The New Haven, CT, site of the first maintenance trial of interpersonal psychotherapy.

Brigitte Prusoff, Dr. Eugene Paykel, Dr. Gerald Klerman, and Eve Geanakopolis in group planning meeting for the first interpersonal psychotherapy trial.

Photos courtesy Dr. Myrna M. Weissman

A Brief History of Interpersonal Psychotherapy

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The story of interpersonal therapy (IPT) began in 1969 at Yale University, when Dr. Gerald Klerman was joined by Dr. Eugene Paykel from London to design a study to test the relative efficacy of a tricyclic antidepressant alone and both with and without psychotherapy as maintenance treatment of ambulatory nonbipolar depression. The evidence for the efficacy of tricyclic antidepressants for reducing the acute symptoms of depression was strong, yet the main treatment for depression at the time was psychodynamic psychotherapy. The few studies testing psychotherapy were behavioral treatments and were limited in scope and sample size. A manual for cognitive therapy (CT) was under development by Dr. Aaron Beck. At the time, it was clear that many patients with acute depression relapsed after termination of tricyclic antidepressant treatment. It was unclear how long psychopharmacologic treatment should continue and whether psychotherapy had a role in the prevention of relapse. Some psychotherapists thought medication would make patients less interested in psychotherapy, whereas some psychopharmacologists felt psychotherapy would undo the positive effects of medication by having patients talk about upsetting material.

Dr. Klerman, then head of the Connecticut Mental Health Center and on the faculty at Yale School of Medicine, felt that a clinical trial of maintenance tricyclic antidepressants should, as much as possible, mimic clinical practice. Be-

cause many patients in actual practice then received both psychotherapy and medication, either together or in sequence, he felt psychotherapy should be included in the maintenance treatment trial, if for nothing more than a milieu effect. He was not convinced he would find a psychotherapy effect, as there were no positive clinical trials of psychotherapy. In fact, there were no trials of patients receiving psychotherapy of sufficient sample size and design to draw any conclusions. Dr. Klerman was convinced that psychotherapy could be subjected to testing in a clinical trial.

In planning the trial, the task was first to define the type of psychotherapy and specify the procedures to be used. Psychotherapists could then be trained, and the quality and stability of treatment could be tested. He felt that the psychotherapy included in the trial should be what made sense in a time-limited treatment of depression. This common-sense clinical approach, initially called "high contact," was the basis for interpersonal therapy (IPT).

CME EDUCATIONAL OBJECTIVES

1. Review a brief history of interpersonal psychotherapy (IPT).
2. Describe the adaptations of IPT.
3. Discuss issues in training and dissemination of IPT.

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Three guiding principles governed this early work. First, randomized controlled clinical trials were important for testing and establishing the efficacy of all treatments including psychotherapy. Second, a broad range of standardized assessments were needed for measuring outcomes, including quality of life and social functioning. Finally, treatment results needed to be replicated. (Dr. Klerman did not develop training programs or make efforts for dissemination of IPT until findings were replicated outside the enthusiastic group of developers.)

So, the process of developing IPT began. The team included Drs. Klerman and Paykel, both psychiatrists; Brigitte Prusoff, a new graduate from the Yale Biostatistics Department; and me. (I was, at the time, an inexperienced social worker who could only work 2 days a week, as I had small children.) The clinical trial included amitriptyline, placebo, or no pill, with or without weekly psychotherapy, for 8 months in ambulatory patients with depression who had responded initially to medication.

We set about designing the psychotherapy. Dr. Klerman was impressed with Aaron Beck's progress in defining cognitive therapy. He gave me an approximately 100-page typed document from Dr. Beck, describing the procedures of CT. Dr. Klerman said that this was what we needed to do for supportive psychotherapy, which was to be used in the new trial, except he said "supportive psychotherapy" was a vague term and needed to be defined, as Beck had done for CT.

Several contextual features, I later realized, defined our approach to designing the psychotherapy. We were working in a psychopharmacologic clinic where making a diagnosis using standardized assessments and following the patient's clinical course were routine. Drs. Klerman and Paykel were developing standardized assessments and using control groups for assessing the role of life events in the onset and relapse of depression. Dr. Klerman was both a psychopharmacologist and psychotherapist, and, as leader of the team, his broad view of depression was reflected in what we did. While he thought depression was basically a biological illness, he was impressed with how social and interpersonal stress could exacerbate an onset and relapse. As he said, "One of the great features of the brain is that it responds to its environment."

Dr. Paykel, a London-trained psychiatrist, had a healthy skepticism about psychotherapy, an excellent knowledge of research design, and an open mind. We did not set out to define a new psychotherapy, but to define what we thought were the important components of good clinical supportive practice with ambulatory patients with depression.

We were given many books and articles to read, but the ones that guided us the most were the work of Sullivan,[1] with his focus on the current interpersonal context of a psychiatric illness. Sullivan stated that interpersonal behaviors of others form the most significant events that trigger emotions in people. Our progress was influenced by the ideas of Adolf Myers,[2] who put great emphasis on the patient's relationship to his or her environment, and the writings of Bowlby,[3] who stated that individuals make strong affectional bonds and the separation or threat of separation of these bonds give rise to emotional distress and depression. We were also influenced by the work on life events, both ours and others, which showed, consistent with the theoretical writings of Sullivan, Myers, and Bowlby, that events that represented exits from the social field were associated with depression.

In preparing the first draft of the psychotherapy (high contact) manual, we decided to begin by defining the dose and frequency of the treatment and the diagnostic process which became the first phase of IPT. This included a diag-

nostic evaluation; a psychiatric history; patient education about depression, the symptoms, and treatment alternatives; an interpersonal inventory of important people currently in the patient's life; the patient's sick role; a linking of symptoms to interpersonal situations; and a choice of problem areas associated with onset of the depressive episode. The problem areas were defined and came naturally from the work in life events: grief, such as complicated bereavement following a death; role disputes, such as conflicts with a significant other in renegotiation, dissolution, or impasse; role transitions, such as change in life status (eg, divorce, moving, retirement); and interpersonal deficits, such as lack of social skills, boredom, loneliness, or paucity of attachments.

The basic assumption was that there is a relationship between the onset and recurrence of a depressive episode and the patient's social and interpersonal relationships at the time. We met weekly to develop the manual, going over cases and developing scripts from actual practice to describe how to carry out the treatment and in what sequence. We were concerned that the procedures be specified so that we could train therapists to be consistent.

The Depression Research Unit, where the project was housed, was a cozy, somewhat dilapidated, wooden frame house converted into offices, two blocks from the new Connecticut Health Center and Yale Medical School. The work we were doing, testing psychotherapy and clinical trials of medication, was not highly regarded in academic circles. Even though Dr. Klerman was head of the Mental Health Center, he could not get space for the project on campus. The images on page 553 show the site of the first maintenance trial of IPT and one of our group planning meetings, including Dr. Paykel, Brigitte Prusoff, Dr. Klerman, and Eve Geanakopolis, an experienced social worker who was hired to conduct the treatment. We were soon joined on the other side of the building by the Yale Drug Dependency Unit, headed by Dr. Herb Kleber, to deal with the emerging drug epidemic in New Haven and most major cities, and the new treatment with methadone. Dr. Klerman, Dr. Kleber, and I formed many collaborations, joined by Dr. Bruce Rounsaville, then a young psychiatrist, on a treatment study of methadone-maintained patients using IPT, a clinical trial with negative results.

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The final piece of work to accomplish before starting the maintenance study was the target psychotherapy outcome measure. Dr. Klerman said medication should help the patient sleep and eat better, but it should not help the patient get along better with a spouse. That is where he felt psychotherapy would likely have its effect. The next task was to design the social functioning measures. Dr. Paykel and I did a review and found the social functioning measures had either too low a threshold, designed for newly ambulatory patients with schizophrenia as part of the National Institute of Mental Health's multisite studies of antipsychotic medication, or were designed for college students and focused on sex and dating. Our patients were primarily middle-aged, married women with children from large, extended families. Their important areas of functioning were not captured by any of the existing scales. Therefore, we took a little from several scales and developed questions on functioning in marriage, children, family, and extended family. Dr. Klerman then said we must test the scale's validity. Could we discriminate cases from controls or acutely ill from recovered patients?

The measure we developed was titled the Social Adjustment Scale and eventually became a self-report (SAS-SR).[4,5] It was first published in 1974 in a book on women with depression, at a time when interest in women's health accelerated by the women's rights movement was beginning to emerge.

The maintenance study results were first published in 1974 and found that drugs prevented relapse and that psychotherapy (called "high contact") improved social functioning.[6] The 1-year follow-up on the patients after maintenance treatment became my dissertation in epidemiology at Yale.[7]

When the first maintenance study showed the efficacy of high contact, we began to more fully describe the treatment and termed it "interpersonal psychotherapy." We designed an acute treatment trial of drugs and IPT alone and in combination. The positive results of the acute study,[8] and particularly the findings that the combination of drugs and psychotherapy was the most efficacious treatment, led to the NIMH Multisite Collaborative Treatment Study of this treatment of depression, testing drugs, CT, and IPT for acute treatment.[9] CT along the way became cognitive-behavior therapy (CBT),

and, according to Beck, the terms are now used interchangeably.

In 1984, with the demonstration of the efficacy of IPT outside our research group, we published the first IPT manual.[10] Dr. Rounsaville and Eve Chevron, a psychologist, were key in developing the IPT treatment training program for the NIMH collaborative study and joined us in putting together the manual for publication. This publication was followed by numerous other modifications and studies of IPT for adolescents, the elderly, pregnant and postpartum women, women following miscarriage, and medical patients, as well as for maintenance therapy for recurrent depression and bipolar disorder, eating disorders, anxiety disorders, borderline personality disorders, and depression in developing countries.

The basic assumption was that there is a relationship between the onset and recurrence of a depressive episode and the patient's social and interpersonal relationships at the time.

The evidence for efficacy of IPT is strongest for depression, is strong for some adaptations, is tentative for others, is negative for the treatment of drug abuse, and remains untested for some new adaptations. Translation into Japanese, Italian, German, and French were undertaken. Adaptations have included group, conjoint, and telephone IPT. Dr. Klerman would not have anticipated the great interest in IPT and its recommendations in several official guidelines in the United States and elsewhere. He died April 3, 1992, before these developments.

In 2000, Dr. John Markowitz, a psychiatrist (then at Cornell, where Dr. Klerman had moved) and Dr. Klerman's last trainee, and I compiled all the new adaptations and efficacy studies in IPT, updated the manual, and published the *Comprehensive Guide to Interpersonal Psychotherapy*.[11] Out of respect for Dr. Klerman's extraordinary contribution, we were proud to have him as posthumous author of this book. A slimmed-down version of the manual for busy clinicians will be forthcoming in 2007.[12]

IPT has been used successfully in a variety of cultures, both within and outside the US. IPT training programs have been conducted in Australia, Austria, Brazil, the Czech Republic, Ethiopia, Finland, France, Germany, Goa, Greece, Hungary, Iceland, Italy, Ireland, Japan, the Netherlands, New Zealand, Norway, Romania, Spain, Sweden, Switzerland, Thailand, Turkey, Uganda, and the United Kingdom. In the United States, IPT has been used successfully in clinical trials with patients from black and Hispanic (mainly Puerto Rican and Dominican) cultures.

Given the considerable cultural differences in these settings, we have been impressed at how minor the adaptations were that were required to translate IPT from one place to the other, and how similar the predicaments of people with depression are, even continents apart. The best example was an efficacy study in Uganda.[13,14] The ease of translating IPT for depression into diverse cultures probably reflects that the problem areas identified in IPT as triggers of depression (eg, death of a loved one, disagreements with important people in one's life, life changes that disrupt close attachments) are intrinsic, universal elements of the human condition, extending beyond the confines of Western culture. The experience of using IPT in diverse cultures suggests that these triggers of depression, disruptions of human attachment, are conserved across cultures.

IPT TRAINING TODAY

It is likely that readers of this article did not learn IPT in a professional training program. This is true for psychiatrists, psychologists, social workers, or any of the mental health professionals who practice psychotherapy. Few training programs, at least in the US, teach IPT as part of a program in evidence-based psychotherapy. If they do, most offer only a didactic course, without hands-on clinical supervision.[15]

Learning IPT is easy if you have had basic training in psychotherapy, including how to listen and talk to patients, express empathy and warmth, hold back your own reactions and opinions, formulate a problem, maintain a therapeutic alliance, understand the limits of confidentiality, and maintain professional boundaries and ethical practice. A basic familiarity with clinical psychiatric diagnosis is essential.

At present, continuing medical education courses on IPT are given at many of the annual professional organizational meetings. The American Psychiatric Association, for example, has had at least two workshops on IPT at its annual meeting for the past 10 years. These are usually half-day or full-day courses and are primarily didactic.

Some academic centers offer 2- to 4-day workshops that are much more intensive, providing some practical, hands-on training. These have been held throughout the world, particularly in England, Canada, New Zealand, the Netherlands, and the US. The best way to learn about workshops and supervision is through the International Society of Interpersonal Psychotherapy (http://www.interpersonalpsychotherapy.org). Every 2 years, the organization holds an international meeting where practitioners and researchers from all over the world present their experiences in using IPT.

Clinicians who would are interested in becoming an expert or a trainer in IPT should obtain clinical supervision with

an experienced IPT clinician. Experts recommend at least two to three supervised cases in IPT completed with an experienced IPT therapist. There is evidence that continuing education or other courses that are simply didactic lectures without interactive supervision do not change clinicians' performance.[16] On the other hand, our own studies show that experienced psychotherapists can perform IPT competently on a high level after as little as one supervised case.[17]

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