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Interpersonal Psychotherapy for Depressed Adolescents (IPT-A)

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Abstract: Objectives: Recently the Food and Drug Administration (FDA) published a black box warning on the use of serotonin receptor reuptake inhibitors for adolescent depression. This situation makes the non-pharmacological therapeutic alternatives more relevant than ever before. The aim of this review is to introduce the theoretical formulation, practical application and efficacy studies of Interpersonal Psychotherapy for depressed adolescents (IPT-A). *Method*: A review is offered of published papers in peer-reviewed journals, books and edited chapters using Medline and PsychInfo publications between 1966 and February 2005. *Results*: IPT-A is an evidence-based psychotherapy for depressed adolescents in both hospital-based and community outpatient settings. *Conclusion*: IPT-A is a brief and efficient therapy for adolescent depression. Training programs for child psychologists and psychiatrists are recommended.

Introduction

The prevalence of adolescent depression in the general population is substantial, ranging from 3% to 9% (1). Major depression has been associated with impairment in psychosocial functioning at school, with friends and with family (2–4). Depression has been identified also as a leading risk factor for suicidal ideation and attempts (5) and completed suicide (6). Studies following depressed adolescents find high rates of recurrence into adulthood (7, 8).

There are many types of treatment for depressed adolescents including psychodynamic/psychoanalytic psychotherapy, cognitive behavioral therapy, family therapy, group therapy and pharmacotherapy. Many of these treatments are widely used in clinical practice despite the fact that they lack sufficient evidence for their efficacy with adolescents. Recently the Food and Drug Administration (FDA) published a black box warning on the use of serotonin receptor reuptake inhibitors (SSRI) for adolescent depression. This situation makes the non-pharmacological therapeutic alternatives more relevant than ever before.

Evidence based therapies include specific adaptations of Cognitive Behavioral Therapy (CBT) and Interpersonal Psychotherapy (IPT) (9). Research has shown CBT to be superior to a variety of therapies, although a substantial number of adolescents still do not benefit from this form of intervention and the reoccurrence of depression after an acute treatment is high (9). Interpersonal psychotherapy for adolescents (IPT-A) is the most recent psychotherapeutic intervention to be developed and has been found to be effective in several clinical trials of acute treatment (10–12).

Interpersonal Psychotherapy (IPT)

Interpersonal therapy (IPT) (13) was initially developed as a time-limited, focused treatment of depressed non-bipolar adult outpatients. The main goals of IPT are to decrease depressive symptomatology and to improve interpersonal functioning. IPT assumes that the development of clinical depression occurs in a social and interpersonal context and that the onset, response to treatment and outcomes are influenced by the interpersonal relations between the depressed patient and significant others (14–16).

Clinical depression in the IPT framework is conceptualized as having three components: symptom

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formation, social functioning and personality. IPT intervenes in the first two processes but it does not purport to have an impact on the enduring aspects of personality (13, 17).

The therapeutic model conceptualizes four specific interpersonal problems: interpersonal disputes, role transitions, grief and interpersonal deficits. The therapy usually focuses on one of these problem areas.

1. Interpersonal Disputes tend to occur in marital, family, social or work settings. They can be conceptualized as a situation in which the patient and other parties have diverging expectations of a situation and this conflict is severe enough to lead to significant distress. In these circumstances, IPT would aim to define how intractable the dispute was and identify sources of misunderstanding via faulty communication and invalid or unreasonable expectations. The therapist aims to intervene by communication training, problem solving or other techniques that facilitate change in the situation.
2. Role transitions are situations in which the patient has to adapt to a change in life circumstances. These may be developmental crises, adjustments in work or social settings or adaptations following life events or relationship dissolutions. In those who develop depression, these transitions are experienced as losses and hence contribute to the development of psychopathology. IPT aims to help the patient with role transition difficulties to reappraise the old and new roles, to identify sources of difficulty in the new role and to develop and implement solutions for these difficulties. Suitable interventions include linking the patient's affect to the difficult transition, clarification of the pros and cons of the new situation in comparison to the old, identification of skills needed to feel more confident and successful in the new role, practicing these skills and applying them to their significant relationships.
3. Grief is simply defined in IPT as loss through death. The grieving process can be abnormal by being delayed, distorted or by becoming a chronic reaction. The IPT therapist helps by reconstructing the patient's relationship with the deceased, helping to address unresolved issues in the relationship, linking the depression to the feelings for the deceased as well as through empathic listening to help facilitate the mourning process. A primary aim of the grief work is to help the patient to establish new relationships and increase their emotional support system.
4. Interpersonal deficits would be diagnosed when a patient reports impoverished interpersonal relationships in terms of both number and quality of the relationships. In many cases the patient and therapist will need to focus upon both old relationships as well as the relationship with the therapist. In the former, common themes should be identified and linked to current circumstances. In using the therapeutic relationship, the therapist aims to identify problematic processes occurring such as excessive dependency, fear of intimacy, deficits in initiating or maintaining relationships, or hostility and will aim to modify these within the therapeutic framework as well as by practicing new approaches to developing new relationships. In this way, the therapeutic relationship can serve as a template for further relationships, which the therapist will strive to help the patient create.

Clinical research has clearly established the efficacy of IPT for the treatment of depression in adults (18, 19). IPT has also been adapted for various populations such as the elderly (20), couples (21) and for various kinds of psychopathological states including bulimia (22) and as an adjunctive treatment for bipolar disorder (23).

IPT in Adolescents (IPT-A)

Mufson and colleagues (24–26) were the first to adapt IPT for use in adolescents with major depression (IPT-A). IPT-A is a manualized treatment, designed to be used once per week for 12 weeks (9, 25). The goals of the treatment are to reduce depressive symptoms and to address the interpersonal problems associated with the onset of the depression. The objectives of treatment take into account the adolescent's developmental tasks including individuation, establishment of autonomy, development of romantic partners, coping with initial experiences of loss

and death and managing peer pressure. IPT-A focuses largely on current interpersonal issues that are likely to be areas of the greatest concerns and importance to adolescents (9).

The treatment manual of the therapy is clear and user friendly (9, 25). It is organized as a step-by-step description of the therapeutic tasks of treatment and includes clinical vignettes to help guide the reader in the implementation of IPT-A. The manual also provides a brief overview of adolescent depression (including diagnosis, assessment, clinical course and other treatments) and efficacy data from clinical trials conducted using IPT-A. The manual has a section on special issues that arise when working with adolescents and how they can be addressed while staying within the IPT-A treatment framework.

Modification for Adolescents

The IPT-A differs from the adult version due to three major modifications: shortening of treatment duration from 16–20 weeks to 12 weeks of individual psychotherapy, adding the involvement of parents and the reconceptualization of the sick role to have a more limited focus.

The involvement of parents is throughout the therapy process. During the initial phase of treatment, the parents receive psychoeducation about depression, the limited sick role and treatment procedures. The adolescents and their parents are informed that the teenager has an illness that may affect his/her school performance and normal activities, but the adolescent is encouraged to participate in as many of his normal activities as possible. The parents are advised to encourage this participation and are informed that the teenager's performance (i.e., grades, cleanliness of room, completion of chores) will improve as the adolescent begins to feel less depressed. The teenager is discouraged from falling prey to the temptation to stay in bed, arrive at school late, cut classes, skip homework, and withdraw from activities with peers. The therapist emphasizes the need for familial support for the teen's treatment. During the sessions, family members are asked to participate in the middle phase of treatment as needed to facilitate work on communication between the adolescent and family members that has been identified as a problem area. In the termination phase of the treatment, a family member is included in a session to discuss progress in treatment, changes in the family as a result of the treatment and the need for further treatment.

Phases of the Treatment

The treatment is divided into three phases: initial phase, middle phase and termination phase. The initial phase focuses on depression diagnosis, psychoeducation about the illness and limited sick role, exploration of the patient's significant interpersonal relations, and the identification of the problem area that will be the focus of the entire treatment.

In the initial phase, the therapist conducts the "Interpersonal Inventory," which is a detailed review of the patient's significant relationships, both current and past. Examples of questions from the inventory are: Who in your family do you feel you confide in and go to help for? What are the positive and negative aspects of your relationship with X? Are there things you would like to change about this relationship? Was there a time when you felt differently about your relationship with X? This inventory is the focus of the initial phase of treatment as it provides the necessary interpersonal data to select one of the four problem areas for focus in the middle phase.

To conduct the Interpersonal Inventory, it is helpful for the therapist to use the "Closeness Circle" (9). This is a series of circles, one within the other with an x in the center, which represents the patient. The goal is to place the adolescent's significant relationships within the appropriate circles of closeness/importance in the teenager's life. The result is a picture of the significant people orbiting the adolescent's life and the emotional valence associated with their position in the adolescent's life.

As in the adult version of IPT, there are four identified problem areas in IPT-A upon which the therapy can be focused: 1. Grief due to death; 2. Interpersonal disputes with friends, teachers, parents and siblings; 3. Role transitions such as changing schools (e.g., elementary to junior high or junior high to high school), entering puberty, becoming sexually active, birth of another sibling, becoming a parent, parental divorce, illness of a parent; and/or 4. Interpersonal deficits such as difficulty in initiating and maintaining relationships and communicating

about feelings. When there seems to be two problem areas, the manual (9) suggests identifying a primary and possibly a secondary problem area.

During the middle phase of the treatment, the therapist teaches the adolescent specific strategies that can help him deal with his interpersonal difficulties within one or two problem areas. The IPT-A's techniques include exploratory techniques, encouragement of affect, communication analysis, behavior change techniques, (including decision analysis and role plays), use of the therapeutic relationship and adjunctive techniques (see details in "Therapeutic Techniques").

The termination phase includes clarification of the adolescent's warning symptoms of future depressive episodes, identification of successful strategies that were used in the therapy, generalization of skills to future situations, emphasis on mastery of new interpersonal skills and discussion of the need for further treatment. In the termination phase, the therapist should encourage the adolescent to identify specific future situations that are anticipated to be difficult or stressful and review the use of the new skills in these situations. This may help reduce relapse and reoccurrence, which are not rare in adolescent depression (2).

Therapeutic Techniques

1. Exploratory techniques include both directive and non-directive techniques. Directive exploratory techniques include targeted questioning and interviewing. The non-directive techniques include supportive acknowledgment, extension of the topic being discussed by the patient and receptive silence (9, 17).
2. Encouragement of affect includes facilitating acceptance of painful affect about events or issues; helping the patient use his/her affective experiences in making interpersonal change; and encouraging the development of new, desirable affects that may facilitate growth and change (17).
3. The communication analysis involves performing a thorough investigation of a specific dialogue or argument that occurred between a patient and another person. Communication analysis identifies ways in which the patient's communication is ineffective and fails to achieve the goal of the communication. The target is to teach the patient to communicate in a more effective manner by increasing his clarity and directness.
4. Directive techniques for behavior change include educating, advising, limit setting and modeling (17). Decision analysis is employed by the therapist helping the patient consider a range of alternative actions that he can take and the possible consequences associated with each of those actions. In role-playing, the therapist and patient act out the skills that the patient is learning in the treatment in a non-threatening way. The therapist can model many useful interpersonal skills such as: affective expression, effective communication and decision-making strategies. The therapist has to select a relevant topic with a manageable task and is encouraged to make it as engaging and fun as possible.
5. The therapeutic relationship in IPT-A provides an example of the patients' relationships and a forum in which skills can be practiced and feedback can be given. Negative feelings are understood as transference phenomena but are not dealt with using a psychodynamic perspective (17).
6. Adjunctive techniques include work assignments to be done at home between the sessions. The assignments usually involve practicing specific skills that were the focus of the sessions. They are referred to with the adolescents as "interpersonal experiments" or "work at home" (9).

Efficacy Research and Effectiveness Studies of IPT-A

IPT-A meets four essential conditions that permit its inclusion as an efficacious treatment: 1. The treatment is manual-based (9, 25); 2. The sample characteristics are detailed; 3. The treatment has been tested in a randomized clinical trial (10, 11); and 4. At least two different investigator teams demonstrated the intervention's effects (10, 12, 27).

The initial open trial conducted by Mufson and colleagues (26) had two phases. In the first phase, the treatment was modified to meet the needs of an adolescent population and was standardized in a treat-

ment manual. In the second phase, 14 depressed adolescents (ages 12–18) entered a 12-week open clinical trial of IPT-A. Subjects were assessed using a semi-structured diagnostic interview, self-report and clinician-administered instruments at six time points: evaluation week and weeks 0, 2, 4, 8 and 12. At termination, the adolescents reported a significant decrease in depressive symptomatology and an improvement in interpersonal functioning. None of the subjects met criteria for any depressive disorder at the conclusion of the study. In a follow-up analysis conducted with 10 of the 14 adolescents one year after the initial study, the adolescents were found to have maintained their state of recovery from depression. Only one of the adolescents (10%) who participated in the follow-up study was suffering from an affective disorder at that time. The majority of the subjects reported few depressive symptoms and had maintained their improvement in social functioning. There were no reported hospitalizations or suicide attempts since the completion of treatment and all were attending school regularly (28). Although this study was based on a very small sample size, it provided preliminary support for the use of IPT-A.

Subsequent work has shown IPT-A to be effective in the treatment of major depressive disorders in adolescents, randomly assigned to IPT-A or clinical monitoring (10). Significantly more IPT-A patients completed treatment. In addition, IPT-A patients reported fewer depressive symptoms, improved overall social functioning and better skills in certain areas of social problem-solving skills.

Rosselló and Bernal (12), who used a different modification of the adult manual, found that 82% of the adolescents receiving IPT compared to 52% of the adolescents receiving CBT met recovery criteria by the end of treatment. Both IPT and CBT were significantly better than the waitlist condition for decreasing depression symptoms. The authors also found that IPT was significantly better than the waitlist condition at increasing self-esteem and improving social adaptation.

A recent effectiveness study has compared IPT-A to treatment as usual (TAU) in the school-based health clinics in New York City as delivered by the clinicians employed in the school-based clinics (11). Treatment as usual consisted of the psychological treatment the adolescents would have received had the study not been in place (generally, supportive, individual counseling). Adolescents treated with IPT-A compared to TAU showed greater symptom reduction, significantly better social functioning, greater decrease in clinical severity of depression and improvement in overall functioning. In addition, the study demonstrated the ability to train community clinicians to deliver IPT-A effectively using a streamlined therapy training program and similarly demonstrated the transportability of IPT-A from the university lab setting to the community (29).

IPT-A has also been adapted to a group format (IPT-AG) that has been recently studied in a pilot controlled clinical trial and the treatment has been outlined (30, 31). The group modality of IPT-A (IPT-AG) is hypothesized to be effective for depressed adolescents since it will address adolescents' need for peer support, allow patients to try new strategies in an actual interpersonal context and to obtain feedback on their execution (30). The group provides the patient with peers who have similar difficulties and who are empowered by the collaborative effort of the group, which is so important for adolescents.

The group manual (30) provides guidelines for working with interpersonal issues and for keeping the group discussion relevant to the group as a whole. Mufson and colleagues (31) recently completed a pilot controlled clinical trial comparing the feasibility and efficacy of individual IPT-A to IPT-AG for the treatment of adolescents with a range of depressive disorders including major depression, dysthymia, adjustment disorder with depressed mood and depressive disorder not otherwise specified. More work is needed to determine the efficacy of IPT-AG, but it holds the potential for being an important cost-effective treatment option for overburdened staff and clinics.

The use of IPT-A in combination with medication has not been studied in a clinical trial. However, it is frequently used in this way, in the outpatient psychiatry clinics in the New York Presbyterian Hospital and has been shown to be beneficial to the adolescents (10).

Conclusions

IPT-A is a focused and brief therapy for depressed

Table 1. *Studies in IPT-A*

	Type of Study	Purpose of study	N	Age	Main results
Mufson et al. (1994, 26)	Open trial	Acceptability and efficacy	14	12–18	↓ Depressive symptoms ↑ General functioning
Mufson et al. (1996, 28)	One year follow up	Follow up	10	12–18	Maintained recovery
Mufson et al. (1999, 10)	Randomized control clinical trial IPT-A vs Clinical monitoring	Efficacy of IPT-A	48	12–18	↑ Treatment completion ↓ Depressive symptoms ↑ General functioning + Interpersonal problem solving skills
Rossello & Bernal (1999, 12)	Randomized control trial: IPT vs CBT vs Wait list	Efficacy of a different modification	71	13–17	↓ Depressive symptoms ↑ Self esteem+ social adaptation (>Wait list)
Mufson et al. (2004, 11)	Community setting: IPT-A vs. TAU effectiveness	Effectiveness study	63	12–18	↓ Depressive symptoms ↑ global+ social functioning
Mufson et al. (2004, 30)	Adaptation to a group format (IPT-AG).	Acceptability and feasibility	One group of 6	13–17	↑ Attendance rate ↓ Depressive symptoms ↑ Children's global assessment scale
Mufson et al (2004, 31)	IPT-A Vs IPT-AG.	Efficacy of IPT-AG	18 (10 in IPT-AG)	13–18	No significant difference in symptoms, overall functioning and social functioning. In some instances greater improvement in IPT-AG

adolescents. IPT-A has been found to be both efficacious and effective in several therapeutic settings. It is important to emphasize that we do not think IPT-A is the only therapy for depressed adolescents and might not even be the best one for all patients. However, it is important for a therapist to be trained in IPT-A and to be able to use it whenever appropriate. The group adaptation (IPT-AG) may be another cost-effective option since it allows staff and clinics to meet the needs of more patients without additional personnel or more clinical hours. However, more research is needed on its efficacy at this time and a new study is soon to be underway.

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