

Review

Interpersonal psychotherapy for depression? The need to define its ecological niche

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Abstract

Background: Interpersonal psychotherapy (IPT) has long been viewed as an efficacious treatment for depression, with a large number of published studies allowing its efficacy and utility to be considered closely.

Methods: We review original studies and the one published meta-analysis of controlled efficacy trials, examining acute-phase and prophylactic studies, comparison studies with cognitive behaviour therapy, and studies evaluating its efficacy in combination with pharmacotherapy.

Results: We highlight difficulties in evaluating any psychotherapy, particularly when tested as having universal application for varying depressive conditions, but do identify circumstances where IPT may have specific salience.

Conclusions: As for other treatments, IPT is unlikely to be a universal therapy for depression. This review offers suggestions as to where its preferential utility may lie, and argues for modified research paradigms to assist definition of its therapeutic niche.

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1. Introduction

Both interpersonal psychotherapy (IPT) and cognitive behaviour therapy (CBT) have come to be regarded as definitive psychotherapies for depression. They have been operationalized through treatment manuals specifying procedural rules, a credible explanatory theory links the treatment approach to predisposing and precipitating factors, and they have been studied extensively in randomized controlled studies. In a previous review (Parker et al., 2003) we examined the efficacy and role of CBT as a psychotherapeutic approach to managing depression. This review similarly considers the efficacy of IPT and argues for a paradigm shift to identify its therapeutic ecological niche.

2. Development of IPT

IPT had its origins as a plausible psychotherapeutic control for studies evaluating the comparative efficacy of drug and psychotherapeutic approaches to depression. Stuart and Robertson (2003) state that it was developed as a “manualized ‘placebo condition’” (p. xii), “inert treatment, or at most was simply a codification of ‘non-specific’ therapeutic factors common to all psychotherapies” (p. xiii), and that it was “largely accidental that IPT was discovered to be of benefit” (p. xii).

An early development paper (Klerman et al., 1974) stated that, while antidepressant drug therapy had established acute-phase efficacy, relatively few “systematic attempts have been made to study psychotherapy in depressed patients” (p. 190). In Klerman et al.’s initial study, psychotherapy commenced following improvement during an open trial of amitriptyline for “neurotic depressed patients”. The psychotherapy was described as a “high contact” condition and hypothesized to have only

a non-specific milieu effect, with an experienced social worker undertaking weekly casework therapy exploring “the patients’ personalities and life experiences” (p. 188). Relapse rates were similar: 12% in those receiving drug and “little psychotherapy” vs. 16% in those receiving “more psychotherapy and no medication”. The psychotherapy was judged as “beneficial to patients with problems of social adjustment and interpersonal relations”, with results encouraging the development of IPT as a definitive rather than a control treatment.

Klerman et al. (1974) subsequently developed the therapeutic approach, its theoretical underpinnings and a codified manual. Such developments and its inclusion in the seminal NIMH Treatment of Depression Collaborative Research Program (Elkin et al., 1989) established its reputation as a psychotherapeutic treatment, and led to a bank of evaluative studies.

3. Logic of IPT

Underpinned by attachment, interpersonal and social theories, IPT assumes that an acute psychosocial stressor, in conjunction with insufficient social support, can lead to depressive symptoms. Interpersonal difficulties may be causal, concomitant or maintaining factors for depression. Stuart and Robertson (2003) defined two therapeutic targets. First, IPT focuses on the conflicts and transitions in the patient’s relationships, to improve communication or readjust expectations. Second, it aims to assist patients to build or better utilize their social support network, facilitating crisis management. In contrast to some other psychotherapies, it does not directly address the patient–therapist relationship. It focuses on ‘here and now’ components rather than developmental issues. In application (Stuart and Robertson, 2003), an Interpersonal Inventory is compiled, a unique feature of

IPT, in which a structured social history is obtained, with a focus on relationship issues relevant to the patient's current psychological distress.

Such a model would appear more suited to those with reactive (or adjustment) depressive disorders and social support limitations. However, like other treatments, IPT has generally been studied as a treatment for major depression. The intrinsic heterogeneity of that diagnosis risks compromising assessment of IPT's efficacy in subgroups that might benefit most.

A decade ago IPT was positioned for mild to moderate depression. Its application has since broadened to include many other psychiatric disorders. The literature on IPT is vast, but our review is restricted to its efficacy in depression.

4. Efficacy of IPT for depression

4.1. Overview

The efficacy of IPT has been considered in numerous individual studies and several aggregated analyses. In relation to the latter, [Thase et al. \(1997a\)](#) undertook a 'mega-analysis' of pooled data from six controlled studies of psychotherapy for patients with major depression, but the analyses aggregated IPT with CBT in quantifying the impact of 'psychotherapy', disallowing IPT's efficacy to be examined by itself. While [Westen and Morrison \(2001\)](#) included many IPT studies, their meta-analysis did not examine its individual or comparative effects. A meta-analysis by [de Mello et al. \(2005\)](#) considered a refined set of 13 studies, with the criterion diagnosis being major depression in eight, neurotic depression in one, dysthymia in two, major depression/dysthymia/double depression in one, and 'mood disorder' in the remaining study. While their selection of studies and analytic strategies can be criticized (with several analyses appearing particularly problematic), it is the only published meta-analysis of IPT, and is used here as an organizing point before considering individual studies.

4.2. Efficacy of IPT vs. 'placebo' in acute-phase studies

The meta-analysis ([de Mello et al., 2005](#)) identified six 'acute treatment' studies (i.e., lasting 16 weeks or less) comparing IPT vs. placebo, with a non-significant trend favouring IPT (with remission rates of 68% vs. 49%, respectively) and with IPT associated with greater depression symptom reduction. However, the meta-analysis included studies with a variety of "control" conditions, with few – if any – credible psychotherapy "placebos" ([Nathan et al., 2000](#)). IPT was compared to a

'waitlist' control in two trials ([O'Hara et al., 2000](#); [Rosello and Bernal, 1999](#)). A third ([Mufson et al., 1999](#)) compared IPT to "clinical monitoring" – variably described as a "call-me-if-you-need-me" or "waitlist" control. The fourth study ([Weissman et al., 1979](#)) compared IPT with "nonscheduled treatment", assigning the subject to a psychiatrist if needed and allowing contact by telephone or for a maximum of one 5-minute session per month. In the fifth study ([Reynolds et al., 1999a](#)), control conditions included placebo tablet plus "clinical management" and placebo tablet plus IPT.

The sixth study was the NIMH-supported Treatment of Depression Collaborative Research Program or TDCRP study ([Elkin et al., 1989](#)). Subjects with major depression were randomly assigned to 16 weeks of either (i) imipramine plus clinical management (CM), (ii) IPT, (iii) CBT, or (iv) drug placebo plus CM. The CM condition involved review of the subject's clinical status, management of medication and side-effects and "direct advice if necessary", described as "minimal supportive therapy...designed to avoid creating a significant overlap with the two psychotherapy conditions" ([Elkin et al., 1985, p. 311](#)).

Among study completers ($n=155$), recovery rates based on Hamilton Depression Rating Scale scores were 57% for the imipramine group, 55% for IPT, 51% for CBT and 29% for CM. While not significant, group differences suggested that the manualized psychotherapies were superior to the non-specific CM control, and equivalent to each other. The intention to treat rates ($n=204$), which included subjects having "at least minimum exposure" ($p. 974$) were 49%, 47%, 40% and 26%, respectively, with a non-significant trend favouring imipramine and IPT to CM.

Although a more rigorous comparator than a waiting list control, the CM condition still lacked the crucial ingredient of credibility, with clinicians specifically directed to withhold interventions they might judge as helpful to their patients. The authors ([Elkin et al., 1989](#)) nonetheless observed there was "limited evidence of the specific effectiveness of IPT or CBT", and that the main reason for non-differential findings reflected the "very good performance" of the CM condition rather than lack of improvement in the psychotherapy groups. Further, the success of the CM comparator was noted to be in sharp contrast to the "fairly poor performance of waiting-list or delayed-treatment groups used as controls in other studies of brief psychotherapies" ($p. 978$).

A key issue in interpreting results from these studies is the nature of the various "placebo" control conditions, an issue relevant to testing any psychotherapy. At a minimum, a credible psychotherapy placebo requires a therapist to offer the same non-specific therapeutic

ingredients (e.g., support, empathy). Allocation to a waiting list is likely to militate against improvement as the therapeutic ‘starting pistol’ has yet to be ‘fired’ and few non-specific therapeutic ingredients activated. Comparisons involving an active psychotherapy to a condition utilizing a placebo tablet with minimal ‘medication management’ are more complicated, as the placebo pill may lead to expectations of improvement by both clinicians and patients. These expectations, however, are likely to be mitigated by requiring the clinicians who provide ‘medication management’ to specifically withhold interventions believed beneficial, disallowing psychotherapeutic management elements.

In sum, while the individual studies support the efficacy of IPT compared to no treatment or minimal intervention, differentiation may more reflect non-specific therapeutic elements.

4.3. Efficacy of IPT alone compared to antidepressant medication alone

Nine studies comparing IPT and medication monotherapy were included in the reference meta-analysis (de Mello et al., 2005). Four (Elkin et al., 1989; Weissman and Markowitz, 1994; Reynolds et al., 1999a,b; Markowitz et al., 1998) were 4-month and two (Klerman et al., 1984; Brown et al., 1996) were 8-month studies; another (Browne et al., 2002) lasted 96 weeks and two (Frank et al., 1990; Reynolds et al., 1999a,b) were 150-week maintenance studies. The drugs received by 459 randomized subjects were amitriptyline, imipramine, nortriptyline and sertraline, while 488 subjects were randomized to IPT. There were no differences between treatments in acute treatment (4 months) studies (51% vs. 44% remission rates for drugs and IPT, respectively). de Mello et al. (2005) reported no significant differences between treatments in the two 150-week prophylactic studies, but a non-significant trend (relative risk = 2.01, CI 0.99–4.05) favouring IPT over drug treatment with respective recurrence rates of 36% and 68%. Their judgments are *the converse* to results from each of the two actual contributing studies: the Frank et al. study (1990) found patients receiving pharmacotherapy had better outcomes on all parameters with mean time to recurrence being 124 weeks for those receiving imipramine and 82 weeks for those receiving IPT; while the Reynolds et al. study (1999a,b) reported recurrence rates of 43% for nortriptyline and 64% for IPT. An erroneous analytic interpretation of the meta-analysis appears to have occurred.

A potential confound in the interpretation of these studies and the validity of combining them in a meta-

analysis is whether the duration of treatment and adherence are comparable. For instance, if psychotherapy was provided for only part of a 6-month acute treatment study, or provided less frequently during a maintenance study while the antidepressant drug was maintained, there is an intrinsic advantage to drug treatment. In fact, the comparison treatments were maintained for the duration of the 4-month studies but were variable in several of the longer studies. Thus, in one 8-month study (Brown et al., 1996), the acute phase of pharmacotherapy and psychotherapy lasted 2 months and 6 months, respectively, while drop-out (non-adherence) rates differed in the continuation phase (40% vs. 20%, respectively).

A second confound is the assumption that contrasting therapies induce responses at the same time. If response trajectories differ, the duration of the study duration may lead to apparent treatment differences. For instance, Watkins et al. (1993) indicated that, in the TDCRP study, response to imipramine occurred in the first 8 weeks with little additional benefit during the second 8 weeks. In contrast, IPT showed little benefit between four and 12 weeks, but there was a sharp improvement between 12 and 16 weeks. While there are many explanations for such a ‘tortoise and hare’ result, results favouring IPT or medication could reflect study end-point choices.

4.4. Efficacy of IPT plus medication (combination therapy) compared to IPT or medication alone

Several early studies (e.g., 14) suggested that the combination of IPT and antidepressant were more effective than either treatment alone, reflecting benefits of medication on depressive symptoms and psychotherapy on psychological vulnerabilities.

The meta-analysis (de Mello et al., 2005) compared combination therapy (i.e., IPT and medication) against medication alone, but not against IPT alone – with no significant differences. Specifically, remission rates for combination treatment compared to medication alone were 77% vs. 68% for acute treatment (16 weeks or less) and 60% vs. 61% for maintenance treatment (more than 6 months), and recurrence rates were 78% vs. 68% in prophylaxis studies. Such results suggest a weak (at best) benefit of combination IPT and medication compared to medication alone.

However, a number of individual studies suggest that ‘adding’ medication to IPT delivers greater benefit than ‘adding’ IPT to medication. In the randomized 3-year maintenance study (Frank et al., 1990), relapse rates were 65% for those receiving placebo, 46% for IPT alone, 18% for imipramine alone and 8% for IPT plus imipramine. In a sample of elderly subjects with

bereavement-related depression (Reynolds et al., 1999a), the acute phase remission rate was 69% for combination therapy, 56% for medication alone and 29% for IPT alone. In the other late-life study (Reynolds et al., 1999b), long-term recurrence rates were 90% for placebo plus medication clinic, 64% for monthly IPT plus placebo, 43% for nortriptyline plus medication clinic, and 20% for nortriptyline plus IPT. Although limited by small subject numbers, study trends suggest combination therapy as superior to monotherapy, with medication the more effective monotherapy than IPT.

Browne et al. (2002) came to a similar conclusion after studying 707 primary care patients with dysthymia. In the acute (6 months) phase, responder rates were 60% for those receiving the SSRI sertraline alone, 47% for IPT alone and 57% for combination therapy. Thus, drug therapy, alone or in combination with IPT, was superior to IPT alone, while combining IPT with medication did not improve the response to medication alone.

In summary, studies suggest an advantage to combination therapy over IPT alone, but no clear advantage for combination therapy over medication alone.

4.5. Efficacy of IPT compared to CBT

The meta-analysis (de Mello et al., 2005) considered three studies (Elkin et al., 1989; Rosello and Bernal, 1999; Markowitz et al., 1998), with 102 subjects randomly assigned to IPT and 102 to CBT. Remission rates for IPT and CBT (56% vs. 47%) did not differ significantly.

The first trial was the NIMH–TDCRP study (Elkin et al., 1989), in which no significant differences between treatments were found in any of the major or secondary analyses. In the second study (Rosello and Bernal, 1999) of depressed Puerto Rican adolescents, both IPT and CBT were superior to the waitlist control. The two psychotherapies were “essentially equivalent in reducing depressive symptoms” but, as some analyses suggested that IPT was superior to CBT in terms of self-concept, social adaptation and functional performance, the authors proposed that IPT might be more compatible with Puerto Rican cultural values favouring family over the individual. The third study (Markowitz et al., 1998) involved HIV seropositive subjects randomly assigned for 16 weeks to the same four study treatments employed in the TDCRP study. IPT was superior here to CBT, with the authors suggesting that IPT might have a preferential advantage by connecting “life events to mood episodes” and so providing a “tailored fit of therapy and patient”. Thus, IPT superiority was suggested in the two samples where depressive disorders were more likely to be ‘reactive’ (HIV subjects and adolescents).

In another TDCRP analysis, Imber et al. (1990) observed that none of the therapies during the acute phase produced clear and consistent effects on measures related to their theoretical origins, and suggested that core processes operated across treatments, overriding differences in techniques. Such a ‘common factor’ proposition argues that shared, rather than unique features of each method are responsible for their outcomes.

But do CBT and IPT differ in vivo? De Rubeis and colleagues (1982) presented videotapes of clinical sessions using each modality to 12 raters. The study defined 38 items discriminating between CBT and IPT, suggesting that procedural differences can be detected in vivo. However, Ablon and Jones (2002) suggested that differentiation may not have occurred in the TDCRP study. They scored the study transcripts of IPT and CBT and compared them to independently derived prototypic descriptions of each therapy. CBT and IPT treatment transcripts were both more strongly associated with the CBT prototype, while the degree of adherence to the CBT prototype correlated with positive outcome for both those receiving IPT and CBT. The authors argued that the two treatments were “by no means pure and distinct”. Thus, despite prescriptive manuals, extensive training, and adherence checks, the psychotherapy ‘delivered’ may not have corresponded to the study objectives. Many commentators have re-analyzed the TDCRP study to argue that IPT or CBT showed some advantage over the other, but such conclusions would appear irrelevant if their delivery cannot be discriminated.

5. Clinical factors influencing response to IPT

Several studies have identified clinical variables that might influence IPT outcomes.

5.1. Depressive sub-type

5.1.1. Melancholia

While there has been a long-standing controversy about the status and classification of melancholia (endogenous depression), defining characteristics include distinctive clinical features, low placebo response rate and preferential response to somatic treatments such as antidepressant drugs and ECT (Parker et al., 1996). Thase and Friedman (1999) concluded there was a lack of evidence that melancholic patients respond to psychotherapy as well as to medications, a conclusion supported by a 16-week controlled trial by Prusoff et al. (1980) comparing amitriptyline, IPT, or their combination. In this study, a diagnosis of endogenous depression predicted a poor response to IPT alone and a good response to

combination treatment, while subjects with “situational” depression responded to all three active treatments. In contrast, Sotsky et al. (1991) reported that patients with endogenous depressive episodes responded favourably to IPT in the TDCRP trial.

Thase et al. (1997b) suggested that neurobiological measures might provide a better means of identifying endogenous depression. Their data indicated that patients with neurobiological disturbances, measured by EEG monitoring of sleep, were less responsive to IPT. Those with abnormal EEG profiles had a higher remission rate with combination drug plus IPT compared to IPT alone (75% vs. 37%).

5.1.2. Atypical depression

Atypical depression may or may not be a distinctive depressive sub-type (Parker et al., 2002). Stewart et al. (1998) examined the response of subjects with atypical depression to the four interventions in the TDCRP study. IPT achieved similar response rates in patients with and without atypical features (i.e., 58% vs. 55%), while CBT response rates were 69% vs. 41%, respectively. They suggested that atypical features conferred “poor tricyclic responsivity” but did not lead to response differences between IPT and CBT, and that CBT was significantly superior to imipramine in patients with atypical features, with a trend for IPT to be superior as well.

5.1.3. Perinatal depression

The psychosocial changes associated with pregnancy and childbirth suggest that IPT may be a salient treatment. In antenatal depression, Spinelli and Endicott (2003) reported that women who received 16 weeks of modified IPT were more likely to recover than controls receiving didactic parenting education (60% vs. 15%). In postnatal depression, O’Hara et al. (2000) compared 12 weeks of IPT with a waitlist control, with those receiving IPT having a greater reduction in depression symptoms, more improvement in psychosocial functioning and better marital adjustment. Zlotnick et al. (2001) reported a pilot prophylactic study in financially disadvantaged pregnant women at risk for postnatal depression. Six of 18 women who received ‘treatment as usual’ developed postnatal depression compared to none of the 17 in the four-session IPT group.

5.2. Depression severity

Several studies have examined whether IPT is efficacious in patients with ‘more severe’ depression. In the TDCRP study, depression severity had a major influence

on outcomes, although the authors (Elkin et al., 1989) cautioned that treatment assignment was not stratified by severity. For less severely depressed subjects, all four treatments were associated with comparable improvement. For more severely depressed subjects, imipramine was the most, and placebo plus clinical management the least effective treatment, with both IPT and CBT intermediate in their effectiveness. A sub-analysis (Taylor et al., 1999) of the late-life Pittsburgh study (Reynolds et al., 1999b) identified severely depressed subjects as more likely to experience a recurrence on maintenance IPT alone, but depression severity did not influence recurrence rates associated with the other three treatments (i.e., medication alone, combined treatment, and placebo).

The suggestion that IPT is less effective in the ‘more severe’ depressive disorders could directly reflect severity or a higher prevalence of melancholic depressive disorders in those with severe disorder.

5.3. Depressive chronicity

The ‘fulcrum’ for IPT is that an interpersonal stressor is central to depression onset and persistence. Thus, it might be expected that IPT would be less relevant to chronic than to acute depression. Markowitz (2003) has considered the adaptation of IPT for chronic depression, arguing that the therapy (IPT-D) may be an alternative therapy for those unwilling or unable to take medication. Because chronic depression compromises interpersonal functioning, IPT is presumed relevant in part by helping patients improve their social skills. Markowitz noted that, while few studies had been undertaken, preliminary analyses failed to find differences in outcome between IPT, pharmacotherapy and brief supportive psychotherapy. However, in a study of dysthymic patients (Browne et al., 2002) involving a 6-month acute treatment phase comparing sertraline alone, IPT alone and combination treatment, responses were equivalent in the two groups taking medication, both of which were superior to IPT alone. After a 2-year naturalistic follow-up, those who had received IPT alone still lagged in outcome, as assessed by social adjustment and family functioning, but interpretation is confounded by a high rate of medication continuation as against poor compliance with IPT.

5.4. Age

In two acute-phase studies of adolescents previously considered (Rosello and Bernal, 1999; Mufson et al., 1999), IPT was reported as superior to clinical

monitoring, with Curry (2001) concluding that “IPT has considerable promise as a treatment for adolescents”.

In older patients, Miller et al. (2001) summarized 10 years of clinical experience, judging that cognitively-intact older depressed patients were able to engage in IPT. Their studies indicated that monthly IPT sessions were an effective monotherapy against recurrence, with added benefit when combined with antidepressant drug maintenance. Further, patients with more severe depression at baseline who took longer than 6 weeks to remit appeared to receive some protection against recurrence with monthly maintenance IPT. Arian and Cook (2002) reviewed psychotherapy, alone and in combination with pharmacotherapy, for acute treatment of ‘late life depression’, concluding that IPT has “not yet garnered support as a stand-alone intervention in the treatment of late life depression”, with the few studies favouring combination treatment over IPT alone.

Thus, while there are indicative data supporting the use of IPT in adolescents and in elderly depressed subjects, more definitive studies are required.

5.5. Social functioning

The theoretical basis of IPT might suggest greater effectiveness in patients with lower levels of social functioning, as confirmed by a study (Feske et al., 1998) of women with major depression and a history of recurrent unipolar depression. However, in an analysis of the TDCRP study (Sotsky et al., 1991), a higher level of initial social adjustment was a predictor of a good response to IPT. The authors interpreted the finding as “consistent with reports in the general psychotherapy literature” (p. 1005), but it appears counter-intuitive for a therapy directed at those with insufficient social support. However, this is not necessarily paradoxical, with Stuart and Robertson (2003) suggesting that those with superior social functioning are likely to have more social support to call on during a crisis.

While the Interpersonal Inventory theoretically and practically allows IPT to be anchored and problem areas to be quantified, we are unaware of evaluative studies considering the capacity of the Inventory to predict likelihood of treatment response. While Stuart and Robertson (2003) suggested that attachment style may be associated with outcome, and noted that the Inventory can be used to assess attachment clinically, there are no supportive empirical data. In addition, the four interpersonal problem areas addressed in IPT (i.e., grief and loss, interpersonal disputes, role transitions, and interpersonal sensitivity/deficits) have not been studied with respect to their association with treatment outcome. Thus, two of

the unique and defining characteristics of IPT – the Interpersonal Inventory and focusing on interpersonal problem areas – have not yet been found to have any specific effects on either depressive symptoms or social functioning.

5.6. Personality disorder

Shea et al. (1990) assessed the influence of personality disorders on IPT response in the TDCRP study. Subjects with personality disorder were more likely to have residual symptoms of depression, show significantly less improvement on social functioning, and have a worse outcome in response to all therapies other than CBT.

5.7. Personality style

Another TDCRP analysis established that perfectionism had a significant negative impact on therapeutic outcome with all therapies (Blatt et al., 1998), with perfectionism judged as interfering with the development of therapeutic alliances (Zuroff et al., 2000). An internal locus of control of health predicted improvement in another study (Brown et al., 2000), with the authors suggesting that it promotes effective engagement in IPT, and a greater capacity to exert control over emerging depressive symptoms.

5.8. Co-morbidity

In a study of IPT with women with recurrent unipolar depression (Feske et al., 1998), high levels of somatic anxiety and a lifetime history of panic disorder predicted a lower rate of remission. Brown et al. (2000) found that lifetime anxiety or personality disorder predicted poorer outcome among dysthymic patients. Additionally, in a sample of geriatric women with recurrent depression (Buysse et al., 1999), non-remitters had higher lifetime rates of comorbid anxiety, eating, and substance abuse disorders.

5.9. Treatment fidelity

In a sub-analysis of a study noted earlier (Frank et al., 1990), Frank et al. (1991) examined the quality of IPT in their 3-year maintenance study. Those whose therapy sessions had a higher interpersonal focus had a distinctly longer period before experiencing any recurrence. In a further report (Spanier et al., 1996), survival time following IPT was longest in those who both received high quality IPT and who had a high delta ratio pre-

treatment sleep pattern, although when each of those two variables was considered together, only treatment specificity was associated with a superior outcome.

6. Discussion

Despite 30 years of research and clear acceptability by many professionals and patients, the specific efficacy and utility of IPT as a psychotherapy for depression remains unclear, principally reflecting problems intrinsic to evaluating psychotherapy research (Norcross et al., 2005). The development of manualized psychotherapies has allowed randomized controlled trials of IPT, but such studies have conformed to drug trial models in focusing on outcome issues and rarely examined process issues. Now that a substantive database exists for IPT, it is time to take stock, and to consider whether it should be conceptualized as a ‘universal therapy’ for all depressive conditions or as having greater utility in defined circumstances – and establish its ‘ecological niche’.

What is established? In terms of acute phase efficacy, IPT appears superior to ‘placebo’ but, as few of the meta-analytic comparators meet criteria for a ‘placebo psychotherapy’ in terms of non-specific therapeutic ingredients, study designs have optimized the identified IPT benefit. Westen et al. (2004) have observed that if the Food and Drug Administration model is used (with the goal of demonstrating the efficacy of a psychotherapy), weak controls (e.g., no treatment, waitlist and placebo) tend to be chosen, risking the conclusion that “doing something intended to be effective is superior to doing something not intended to be effective” (p. 651).

Secondly, IPT appears broadly comparable to CBT, in terms of outcome, while it has not been establishing that IPT works better than any other psychotherapy. That this question is unanswered – and risks remaining so – hinges on the nature of psychotherapeutic interactions, and their impact in standard randomized controlled trials (RCTs). Scott (1995) has described features common to successful psychotherapies for depression. They include providing the patient with a salient model of depression, providing a therapy with an understandable and reasonable rationale, intervening with change strategies in a logical sequence, encouraging independent use of skills to promote change, and attributing change to the individual rather than to the therapist’s skill. Optimal ‘non-specific’ therapist variables (e.g., interest and empathy) are also therapeutic. As such ‘common factors’ (Wampold, 2005) are integral to all psychotherapies and contribute to robust ‘placebo effects’ comparable to ‘treatment effects’, demonstrating the efficacy of any psychotherapy (including IPT) is probably impossible using standard RCT strategies – unless a

control lacking such ingredients is chosen, and ensuring “intent-to-fail” conditions (Westen et al., 2004).

Lambert (1992) has argued that outcome in psychotherapy is influenced 40% by patient factors, 30% by the therapeutic relationship, and 15% by placebo effects, with technical aspects (i.e., the specifics of the particular psychotherapy) contributing only 15% to outcome. This suggests another reason as why demonstrating the specific efficacy of IPT (compared to any other psychotherapy) should not be expected. Moreover, specific and non-specific therapeutic ingredients may not be independent. Thus, rather than “adding value” by including *specific* therapeutic components, manual-guided therapies may be more effective simply because they encourage more *general* therapeutic engagement and more effective delivery of non-specific factors. As Ablon and Jones (2002) note, “nonspecific” factors “may actually represent the specific effects of shared processes”. In their analysis of TDCRP study transcripts, they noted that the therapists used differing terminologies to describe similar psychological processes and constructs. Thus, assessing IPT’s specific efficacy will not emerge from standard RCTs.

As for pharmacotherapy and CBT, IPT is commonly tested as a treatment for broad non-specific depressive conditions (e.g., major depression), as if it has ‘universal’ application. It was designed as a treatment for individuals who had developed depression as a consequence of acute psychosocial stressors, where the stressor is a primary cause, so that if it were neutralized, processed or resolved by the therapeutic process, then episode remission would be expected. Thus, IPT might, in fact, be a differentially superior ‘specific’ treatment for those with adjustment and reactive depressive disorders, with its salience attenuated by extending its theoretical boundaries.

As argued elsewhere (Parker, 2005), a diagnosis of ‘major depression’ homogenizes multiple depressive conditions that are likely to have differing causes, and benefit from differing cause-specific treatments. A metaphor assists: a diagnosis of ‘major dyspnoea’ is simply a severity of symptom judgment, requiring a more specific diagnosis for rational specific treatment of underlying causes. Further, let us imagine a controlled trial of patients with major dyspnoea randomly assigned to an antibiotic, a bronchodilator and a placebo. If the sample comprised few people with an infection or asthma, then the ‘active treatments’ may not differentiate from placebo, while the prevalence of the underlying disorders would influence comparative estimates. Similarly, testing an antidepressant treatment (IPT) as if it has non-specific universal application against a non-specific heterogeneous condition – even if highly efficacious for

certain expressions of depression – risks underestimating its true benefits to salient sub-groups.

McHugh (2005) has argued the need to shift to a classificatory system of psychiatric disorders that emphasizes ‘aetiopathic clusters’. He formulated four “simple and comprehensive clusters”, with three relevant here. First, “brain diseases that directly disrupt the neural underpinnings of psychological faculties”, with the melancholic depressive sub-type appearing representative. Secondly, “patients vulnerable to mental unrest because of their psychological makeup”, a diathesis-stress model emphasizing predisposing factors (e.g., personality style). Thirdly, “patients with distressing mental conditions provoked by events thwarting or endangering their hopes”, a model emphasizing the stressor. Conceptually, IPT would appear of little primary benefit for those in the first cluster, of some possible utility to the second cluster, and highly salient to the third cluster. The IPT studies noted earlier involving women with post-partum depression (O’Hara et al., 2000) and HIV-positive patients (Markowitz et al., 1998) are examples of ideal theoretical targets for testing IPT’s claims with respect to stressful events, role transitions and social world changes.

In contrast, it is difficult to imagine IPT alone as a primary treatment for disorders in the first cluster, such as melancholia, an impression supported by several studies noted earlier. In such conditions, primary perturbations in neurobiological systems are likely to require somatic treatment (e.g., antidepressant drugs), with IPT (or any psychotherapy) having some augmenting benefit (at best) by addressing second-level psychosocial factors.

Wampold et al. (2005) has made the following conclusions about the psychotherapies: those intended to be therapeutic produce similar results; evidence of specific effects is lacking; treatments without specific ingredients approach benefits of non-specific treatments; psychological mechanisms do not mediate treatment effects – with benefits obtained before the specific ingredients are delivered; treatments designed for particular deficits are no more effective than treatments designed to address other deficits; outcome variability more reflects variability in therapists than in treatment type; and outcome is strongly related to therapist allegiance to the therapy. If true, how might evaluative studies (of IPT and other specific psychotherapies) proceed? In essence, how can a ‘common factor’ model be contradicted empirically?

One possibility would respect three principles proposed by Barlow (2004), matching the intervention to: (a) the psychological disorder; (b) patient characteristics; and (c) actual settings in which the treatment is to be provided. Operationally, it might involve selecting

patients for IPT who are ‘high salience and ‘low salience’ (both in terms of the ‘type’ of depression as noted above and its causal determinants, and with ‘salience allocation’ forming an internal control) in relation to IPT’s theoretical rationale. Then controlled trials in clinical practice settings could be undertaken without constraining comorbidity, comparing IPT against a non-specific psychotherapy with matching ‘common factor’ ingredients (the external control). The impact of the therapy on the causal factors, symptom severity, and on patient satisfaction with the therapeutic paradigm would be measured sequentially, to pursue specific and non-specific effects.

The focus of such ‘matrix’ studies would not be to determine whether IPT is superior to the comparator, but pursue evidence of differential efficacy when the therapeutic approach is congruent with the putative diathesis-stress lever, and whether improvement in depression corresponds temporally with addressing the putative determinant or appears to relate more to non-specific therapeutic ingredients. Confirmation would allow IPT’s ecological niche to be defined – across efficacy, ease of administration, client satisfaction and other parameters – and shape extension studies testing the boundaries of any specificity.

The issue of combination therapy (i.e., IPT plus medication) also requires consideration. In research studies, IPT has rarely provided additional benefit when added to pharmacotherapy, but pharmacotherapy added to IPT is more commonly beneficial. The risk of such findings is to encourage a simplistic homogenizing therapeutic guideline recommending combination therapy above monotherapy. Is that logical, or should we not again use a ‘horses for courses’ paradigm (Parker et al., 2003)? For some individuals who develop a melancholic depression, it might be expected that antidepressant medication alone would ensure recovery even in the presence of psychosocial stressors. For some non-melancholic disorders, IPT may be necessary and sufficient (and medication an inappropriate treatment), and for other conditions a synergistic combination might be superior. In addition to contributing specific ingredients, combination therapy may provide the more general benefits of pluralistic treatment appreciated by most patients. As Jamison (1995) observed, “...lithium... diminishes my depression...But, ineffably, psychotherapy heals.” Establishing the circumstances in which a combination including IPT offers additional benefits may, however, prove more difficult than establishing the niche of IPT as a monotherapy.

As for other therapies (pharmacotherapy, CBT), the original boundaries for IPT have expanded, a process that progressively strains therapeutic credibility. We

previously argued against any therapy being viewed as a 'universal treatment' (Parker et al., 2003) and for defining the specific advantages for individual treatments. Progress depends on identifying when antidepressant drugs and various types of psychotherapy are most useful, thereby defining their ecological niche.

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