The Future of Interpersonal Psychotherapy

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This article briefly reviews the past and present and speculates on the future of interpersonal psychotherapy (IPT), a time-limited, empirically supported treatment for depression and other psychiatric syndromes. IPT and other psychotherapies face a role transition in adjusting to an economically and otherwise turbulent future. The author speculates on the outcome in clinical, research, and other domains. (The Journal of Psychotherapy Practice and Research 1997; 6:294–299)

Like the rest of psychotherapy and of medicine, interpersonal psychotherapy (IPT) is itself in a role transition. By definition in IPT, a role transition is a life change that a patient has trouble navigating and that is associated with depressive symptoms. The change in life situation feels to the patient chaotic, out of control, a free fall. The patient nostalgically recalls the time prior to the transition as halcyon, a golden age, while viewing the present and future as drear and hopeless. The current role transition of the field of psychotherapy has been induced in part by scientific advances, but principally by economics. As an empirically tested psychotherapy, IPT is both agent and victim of the upheaval: in part a cause of the change and in part buffeted by it.

It may be discomfort with this role transition in psychotherapy that prompted the symposium on “The Future of Psychotherapy” at which this paper was presented. Perhaps we are seeking hopes and answers for a happier future. (This would be a concretely adaptive effort, the sort of pursuit of options IPT espouses for patients.) Adjusting appropriately to a role transition requires that one mourn the loss of what was good in the old, lost role, but also recognize its disadvantages—and, conversely, that one appreciate the potential present and future good of an uncomfortable new role in addition to recognizing the adversities that may accompany it. To successfully resolve
a role transition, the IPT patient must make changes in his or her life situation and acquire new coping skills, not simply an understanding of the changed role. I propose that we hold ourselves to the same approach.

**IPT: Past and Present**

Interpersonal psychotherapy\(^1\) is now 20-odd years old. Begun as a research intervention, IPT developed into a highly regarded, empirically tested, time-limited psychotherapy of particular psychiatric disorders. Its success in a series of controlled clinical trials demonstrated the efficacy of IPT with various subtypes of depressed patients as well as patients with some nonaffective disorders.\(^2,3\) It remained, however, almost exclusively a research intervention, available only at a few research centers and practiced by a handful of research clinicians.

The basic principle of IPT is that depressive (or other psychiatric syndromal) episodes occur in an interpersonal context. Interpersonal life events affect mood, and mood affects how the individual handles his or her life role. A time-limited treatment with a predetermined 12- to 16-week duration, IPT provides pragmatic, coherent strategies that focus on one or two of four research-derived interpersonal problem areas: 1) grief (complicated bereavement), 2) role dispute, 3) role transition, and 4) interpersonal deficits. This interpersonal focus is linked to the depressive episode, which is defined as a medical illness. The IPT therapist uses the connection between mood and life situation to help the patient understand, gain control of, and change his or her life role. The resolution of the interpersonal problem area represents a positive good in itself and a major accomplishment by a patient who had been feeling depressed and incompetent. Moreover, it alleviates the depressive syndrome. IPT focuses on the "here and now" in the patient's life outside the office; it looks forward rather than backward in time; and it counters the patient's depressed outlook with an optimistic, can-do emphasis on concrete life gains.\(^4\)

IPT is now an established treatment in the United States. It is included in several treatment guidelines and recognized as an indicated treatment for several disorders, including depressive subtypes and bulimia. Clinicians are starting to present IPT training as a credential for academic and managed care positions. Yet how many of us are familiar with IPT? Many still know it only from research reports and are unschooled in its strategy and techniques. This highlights a problem with IPT at present (Table 1).

The number of clinicians trained in IPT remains small, but training is now available at several sites (Cornell University in New York City; the University of Pittsburgh; and the Clarke Institute in Toronto) and in an increasing number of courses and workshops. Interest in IPT has also spread from the United States to Canada, Europe, Asia, and Australia.\(^5\) A series of clinical trials is under way or planned to test the efficacy of IPT in the treatment of mood, anxiety, and other psychiatric disorders. This is the state of IPT as it faces the transition in mental health and health care at the close of the 20th century.

**The Future of IPT**

What may we expect IPT to become as we approach the 21st century? As one of the workers involved in carrying on the development of this treatment, which was first developed by the late Gerald L. Klerman, M.D., the still very active Myrna M. Weissman, Ph.D., and their colleagues, I shall offer my speculations on the clinical, research, and political developments affecting IPT to come (Table 2).

**TABLE 1. Current status of IPT**

- Established efficacy for unipolar depression, some other disorders
- Largely a research intervention; little clinical dissemination until recently
- Efficacy better studied than effectiveness
- Guideline and managed care "endorsements"
Clinical Training in IPT

Many research goals remain, but probably the most pressing issue for IPT is its translation from a purely research therapy to a clinical treatment. For IPT to survive and develop as a psychotherapy, it must ultimately become more than simply a research intervention. How this process occurs may importantly influence the nature of training programs, the certification of IPT therapists, and other aspects of IPT. Research should determine clinical indications for IPT, but what should be the standards for training and certifying clinicians?

As a useful comparison, cognitive-behavioral therapy (CBT), another time-limited, research-tested psychotherapy of similar age, established clinical training institutes early in its existence. There are meetings and journals devoted to CBT, and an organizational body is being formed to set standards for formally certifying CBT psychotherapists. An unintended consequence of its clinical dissemination is that CBT, although invented by a psychiatrist, has become largely the province of psychologists.

In contrast, Klerman and colleagues declined to train therapists in IPT before the treatment had been repeatedly tested. Klerman’s death then further delayed the dissemination of training. As a result, a relative handful of clinicians were trained in IPT, and almost solely for research protocols. Increasingly, however, there have been workshops at academic institutions and hospital clinics; courses at the American Psychiatric Association annual meeting and elsewhere have regularly filled up; and psychiatrists in numerous countries have requested training. Therapists and institutions seek to learn IPT in order to ensure managed care reimbursement for a “proven” therapy. IPT is being translated into languages other than English, and we have trained some international IPT clinicians via long-distance supervision by videotape, Federal Express, and telephone. Some residency training programs are also incorporating IPT into their curricula. Even more impressively, patients who have read about IPT frequently call for referrals—often to be disappointed to learn that there are no trained IPT therapists in their area. Managed care may also have an interest in time-limited therapies of proven efficacy, although the managed care conception of time-limited therapy, based on short-sighted economics rather than empirical outcome data, is usually radically shorter than the 12 to 16 weekly sessions of acute IPT.

Because IPT has not yet spread widely in clinical circles, it may have preserved a relative “purity” in comparison to psychodynamic psychotherapy and CBT, which doubtless have developed variants over geography and time. The opportunity exists to provide quality control for IPT earlier in the dissemination process, establishing standards at the outset for training, certification, and credentialing. We know that IPT works in the hands of well-trained psychotherapeutic clinicians who get research-level IPT training (typically 3 audio- or videotaped cases, supervised hour by hour). There is presumably a decrement in efficacy in cases where training rigor and clinical talent are less. We need to determine thresholds and requirements for training for clinicians at large.

The risks and benefits of setting standards are apparent. Without guidelines and standards, IPT is likely to become a catchphrase without much actual value: therapists will take a brief course and then tell patients, “Oh, yes, I do IPT.” On the other hand, I have concerns about creating a bureaucratic monster to oversee the clinical spread of IPT. IPT has had no central agency: as with many therapies, people have looked to its inventors for training and approval. Drs. Klerman and Weissman kept
matters informal, an approach that was feasible when IPT was small and research centered.

As IPT grows, some more formal—but, one hopes, not too formal—organizational approach will be needed. Sessions at the upcoming annual meeting of the American Psychiatric Association and elsewhere should provide forums to discuss clinical credentialing for IPT both in the United States and abroad. I believe that three supervised cases provide a solid background for most clinicians, although some could probably get by with fewer. There should probably be some central board to certify qualified therapists, and a newsletter might be useful to keep IPT therapists abreast of developments in the field.

Other educational issues require the participation of mental health leaders who may not themselves know IPT. For example, should IPT be taught in residency training programs? Unlike training in psychodynamic psychotherapy and cognitive-behavioral therapy, training in IPT is not mandated by the Program Requirements for Residency Education in Psychiatry of the Accreditation Council for Graduate Medical Education. Some foresighted training directors have incorporated IPT into time-limited therapy curricula, but these programs as yet constitute a small minority. It is noteworthy, however, that the programs that do teach IPT include, but are not limited to, those with strong traditions of psychotherapy training, such as Cornell and Columbia. Some residency programs that used to disdain psychotherapy instruction and provide the bare minimum of it have come around to time-limited treatments, in large part because of the empirical evidence supporting the efficacy of IPT and CBT.

I believe that IPT, CBT, and other focal treatments are valuable aspects of a modern psychiatric and mental health education—additions to the psychodynamic approaches that should probably remain the foundation of the resident’s education. IPT (like CBT) is a simple, practical approach that residents in their second postgraduate year (PGY-II) may be able to use in working with depressed inpatients, rather than holding their tongues and feeling they have nothing to say. PGY-III and PGY-IV residents should be learning an array of techniques. Rather than learning one psychotherapy to treat all comers, they should be familiar with a range of psychotherapies—alogous to the range of pharmacotherapies—and comfortable with taking a differential therapeutic approach, matching the best available treatment to the needs of the patient.

Future Research in IPT

Relative to its clinical spread, IPT has been employed in a great deal of research. This has established both its efficacy for some populations (especially mood disorder patients; also bulimic patients) and its limitations for others (negative studies for opioid and cocaine patients). Yet much more research must be done to fully determine its therapeutic limits for a range of disorders, as well as its optimal dosing and duration, its sequencing and combination with pharmacotherapy, and its translation from efficacy studies to effectiveness in general practice (Table 3).

Interpersonal issues are ubiquitous, but are they always the royal road to treating a disorder? The negative outcome findings for substance abuse suggest that they are not. Thase et al. have shown that IPT works less well for depressed subjects with abnormal sleep EEG profiles. Thus, IPT is no panacea; nor should we expect any one treatment to be.

The first trials are now getting under way to determine the efficacy of IPT as a treatment for anxiety disorders. I predict that these will have positive outcomes. In discussing the adaptation of IPT to social phobia and panic disorder with some of the investigators, I have been impressed at how well the IPT paradigm for mood disorders fits the needs of anxious patients. For anxiety disorders strongly linked to social situations (such as social phobia) or traumatic life events (such as posttraumatic stress disorder), IPT can offer a credible psychosocial formulation and rationale for
treatment. Similarly, I anticipate that IPT will be a good treatment for depressed caregivers of Alzheimer's patients, for patients in early recovery from alcohol dependence, and for other patient populations where interpersonal issues weigh heavily.

The medical model of IPT fits neatly with that of pharmacotherapy, and research has suggested acute, although not chronic, synergy of IPT and antidepressant medication. Far more needs to be learned about the indications and the timing of combined treatments: that is, for which patients, and with what timing, should IPT and medication be combined? We also need more than the scarce current data on serial treatment: that is, when psychotherapy fails, should one try pharmacotherapy, and vice versa?

IPT as an acute treatment is generally set at 12 to 16 sessions for somewhat arbitrary reasons related to comparison with pharmacotherapy in outcome research. We do not know the optimal length or dosage of IPT for particular disorders. And although IPT is the only therapy whose maintenance efficacy has been demonstrated in the treatment of major depression, there is only one study, at one dosage, currently in the literature. (Another study, testing different maintenance doses, is ongoing in Pittsburgh [E. Frank, personal communication, April 1997].) We also know little about adapting IPT to other modalities: for example, group IPT or IPT by telephone.

Future research must study the translation of efficacy in research trials to effectiveness in standard clinical settings. There has been little research attention to effectiveness for most psychiatric treatments, including most psychotherapies. Because IPT has been almost entirely a research intervention, the need to study its clinical effectiveness is the more pressing.

We also know relatively little about the process of IPT. Whereas historically psychotherapy process research overwhelmed outcome research, Dr. Klerman felt that process research was superfluous until you had determined that the treatment worked: if it lacked efficacy, why would the ingredients of the therapy matter? Now that the efficacy of IPT has been demonstrated for some disorders, exploration of its active ingredients deserves greater attention. What makes IPT work? Its focus on life events seems to make it a credible approach for patients who have experienced significant life changes. But that premise deserves careful assessment.

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<th>TABLE 3.</th>
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<td>• Antidepressant pharmacotherapy nonresponders</td>
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<td>• Anxiety disorders</td>
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<td>• Social phobia, PTSD, panic</td>
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<td>• Recovering alcohol-dependent patients</td>
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<td>Sequencing/dosing studies</td>
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<td>• Maintenance dosing frequency</td>
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<td>• CBT, brief psychodynamic therapy</td>
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<td><strong>Note:</strong> PTSD = posttraumatic stress disorder; CBT = cognitive-behavioral therapy.</td>
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**IPT as a “Niche” Treatment**

No psychotherapy should aim to provide all things to all patients or to all therapists. From its inception, IPT has been driven by research and targeted to diagnosis, and it has staked out one diagnostic area after another based on empirical outcome findings. This approach should continue. We should determine treatment on the basis of outcome findings rather than ideology. Psychotherapies should learn to coexist in the future, even within the same psychotherapist. The best-prepared psychotherapist will be the one who can choose among psychotherapies in his or her treatment armamentarium, applying the optimal strategy to a given diagnosis or difficulty. IPT can be delivered by mental health professionals of
varying backgrounds. It remains to be seen to what degree psychiatrists will practice it.

How will IPT survive the role transitions of clinical expansion, further research testing, and the shifting economics and practice of psychiatry and other mental health professions? I think it is likely to come through well; it should be a growth industry. With appropriate preparation, its clinical expansion can maintain a high quality of training without unduly burdensome bureaucratization. The research accomplishments of the past provide a template and a direction for future studies. And because of its limited treatment aims (limited, that is, by diagnosis) and support from empirical testing, it should adjust to the economic future of psychotherapy relatively well.

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**References**