

# To prevent depression recurrence, interpersonal psychotherapy is a first-line treatment with long-term benefits

## Algorithm helps determine when behavioral therapy, medication are appropriate

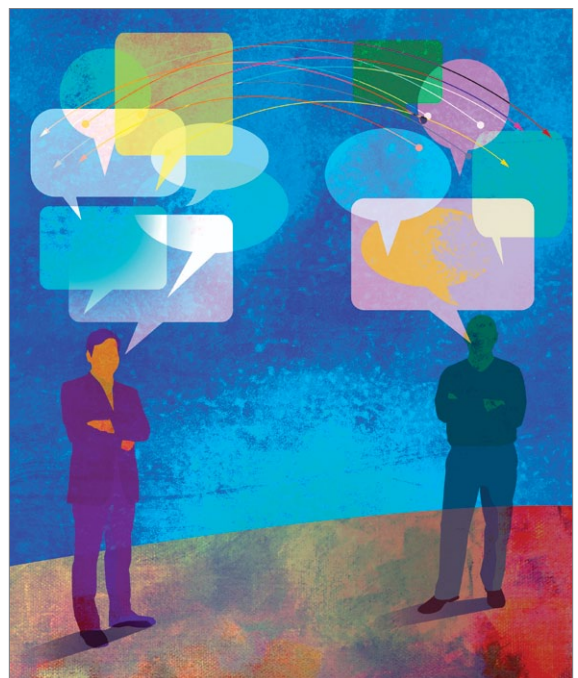
**M**ajor depressive disorder (MDD) frequently is recurrent, with new episodes causing substantial social and economic impairment<sup>1</sup> and increasing the likelihood of future episodes.<sup>2</sup> For this reason, contemporary psychiatric practitioners think of depression treatment as long-term and plan thoughtfully for maintenance therapy.

Recognizing the importance of engaging depressed individuals beyond the initial response,<sup>3</sup> American Psychiatric Association practice guidelines conceptualize depression treatment as 3 phases:

- acute treatment, with the aim of remission (symptom removal)
- continuation treatment, with the aim of preventing relapse (symptom return)
- maintenance treatment, with the aim of preventing recurrence (new episodes).<sup>4</sup>

Interpersonal psychotherapy (IPT) is an evidence-based psychosocial treatment that adheres to this model.<sup>5</sup> As a time-limited, manual-driven<sup>6,7</sup> approach, IPT focuses on interpersonal distresses as precipitating and perpetuating factors of depression.<sup>8</sup>

Acute IPT's efficacy is well-established across >200 empirical studies—making it an evidence-based, first-line treatment for adult depression.<sup>4,9,10</sup> Meta-analyses show that acute IPT is superior to placebo and no-treatment controls, and largely comparable to antidepressant medication and other active, first-line psychotherapies, such as cognitive-behavioral therapy (CBT).<sup>11,12</sup>



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#### Disclosures

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

continued



## Interpersonal psychotherapy

### Clinical Point

IPT focuses on interpersonal distresses as variables that precipitate and perpetuate depression

Table 1

## Examples of techniques used in acute-phase interpersonal psychotherapy

Technique	Purpose/description
Diagnostic assessment	To help determine treatment focus and fit for interpersonal therapy, which is suited for patients with mood and anxiety disorders, as well as more circumscribed interpersonal problems
Interpersonal assessment	To help understand patients' biopsychosocial vulnerabilities and stressors as related to their working models of self and others, and to determine treatment foci (grief and loss, interpersonal disputes, role transitions, and/or interpersonal/communication deficits)
Build therapeutic alliance	Use strategies such as eliciting feedback; conveying empathy, genuineness, and warmth; and taking responsibility for any missteps to build trust and working rapport/collaboration
Consciousness raising	Help patients view depression as an illness caused by their interpersonal contexts, and to understand those contexts, their expectations of others, and their desired changes
Communication analysis	Analyze interpersonal incidents to evaluate patients' communication styles and interpersonal expectations, and help them communicate their needs more effectively to others
Use affect	Attend to patient's affective state, especially when patient may be avoiding affect, in the service of increasing motivation to change behaviors and communications to improve affect
Problem-solving	Help patients brainstorm and implement more adaptive communication patterns and methods to garner social support, routinely assess their effectiveness, and revise as needed
Tapering	After the patient has responded to treatment, flexibly increase the interval between sessions to help consolidate treatment gains and prevent relapse of the acute distress episode

**Note:** Many techniques are used in IPT, and no therapeutic strategy is proscribed. However, all techniques are used explicitly to help patients modify their interpersonal relationships as a mechanism for decreasing their distress. The ultimate value of an intervention is gauged by its helpfulness to the patient.

Although this review, as well as the literature, focuses largely on adult outpatients with depression, evidence of IPT's general efficacy exists for adolescents,<sup>13</sup> chronically depressed patients,<sup>11</sup> and depressed inpatients.<sup>14</sup> This article presents a case study to describe the structure of IPT when used to treat depressed adults. We also present evidence of IPT's acute and long-term efficacy in preventing depression recurrence and data to guide its use in practice.

### CASE REPORT

#### 'Safe' but depressed

Timothy, age 18, is a first-year college student who presents for outpatient psychotherapy to address recurrent depression. He reports general unhappiness, loss of interest in things, low energy, sleep problems, poor academic and work functioning, and low self-esteem. He experienced at least 3 similar depressive episodes while in high school.

The therapist's diagnostic and interpersonal assessment suggests that Timothy's depression is interpersonally driven. Timothy longs for relational intimacy but fears he will fail or burden people with his needs. He has difficulty gauging appropriate levels of enmeshment with others and either becomes overdependent or stays at a distance. This "safe" approach to relationships contributes to boredom, loneliness, and isolation. His recent transition to college away from home and the failure of a romantic relationship have compounded these experiences.

### Interpersonal model of IPT

IPT conceptualizes depression as involving predisposing, precipitating, and perpetuating biopsychosocial factors, including:

- underlying biological and social vulnerability, such as insecure attach-



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ment (ie, tenuous and often negative views of self and others)

- current interpersonal life stressors
- inadequate social supports.<sup>15,16</sup>

For example, poor early attachment to caregivers can give rise to despair, isolation, and low mood. In turn, this can be exacerbated by poor social and communication skills that promote further rejection and withdrawal of social support and thus, intensified despair, isolation, and low mood. As in Timothy's case, this vicious cycle underscores psychosocial stressors as a causal factor, maintaining factor, and result of depression. Specifically, IPT conceptualizes 4 main biopsychosocial problem domains:

- grief and loss
- interpersonal disputes
- role transitions
- interpersonal/communication deficits (often connected to isolation).

Working within 1 or 2 of the most salient problem domains, IPT centers on strategies for helping patients solve interpersonal problems based on the notion that modified relationships, revised interpersonal expectations, improved communications, and increased social support will lead to symptom reduction.<sup>15-17</sup>

Many techniques are utilized in IPT (*Table 1*) to help patients modify their interpersonal relationships as a mechanism for decreasing their distress. IPT is problem-focused, aiming to improve patients' relationships by drawing on their assets and helping to build skills around shortcomings. Therefore, IPT focuses on observable interpersonal patterns, as opposed to latent personality dynamics.

#### CASE CONTINUED

### Setting goals

When the clinician explains in non-technical terms the data supporting IPT's efficacy for depression, including with young adults, Timothy agrees to treatment with acute IPT. The therapist begins with consciousness-raising techniques to help Timothy adopt the "sick role" by viewing depression as an illness to be cured. Collaboratively, they establish treatment goals that fit the IPT formulation of depression—ie, revising current relationships

and expectations of them, increasing social support, improving communication skills, and solving problems within 1 or 2 of the IPT problem domains.

For Timothy, the most pressing psychosocial problems seem to be interpersonal deficits and role transitions. He appears to be insecurely attached to others, which is a risk factor for poor facilitation of, and boundaries around, good relationships. A transition to a new and intimidating interpersonal context—living on a college campus—compounded his vulnerabilities and increased his depression.

**Acute treatment.** The acute phase of IPT is time-limited—often, 12 to 16 sessions with gradual tapering toward the end (akin to a continuation phase). The time limit's purpose is to focus both patient and therapist on the specific goal of removing the acute "illness" of depression. The IPT clinician takes an interpersonal inventory to learn about the patient's most important relationships and hones in on the IPT domain foci. Working collaboratively, the therapist might help the patient mourn a loss, reconstruct a narrative with a deceased loved one, consider ways to increase social contact, develop assertiveness, label feelings and needs, resolve an impasse with a significant other, and so forth.

The IPT therapist is an advocate for the patient and adopts an active stance laced with empathy and warmth. However, the therapist is more than unconditionally accepting as depression is viewed as a problem to be actively resolved.

#### CASE CONTINUED

### Creating new patterns

The therapist uses various IPT strategies to work collaboratively with Timothy. She attempts to develop a strong working alliance by building interpersonal safety and trust—which take time with an insecurely attached patient. She tries to provide a new model for how close relationships can develop, while also focusing on current relationships. She and Timothy address his romantic desire for a coworker and work on developing realistic expectations and effective methods for conveying his interest.

### Clinical Point

**IPT is problem-focused, aiming to improve patients' relationships by drawing on their assets and build skills around shortcomings**



## Interpersonal psychotherapy

### Clinical Point

For patients with high cognitive dysfunction, IPT outperforms CBT

Table 2

## Variables shown to predict outcomes of acute IPT for depression

- A positive therapeutic alliance is related to better treatment outcome.<sup>2a-2c</sup>
- Therapist warmth is related to reduced depression and improved social functioning.<sup>2d</sup>
- Greater patient intimacy-seeking with the therapist is associated with positive outcome.<sup>2e</sup>
- Adherence to IPT and interpersonal themes and competence in IPT delivery are related to depression reduction.<sup>2f-2i</sup>
- Psychotherapist use of exploratory techniques is related to depression reduction.<sup>2d</sup>
- Depressed patients with higher fearful attachment are less likely to achieve remission.<sup>2j</sup>
- Reduction in interpersonal problems, lower attachment anxiety, and lower attachment avoidance are related to adaptive treatment outcome.<sup>2k</sup>
- Improved marital adjustment is related to adaptive treatment outcome.<sup>2l</sup>
- Resolution of interpersonal problems is related to adaptive treatment outcome.<sup>2m</sup>
- Patients with longer EEG sleep latencies, lower sleep efficiency, and increased automated measures of phasic REM activity are less likely to respond.<sup>2n</sup>

EEG: electroencephalography; IPT: interpersonal psychotherapy; REM: rapid eye movement

Sources: 2a. Krupnick et al. (1996); 2b. McBride et al. (2010); 2c. Zuroff et al. (2007); 2d. Rounsaville et al. (1987); 2e. Albon and Jones (1999); 2f. Crits-Christoph et al. (2010); 2g. Crowe and Luty (2005); 2h. Frank et al. (1991); 2i. Spanier et al. (1996); 2j. Constantino et al. (2013); 2k. Ravitz et al. (2008); 2l. Whisman (2001); 2m. Markowitz et al. (2006); 2n. Buysse et al. (1992)

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When Timothy approaches his coworker, she does not reject him—as he expected—but wants to pursue friendship before possibly dating. The therapist then works with Timothy's emotional reaction and explores ways to effectively convey his emotions to this young woman. Drawing on communication analysis and problem-solving strategies, Timothy is able to sustain this friendship—a shift from his typical retreat when relationships have not gone as hoped or expected.

Timothy develops confidence to take more risks in initiating social encounters and starts to confide in his roommates when he feels upset. After 3 months of treatment, his expanded social network and improved interpersonal skills result in decreased depression. When Timothy suggests termination, he and the therapist agree to end acute IPT but—given his history of depression—to continue maintenance sessions.

Limited data exist on variables that relate to IPT's acute success or conditions under which it works best. Although process research lags behind acute IPT outcome research, some findings can help guide the IPT practitioner. For example, variables shown to predict outcomes of acute IPT for depression include a positive therapeutic alliance, therapist warmth, and psycho-

therapist use of exploratory techniques (Table 2).

Similarly, IPT has been shown to be more effective in some patients than others, depending on various moderators of depression. For example:

- For patients with high cognitive dysfunction, IPT outperforms CBT.
- For patients with higher need for medical reassurance, IPT outperforms selective serotonin reuptake inhibitor (SSRI) pharmacotherapy.
- For patients with severe depression, CBT outperforms IPT.
- For patients with low psychomotor activation, response is more rapid with an SSRI than with IPT (Table 3).<sup>18</sup>

### Durability of acute IPT

One way to understand recurrence prevention is to examine the durability of a treatment's acute effect in the absence of a specific maintenance plan. In theory, patients will continue to apply the skills learned in acute IPT to maintain gains and prevent recurrences, even after they stop seeing the psychotherapist.

**Initial findings.** Some research speaks to IPT's acute-phase durability. The inaugu-

Table 3

## Which treatment for your depressed patient: IPT or another option?

### Depression moderators shown to favor IPT

For patients with high cognitive dysfunction	IPT outperforms CBT <sup>3a</sup>
For patients with higher need for medical reassurance	IPT outperforms SSRI pharmacotherapy <sup>3b</sup>
For patients with high delta sleep ratio (a biomarker of depression vulnerability)	Gains achieved last longer after IPT than after medication maintenance treatment <sup>3c</sup>
For patients who reported childhood trauma	IPT plus medication outperforms medication alone <sup>3d</sup>
For patients who experience severe life events before or during treatment	Response rates are higher with IPT and CBT than with pharmacotherapy <sup>3e</sup>
For patients with severe depression or endogenous depression	IPT plus medication outperforms IPT alone <sup>3f-3g</sup>

### Depression moderators shown to favor other options

For patients with severe depression	CBT outperforms IPT <sup>3h</sup>
For patients with low psychomotor activation	Response is more rapid with an SSRI than with IPT <sup>3b</sup>
For patients with comorbid personality disorders	CBT outperforms IPT <sup>3i-3j</sup>
For patients with high harm avoidance, low self-directedness, low novelty-seeking, and low reward dependence	These traits relate to poorer outcome with IPT but not with CBT <sup>3i</sup>
For patients with high attachment avoidance	Symptom reduction is greater with CBT than with IPT <sup>3k</sup>

CBT: cognitive-behavioral therapy; IPT: interpersonal psychotherapy; SSRI: selective serotonin reuptake inhibitor

Sources: 3a. Sotsky et al. (1991); 3b. Frank et al. (2011); 3c. Kupfer et al. (1990); 3d. Zobel et al. (2011); 3e. Bulmash et al. (2009); 3f. Thase et al. (1997); 3g. Prusoff et al. (1980); 3h. Luty et al. (2007); 3i. Carter et al. (2011); 3j. Joyce et al. (2007); 3k. McBride et al. (2006).

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### Clinical Point

For patients with low psychomotor activation, response is more rapid with an SSRI than with IPT

ral clinical trial of IPT by Weissman et al<sup>19</sup> included 4 months of acute treatment and a 1-year uncontrolled naturalistic follow-up assessment. At follow-up, depression and global clinical symptoms were the same, whether patients had been acutely treated with IPT alone, pharmacotherapy alone (amitriptyline), combined IPT and pharmacotherapy, or nonscheduled treatment with a psychiatrist.

Some patients continued to function well, whereas others did not fully maintain acute treatment gains. Patients who received IPT acutely, either singly or with medication, showed better social functioning at follow-up compared with patients who did not receive IPT. This long-term durability of social improvements was an obvious target of IPT.

**Support from TDCRP.** In the National Institute of Mental Health Treatment of

Depression Collaborative Research Project (TDCRP),<sup>20</sup> patients in the acute phase of depression were assigned to 16 weeks of IPT, CBT, pharmacotherapy (imipramine) and clinical management (CM), or placebo plus CM. Among those who recovered by acute treatment's end, MDD relapse rates at 18-month naturalistic follow-up were 33% for IPT, 36% for CBT, 50% for imipramine, and 33% for placebo. Between-group differences were not statistically significant.

Because acute responders to different types of treatment might have different inherent relapse tendencies, these data do not support causal attributions about the enduring effects of acute-phase treatment. The relapse rates do suggest, however, that 16 weeks of acute treatment, irrespective of kind, was insufficient for some patients to achieve full recovery and lasting remission. Consistent with the initial IPT trial,<sup>19</sup> IPT (and CBT) outperformed medi-



## Interpersonal psychotherapy

### Clinical Point

**IPT-M is an option for patients who are unwilling to remain on acute medication that has been shown to prevent recurrence**

cation and placebo in maintaining relationship quality.<sup>21</sup>

**Long-term benefits.** A more recent trial by Zobel et al<sup>22</sup> examined the durability of benefits from 5 weeks of acute IPT plus pharmacotherapy and pharmacotherapy plus CM for inpatients with MDD. Although caution is required in interpreting naturalistic follow-up studies, patients in both groups showed decreased depression from baseline to 5-year follow-up. Early symptom reduction was more rapid for patients in the IPT plus pharmacotherapy group, but no significant difference existed at 5 years. More IPT patients than CM patients showed sustained remission (28% vs 11%, respectively). These rates demonstrate a need for longer-term potency of acute treatments and more targeted maintenance treatments.

### IPT-M for preventing recurrence

A second way to understand recurrence prevention is to examine the efficacy of a treatment's maintenance protocol added to an acute treatment phase. IPT has been adapted as a maintenance treatment (IPT-M), with emphasis on keeping patients well. With this revised focus, IPT-M differs somewhat from acute IPT. Although treatment continues to center on interpersonal functioning, IPT-M favors:

- vigilance for possible triggers of new depressive episodes
- longer-term contact with a therapist
- reinforcing skills learned
- addressing an expanded number of interpersonal problem areas (given that such problems can be addressed more efficiently relative to acute treatment).

**Efficacy of IPT-M.** In the initial trial, Frank et al<sup>23</sup> compared the efficacy of IPT-M with that of pharmacotherapy (imipramine) in preventing depressive relapse among patients with recurrent depression who had responded to  $\geq 16$  sessions of acute IPT and imipramine and remained well during a 17-week continuation phase. For maintenance, patients were assigned to IPT-M alone, imipramine alone, placebo alone, IPT-M

plus imipramine, or IPT-M plus placebo. Maintenance imipramine was continued at the acute dosage (target 200 mg/d; up to 400 mg/d was allowed). Maintenance IPT was monthly sessions. Patients remained in the trial for 3 years or until depression recurred.

On its own, IPT-M showed some efficacy in preventing recurrence, as the mean time to recurrence was 82 weeks for IPT-M alone and 74 weeks for IPT-M plus placebo. The prophylactic effect of imipramine was stronger, however. The mean time to recurrence for imipramine with IPT was 131 weeks, and the mean time to recurrence for imipramine without IPT was 124 weeks. Therefore, whereas monthly IPT-M can certainly help prolong wellness and delay recurrence, IPT maintenance treatment with acute doses of imipramine might be even more effective—if the patient is willing to take medication. These findings must be considered with caution because of the inherent inequity between imipramine and IPT-M in regard to maintenance dosage strength.

**Frequency of treatment.** In another trial, Frank et al<sup>24</sup> examined whether the frequency of maintenance IPT sessions played a role in its prophylactic effect. Adult women who had achieved depression remission with acute IPT (alone or in combination with SSRI pharmacotherapy) were randomized to weekly, bi-weekly, or monthly IPT-M alone for 2 years or until recurrence. Depression recurred during IPT-M in:

- 26% of patients who had received acute IPT alone
- 50% of those who had received acute IPT plus an SSRI.

Frequency of IPT-M sessions did not affect time to recurrence. Thus, for women who can achieve remission with IPT alone, varied frequencies of IPT-M can be good prophylaxis. For women who need an SSRI to augment acute IPT, IPT-M alone at varied dosages is less effective in preventing depression recurrence. Therefore, acute treatment response patterns can inform maintenance plans, with the most prudent maintenance strategy being to maintain the acute treatment strategy over a longer period.

Table 4

### Predictors of outcomes with IPT-M, based on secondary data analysis

Parent study authors	Findings from secondary analyses of data from parent studies	Data analysis authors
Frank et al (1990) <sup>23</sup>	High interpersonal focus in IPT-M sessions is related to longer time to recurrence	Frank et al (1991)
	Greater variability of depression symptoms during all forms of maintenance treatment is related to a greater risk for recurrence	Karp et al (2004)
Frank et al (2007) <sup>24</sup>	Persistent insomnia is related to greater risk of depression recurrence	Dombrovski et al (2008)
	A greater number of nonsevere life events is related to greater risk for depression recurrence	Lenze et al (2008)
Reynolds et al (1999) <sup>25</sup>	Patterns of acute depression response predict differential response to different maintenance therapies:	Dew et al (2001)
	Rapid acute responders had less recurrence risk with combined IPT-M and antidepressant medication or either monotherapy, compared with placebo	
	For mixed and delayed acute responders, combined maintenance therapy was superior to placebo	
	For prolonged acute nonresponders, no maintenance treatment was helpful	
	IPT-M is more helpful than maintenance placebo plus clinical management for patients whose treatment focused on the IPT domain of role conflict	Miller et al (2003)
Reynolds et al (2006) <sup>26</sup>	Maintenance antidepressant treatment outperforms placebo in preserving acute treatment improvements in well-being, social functioning, and role performance; this advantage over placebo was not found for IPT-M	Dombrovski, Lenze, et al (2007)
	Residual anxiety and sleep disturbance are related to greater risk of depression recurrence across maintenance treatment	Dombrovski, Mulsant, et al (2007)
	Relative to maintenance clinical management, patients with lower cognitive performance had a longer time to recurrence in IPT-M	Carreira et al (2008)

IPT-M: interpersonal psychotherapy adapted for maintenance treatment

Source: For full reference citations, see this article at CurrentPsychiatry.com

### Clinical Point

Frequency of IPT-M sessions did not affect time to recurrence in women who had achieved remission with acute IPT, alone or with an SSRI

**IPT-M for late-life depression.** A trial by Reynolds et al<sup>25</sup> examined the efficacy of maintenance nortriptyline and IPT-M in preventing depression recurrence in patients age ≥59 who initially recovered after combined acute and continuation IPT plus nortriptyline. The 4 conditions (with their recurrence rates) were:

- monthly IPT-M with nortriptyline (20%)
- monthly IPT-M with placebo (64%)
- nortriptyline plus medication visits (43%)
- placebo plus medication visits (90%).

Clearly, the combined active treatments outperformed placebo and antidepressant alone in terms of delaying or preventing recurrence, which suggests an

optimal maintenance strategy with this population.

**IPT-M for later life.** Another trial by the same group<sup>26</sup> enrolled patients age ≥70 with MDD that responded to acute IPT plus paroxetine. The maintenance treatments to which they were randomly assigned (and recurrence rates within 2 years) were:

- paroxetine plus IPT-M (35%)
- placebo plus IPT-M (68%)
- paroxetine plus clinical management (37%)
- placebo plus clinical management (58%).

Recurrence rates were the same for patients receiving medication plus IPT-M



## Interpersonal psychotherapy

### Clinical Point

After successful acute treatment, continuing that approach long-term appears to be the optimal maintenance strategy for adults

## Related Resources

### Media

- Video demonstration, role-play transcripts, lesson plans, and quizzes. In: Appendices in and DVD companion to Ravitz P, Watson P, Grigoriadas S. *Interpersonal psychotherapy for depression*. New York, NY: Norton; 2013.
- Video demonstration of IPT sessions. In: DVD companion to Dewan, M, Steenbarger, B, Greenberg, R, eds. *The art and science of brief psychotherapies: An illustrated guide*. 2nd ed. Arlington, VA: American Psychiatric Publishing; 2012.

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### Websites

- Interpersonal Psychotherapy Institute. <http://iptinstitute.com>.
- International Society for Interpersonal Psychotherapy. <http://interpersonalpsychotherapy.org>.

### Drug Brand Names

Amitriptyline • Elavil	Nortriptyline • Pamelor
Imipramine • Tofranil	Paroxetine • Paxil

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and medication plus clinical management, and depression was 2.4 times more likely to recur in patients receiving placebo vs active medication. Therefore, for later life depression, the optimal maintenance strategy was the SSRI.

**Secondary analyses of data** from these seminal trials of IPT-M point to other predictors of how and for whom maintenance IPT may work (*Table 4, page 39*). For example:

- Greater variability of depression symptoms during all forms of maintenance treatment is related to a greater risk of recurrence.

- Persistent insomnia is related to greater risk of recurrent depression.

- High interpersonal focus in IPT-M sessions is related to longer time to recurrence.

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## Bottom Line

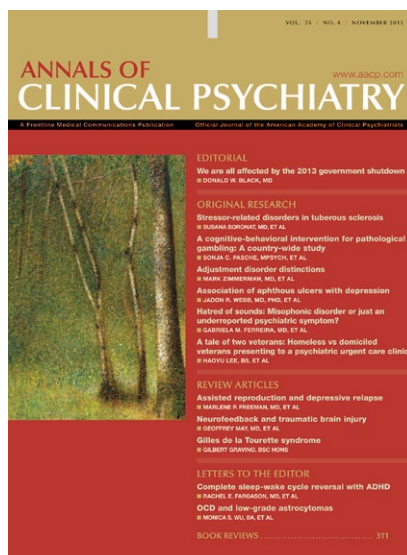
Interpersonal psychotherapy (IPT) is efficacious for acute depression and for preventing recurrences. Patients treated successfully with acute IPT alone benefit from varied doses of maintenance IPT. Combining IPT-M with antidepressant medication can be more potent than IPT-M alone. For late-life depression, medication appears to be most effective for maintenance treatment.



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**Table 2**

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**Table 3**

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**Table 4**

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