).

Klerman advocated for research standards in psychotherapy that were comparable to those in pharmacotherapy research. He suggested that there be an equivalent of the Food and Drug Administration for psychotherapy (London & Klerman, 1982). Klerman felt that psychotherapy strategies should be specified in a manual with scripts to guide training and communication to ensure that psychotherapy procedures were comparable across therapists. He and Aaron Beck were friends and most respectful of one another. IPT and CBT developed in parallel until Klerman's untimely illness and death, which slowed IPT's development until recently.

EFFICACY AND EFFECTIVENESS

The efficacy of individual IPT for adults with major depression, which forms the platform for the manual, has been tested in many controlled clinical trials (Cuijpers et al., 2011). There are more than 100 clinical trials of IPT (Barth et al., 2013; Cuijpers et al., 2008, 2011, 2016). Based on careful reviews, the efficacy of IPT is well established compared to CBT, medication, and for other forms of mood and non-mood disorders. The efficacy for adaptations of major depression in different formats, age groups, and subtypes is presented in relevant chapters of this book.

2

An Outline of IPT

As an acute treatment, IPT has three phases: a beginning, a middle, and an end. Each phase lasts a few sessions and has specific tasks. A fourth phase may follow acute treatment: namely, continuation or maintenance treatment, for which therapist and patient contract separately (see Chapter 7). Table 2.1 (located at the end of this chapter) outlines the phases and strategies of IPT for major depression presented in Chapters 2 through 9. Most of the adaptations of IPT for other disorders or treatment populations follow a similar outline, with specific adaptations indicated in each chapter.

INITIAL SESSIONS

As treatment begins, the therapist works to establish a positive treatment alliance by listening carefully; eliciting affect; helping the patient to feel understood by identifying and normalizing feelings; and providing support, encouragement, and psychoeducation about depression. At the same time, the therapist has a sequence of tasks specific to IPT. Defining and diagnosing depression, exploring the patient's interpersonal inventory of current relationships to find potential social supports and interpersonal difficulties, providing the sick role, defining an interpersonal focus, and linking the focus to the depressive diagnosis in a focal formulation are key steps that set the stage for subsequent phases of the treatment. These initial steps also tend to provide early symptomatic relief.

Here are the steps for diagnosing depression:

1. Review the depressive symptoms or syndrome. Assess the patient's symptoms and their severity. Use a symptom presentation from the DSM-5 or ICD-11 to help the patient understand the diagnosis. Use a scale such as the Hamilton Rating Scale for Depression (Hamilton, 1960), the Beck Depression Inventory (Beck, 1978), QIDS (Rush et al., 2003), or PHQ-9 (Kroenke et al., 2001) to help the patient understand the severity and the nature of her symptoms. The Ham-D and the PHQ-9 appear in the appendices of this book. Explain what the score means, and alert the patient that you will be repeating the scale regularly to see

how treatment is progressing. (For a fuller range of depression and other rating scales, see APA & Rush, 2000.)

2. Give the syndrome a name: *"You are suffering from major depression."* Explain depression as a medical illness, and explain its treatment. Depression is an *illness*, a *treatable* illness, and *not the patient's fault*. Despite its symptom of hopelessness, depression has a good prognosis. Explain that you will be repeating the depression scale periodically so that both you and the patient can assess her progress.
3. Give the patient the **sick role**: "*If there are things you can't do because you're feeling depressed, that's not your fault: you're ill.*" However, the patient has a responsibility to work *as* a patient to get better.
4. Set a **time limit**. Explain to the patient that IPT is a time-limited treatment that focuses on the relationship between interactions with other people and how she is feeling. You will be meeting for X weekly sessions (define the number: generally eight to sixteen sessions in as many weeks), and the patient has a good chance of feeling better soon.
5. Evaluate the patient's need for medication. Prescribing medication may depend on symptom severity, comorbidity, the patient's treatment preference, and other factors. Many patients may recover from major depression with IPT alone. (If you do not prescribe medications, consider having the patient consult with someone who does.)
6. Relate depression to an interpersonal context by reviewing with the patient her current and past interpersonal relationships. Explain their connection to the current depressive symptoms. Determine with the patient the **interpersonal inventory**:
   - Nature of interaction with significant persons: How close does the patient get to others? How does she express anger?
   - Expectations of the patient and significant persons; differentiate them from one another and discuss whether these expectations were fulfilled
   - Satisfying and unsatisfying aspects of the relationships
   - Changes the patient wants in the relationships
7. Identify a **focal problem area:** grief, role disputes, role transitions, or interpersonal deficits.
   - Determine the problem area related to current depression, and set the treatment goals.
   - Determine which key relationship or aspect of a relationship is related to the depression and what might change in it.
8. Explain the IPT concepts and contract. Outline your understanding of the problem, linking illness to a life situation in a **formulation**:

   You're suffering from depression, and that seems to have something to do with what's going on in your life. We call that (complicated bereavement, a role dispute, etc.). I suggest that we spend the next X weeks working on solving that difficult life crisis. If you can solve that problem, your depression is likely to lift as well. Does that make sense to you?