Interpersonal Psychotherapy: History and Future

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This review details the history of the development of interpersonal psychotherapy (IPT), beginning at Yale University when Dr. Gerald Klerman led a maintenance study of the treatment of depression. The trial aimed to mimic clinical practice and, therefore, included psychotherapy. This review describes the first IPT clinical trial, subsequent trials, and numerous IPT adaptations for different age groups, formats (group, telephone, computer), disorders, and educational levels of mental health trainees. As of 2017, at least 133 clinical trials of IPT had been carried out worldwide. This review also describes challenges associated with training clinicians to deliver evidence-based psychotherapy. It concludes with a discussion of future directions for IPT, which include expanding training to community health workers and testing IPT in low- and middle-income countries.

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The story of interpersonal psychotherapy (IPT) began at Yale University in 1970, 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, both with and without psychotherapy, as maintenance treatment for ambulatory nonbipolar depression. The evidence for the efficacy of tricyclic antidepressants in 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 focused on behavioral treatments and were limited in scope and sample size. A manual for cognitive-behavioral therapy (CBT) 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 or whether psychotherapy had a role in the prevention of relapse. Some psychotherapists thought taking 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 experiences.

Dr. Klerman, then head of the Connecticut Mental Health Center and faculty at Yale School of Medicine, felt that a clinical trial of maintenance tricyclic antidepressants should, as much as possible, mimic clinical practice. Because many patients 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 because no positive clinical trials of psychotherapy had been conducted. In fact, prior trials that examined patients receiving psychotherapy lacked the design necessary to draw any conclusion. However, Dr. Klerman was convinced that psychotherapy could be subjected to rigorous testing in a clinical trial.

In planning the trial, Dr. Klerman was first tasked with defining the type of psychotherapy and specifying 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 tested in the trial should be suitable for a time-limited treatment of depression. This common-sense clinical approach, initially called "high contact," was the basis for IPT. A time-limited psychotherapy, such as IPT or CBT, defined in a procedural manual used to train therapists and subjected to testing similar to medication testing, was a novel idea at the time and drew much skepticism from clinicians.

Three guiding principles governed this early work. First, randomized controlled clinical trials were important for testing and establishing the efficacy of all treatments,

HIGHLIGHTS

- Early researchers of interpersonal psychotherapy (IPT) were not convinced they would find a psychotherapy effect in efficacy studies but were convinced that psychotherapy could be subjected to testing in a clinical trial.
- The first IPT manual was published in 1984, after the demonstration of the therapy's efficacy in clinical trials conducted by research groups other than those who developed IPT.
- As of 2017, over 130 clinical trials had included IPT.
- The most up-to-date information on IPT can be found on the Web site of the International Society of Interpersonal Psychotherapy (www.interpersonalpsychotherapy.org).

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including psychotherapy. Second, a broad range of standardized assessments was 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 attempt to disseminate IPT until findings were replicated outside the original group of enthusiastic developers.

The team tasked with developing IPT included Dr. Klerman and Dr. Paykel, both psychiatrists; Dr. Brigette Prusoff, a recent graduate from the Yale Department of Biostatistics; and me. I was, at the time, an inexperienced social worker who could work only 2 days a week because I had small children. The clinical trial tested amitriptyline, placebo, and no pill, with or without weekly psychotherapy, for 8 months among ambulatory patients with depression who had responded initially to medication. We set about designing the psychotherapy. Dr. Klerman was impressed with Dr. Beck's progress in defining cognitive therapy. He gave me a typed document of approximately 100 pages from Dr. Beck describing the procedures for CBT. Dr. Klerman said a similar document would be needed for supportive psychotherapy, which was to be used in the new trial. He noted that "supportive psychotherapy" was a vague term that needed to be defined, as Beck had done for CBT. He then said to me, "Design the psychotherapy." I was so surprised and pleased to be given this assignment—I had had little experience designing and documenting clinical procedures—that I set about writing scripts detailing the procedures and dialogue of the psychotherapy on days when I was not supposed to be in the office. It was a challenging and exciting assignment. It became an iterative group process: Dr. Klerman, or Gerry as we all called him, took the lead and reworked the scripts I wrote, and others contributed data (e.g., life events or cases) to illustrate a point.

Several contextual features, I later realized, defined our approach to designing the psychotherapy. We were working in a psychopharmacologic clinic where we routinely made a diagnosis using standardized assessments and followed the patient's clinical course. Dr. Klerman and Dr. Paykel were developing standardized assessments and using control groups to assess the role of life events in the onset of depression and relapse. Dr. Klerman was both a psychopharmacologist and psychotherapist, and, as leader of the team, he held a broad view of depression that influenced the direction of our work. Although he thought depression was basically a biological illness, he was impressed with how social and interpersonal stress could exacerbate 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. Working together, 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 for ambulatory patients with depression.

We were given many books and articles to read, but the ones that guided us the most were the works of Harry Stack 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. Our progress was also influenced by the ideas of Adolf Meyer (2), who put great emphasis on the patient's relationship to his or her environment, and by the writings of John Bowlby (3), who stated that individuals make strong affectional bonds and that the separation of these bonds, or the threat of separation, gives rise to emotional distress and depression. We were also influenced by the work on life events—both our own and others'—which showed, consistent with theoretical writings of Sullivan, Meyer, and Bowlby, that events that represented exits from the social field were associated with depression. (Weissman and colleagues [4] provide a description of the theoretical and empirical thinking underlying the development of IPT.)

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 that became the first phase of IPT. This phase included a diagnostic evaluation; a psychiatric history; patient education about depression, its symptoms, and treatment alternatives; an interpersonal inventory of important people currently in the patient's life; the sick role allowing the patient to receive help; a discussion linking symptom onset to interpersonal situations; and the identification of problem areas associated with the onset of the depressive episode. The group's work in life events allowed us to identify and define the key problem areas: grief and complicated bereavement after a death; role disputes and conflicts with a significant other in renegotiations, dissolution, or impasse; role transitions and changes in life status (e.g., divorce, moving, retirement); and interpersonal deficits, such as lack of social skills, boredom, loneliness, or paucity of attachments.

The basic assumption was the onset and recurrence of a depressive episode were related to the patient's social and interpersonal relationships at the time. We met weekly to develop the manual, reviewing cases and creating scripts from actual practice to describe how to carry out the treatment procedures and in what sequence. We were concerned that the procedures be specific enough so that therapist training would 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. Our work, testing psychotherapy and conducting 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 Yale Drug Dependency Unit headed by Dr. Herb Kleber soon moved into the other side of the building to work on understanding and developing treatment for the emerging drug epidemic in New Haven and many major U.S. cities. Dr. Klerman, Dr. Kleber, and I frequently collaborated. We were much later joined by Dr. Bruce Rounsaville, then a young psychiatrist, to carry out a treatment study we developed of patients undergoing methadone maintenance, which included IPT.

The final piece of work to accomplish before starting the maintenance study was to develop the target psychotherapy outcome measure. Dr. Klerman said medication should help the patient sleep and eat better, but it would probably not help the patient get along better with his or her 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 found that the social functioning measures designed for newly ambulatory patients with schizophrenia as part of the National Institute of Mental Health's multisite studies of antipsychotic medication included tasks that were too simple, such as dressing and grooming. Other measures were designed for college students and focused on sex and dating. Our patients were primarily middle-aged, married women who had children and were from large extended families. Their important areas of functioning were not captured by any of the existing social functioning measures. Borrowing from several preexisting scales, we developed questions on functioning in relation to marriage, children, family, and extended family. Dr. Klerman then advised us to 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, which eventually became a self-report (SAS-SR). It was first published in a book on women with depression in 1974, when interest in women's health, accelerated by the women's rights movement, was beginning to emerge (5, 6).

The maintenance study results, also first published in 1974, showed that drugs prevented relapse and that psychotherapy improved social functioning (7). The 1-year follow-up on the patients after maintenance treatment became my Ph.D. dissertation in epidemiology at Yale (8).

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 a trial of acute depression treatment that tested drugs and IPT alone and in combination (9). This was my first large National Institute of Mental Health (NIMH) grant. The positive results of the acute study, and particularly the findings that the combination of drugs and psychotherapy was the most efficacious treatment for depression, led the NIMH Treatment of Depression Collaborative Research Program to test drugs, CBT, and IPT for treatment of patients with acute depression (10).

In 1984, after the efficacy of IPT had been demonstrated outside our research group, we published the first IPT manual (11). Dr. Rounsaville and Dr. Eve Chevron, a psychologist, made key contributions to the IPT treatment training program for the NIMH collaborative study and joined us in preparing the manual for publication. This publication was followed by numerous modifications to and studies of IPT, including examinations of IPT for adolescents, the elderly, pregnant and postpartum women, women after miscarriage, medical patients, and as part of maintenance therapy for recurrent depression and bipolar disorder, eating disorders, anxiety disorders, posttraumatic stress disorder, and depression in developing countries (4).

The evidence for the 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 (12). The IPT manual has been translated into 10 languages. Adaptations have included group, conjoint, and telephone IPT. Dr. Klerman could not have anticipated the great interest in IPT that has ensued nor the recommendation of IPT in several official guidelines in the United States and elsewhere as the first-line treatment for depression. In February 2019, IPT and CBT were recommended by the U.S. Preventive Services Task Force for treatment of depression during pregnancy (13, 14). Dr. Klerman died on April 3, 1992, before these developments occurred. Dr. John Markowitz, one of Dr. Klerman's last trainees, has joined me in updating the manual over the years. An updated version of the manual was last published in 2018 (4). We have always kept Dr. Klerman as an author because his seminal contributions continue to form the core of IPT, unchanged since its inception. Many other specialized manuals of IPT have appeared using the fundamental principles our team established with special adaptations and case material for specific age groups or disorders. Descriptions of the major adaptations can be found on the Web site of the International Society of Interpersonal Psychotherapy (isIPT) (www.interpersonalpsychotherapy.org).

IPT TRAINING

Training in IPT rarely occurs in graduate or residency training programs. This is true for all of the mental health professionals who practice psychotherapy, including psychiatrists, psychologists, and social workers. Few training programs in evidence-based psychotherapy teach IPT, at least in the United States. Of those that do, most offer only a didactic course without hands-on clinical supervision. Weissman and colleagues' (15) 2006 survey of residents and graduate students documented the low rate of training in evidence-based psychotherapy. Thus, IPT training is typically undertaken by interested clinicians after graduate school. The inclusion of evidence-based psychotherapy, including IPT, should be an accreditation requirement for

FIGURE 1. Locations where interpersonal psychotherapy training has been undertaken

psychotherapy training programs. Such a requirement would rapidly accelerate training in IPT and, therefore, increase the number of practitioners capable of providing the therapy.

Learning the procedures of IPT is easy for those who have had basic training in psychotherapy, including how to listen to and talk to patients, express empathy and warmth, withhold personal reactions and opinions, formulate a problem, maintain a therapeutic alliance, understand the limits of confidentiality, maintain professional boundaries, and make a psychiatric diagnosis. Excelling in any psychotherapy may take considerably more time.

Continuing medical education courses on IPT are offered through many professional organizations. The American Psychiatric Association provides workshops on IPT at many of its annual meetings. These half-day or full-day courses are primarily didactic. Some academic centers offer 2- to 4-day workshops that are much more intensive and include experiential learning opportunities. These have been held throughout the world, including as part of annual trainings in London, Toronto, and elsewhere. The best way to learn about IPT workshops and supervision is through isIPT. Every two years, isIPT holds an international meeting where practitioners and researchers gather to host training workshops, present IPT research, and discuss IPT dissemination. isIPT maintains a Web site with detailed information for members on training, research, and new developments. In 2019, members of the organization compiled a list of past and present IPT trainings worldwide. Workshops included those organized for research studies, humanitarian efforts, and purely educational needs. This list is routinely updated on the isIPT Web site, and Figure 1 shows the growing reach of IPT training.

Clinicians who are interested in becoming an IPT therapist should complete didactic coursework in IPT then work with two to three patients while being overseen by an IPT supervisor. Because isIPT does not yet offer IPT certification—although it will in the future—this recommendation is only a guideline. It is my experience that continuous education and courses that are simply didactic lectures without interactive supervision do not substantially change clinicians' performance. On the other hand, studies show that experienced psychotherapists can perform IPT at a high level after as little as one supervised case. Many clinicians, especially those who do global work, also have had considerable success in training community health workers without advanced degrees. There are efforts underway to facilitate training through interactive Web sites. The best way to keep informed of new developments in IPT training is through the isIPT Web site. Membership fees are nominal.

THE FUTURE OF IPT

It is nearly impossible to tally the total number of clinical trials of IPT because the figure has changed rapidly. In a review of studies between 1974 and 2017, Ravitz et al. (16) counted at least 133 clinical trials, with more publications emerging every year since IPT's inception. Although the earliest papers focused almost exclusively on depression, publications have emerged in recent decades on IPT as treatment for many disorders and in many settings. This review identified over 1,000 IPT papers, which included process-focused analyses. Cuijpers and colleagues (12, 17) conducted meta-analyses of IPT trials, including 120 studies. Notably, this meta-analysis applied strict criteria for inclusion and therefore excluded studies of adolescents, inpatients, and self-help.

The most exciting developments and areas of future progress in IPT are in globalization. In the United States, IPT has been tested successfully in clinical trials that included individuals with diverse backgrounds, such as predominantly black, Hispanic, and low-income populations (18–20). It has been used in low-income countries where issues related to natural disasters, refugee migration, civil war, and their aftermaths have made psychotherapy the preferred treatment (21). The best example is the efficacy study in Uganda in which 248 adults with depression (males and females in separate groups) were given either group IPT or treatment as usual. Results showed a highly significant reduction in symptoms and improvement in social functioning with IPT (21). After 16 weeks, 6.5% of the IPT group and 54.7% of the control group met criteria for major depression. These differences were maintained 6 months later.

Given the considerable cultural differences across these settings, I have been impressed by how few adaptations were required to ensure that IPT remained relevant across settings. The predicaments of people with depression are very similar, even continents apart. The ease of translating IPT for depression across diverse cultures probably reflects that the problem areas identified in IPT as triggers of depression (e.g., 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 encountered across cultures.

The application of IPT in Uganda has been sustainable and is now led by Sean Mayberry in an organization called Strong

Minds. His work followed the first clinical trial of IPT (21) in Uganda, which employed the health workers who had been trained there. Mayberry employed these health workers in order to offer IPT on a humanitarian basis. He has now treated over 30,000 Ugandan women with depression in IPT groups and has begun to expand this work into Zambia. The best way to follow his humanitarian work is through the Web site of his nongovernmental organization, Strong Minds (www.strongminds.org). The success of the Uganda clinical trial, isIPT's success in bringing together clinicians and investigators from around the world, and encouragement from the World Health Organization have escalated the presence of IPT in low-income countries in the last decade. For example, sites where IPT has been implemented include Lebanon, Egypt, Myanmar, Ethiopia, Rwanda, and South Africa. Notably, Milton Wainberg is implementing training for and testing of a comprehensive screening and mental health treatment program in Mozambique. The program features a brief form of IPT specifically developed for primary care, and group IPT is conducted on tablets for ease of administration. In the United States, the U.S. Preventive Services Task Force's recommendation of IPT for the prevention and treatment of depression in pregnancy may spark new implementation trials (13, 14).

Much-needed efforts are underway to develop IPT training methods and self-help and guided IPT treatment online. Those who have tried to develop online training realize that interactivity can be difficult to achieve and requires special skills beyond posting a didactic excerpt from the IPT manual. Additionally, more training of health workers is needed in the future to increase the labor force economically and in a way that benefits communities.

Finally, after much writing and talking, administrators still have not required evidence-based psychotherapy in the educational programs that train mental health professionals who provide psychotherapy. CBT has made inroads in psychiatry, and some programs in psychology and social work include some CBT and IPT. But without a mandate for accreditation, training in evidence-based psychotherapy remains spotty, at least in the United States. If *Nature*, a prominent science journal, is compelled to publish an editorial entitled "Therapy Deficit: Studies to Enhance Psychological Treatments Are Scandalously Under-Supported," then it is time for the training programs to take up the challenge (22).

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