



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

G. Parker et al, *Journal of Affective Disorders*.

This is a shortened, simplified version of the above paper, published in the *Journal of Affective Disorders* 95 (2006) 1-11.

This paper looks at Interpersonal psychotherapy (IPT), a form of psychological therapy widely used to treat depression, and argues that its usefulness as a universal depression treatment might have been overstated. It suggests that IPT might be beneficial for certain types of depression but that further study is needed to establish its 'niche' as a depression treatment.

Key conclusions

In spite of 30 years of research and acceptance among many health professionals and patients, the specific value of IPT as a depression treatment remains unclear, principally, for reasons to do with the limitations of research into psychotherapies.

- IPT appears superior to 'placebo' as an acute treatment, but this finding is limited by methodological flaws in the relevant studies.
- IPT seems broadly comparable in outcome to CBT, but IPT has not yet been found to have particular advantages over any other psychotherapy – again, for reasons to do with limitations of psychotherapy research.
- IPT might be a superior specific treatment for those with adjustment and reactive depressive disorders. For those with other sub-types of depression its benefits are not yet known.
- Two groups where the particular benefits of IPT could be tested include (i) people who are vulnerable to developing depression because of their psychological make-up (personality style); and (ii) people with distressing mental conditions who experience stressful life events.
- Difficulties in assessing the specific effects of IPT (and other psychotherapies) might be overcome if interventions were better matched to:
 - the psychological disorder
 - patient characteristics
 - actual treatment settings.
- Research shows that drug therapy added to IPT is more beneficial than adding IPT to drugs, but it's also important to remember the 'horses for courses' approach where treatments are best matched to the particular type of depression a person has.
- Progress depends on identifying when antidepressants and various types of psychotherapies are most useful.

1. What is Interpersonal therapy?

IPT was developed in the 1970s by researchers wanting to compare the relative efficacy of drugs and psychotherapies to treat depression, and so developed a treatment using 'non-specific' principles common to all psychotherapies. Relapse rates were similar for those receiving drugs and psychotherapy, leading the researchers to believe IPT had potential as a depression treatment in its own right, rather than just a control treatment. A therapeutic approach was subsequently developed, along with a codified manual, and its reputation as a psychotherapeutic treatment was firmly established by around 20 years later.

Interpersonal therapy (IPT) assumes that depression can be caused by an acute psychosocial stressor and insufficient social support. It focuses on the conflicts and changes in the patient's relationships, in order to improve communication and readjust expectations. It aims to assist patients to build or better utilise their social support network to help them manage crises. A unique feature of IPT is an Interpersonal Inventory, which is compiled to obtain a structured social history, focusing on relationship issues relevant to the patient's current psychological distress.

IPT was earlier seen as a treatment for mild to moderate depression. It has since been studied as a treatment for major depression and its application has broadened to include many other psychiatric disorders.

2. Is IPT efficacious for depression?

A number of studies have looked at the efficacy of IPT, but few have allowed IPT's efficacy to be examined by itself. There is only one published aggregated study of IPT (conducted by de Mello et al (2005)), and this was a review of 13 studies where IPT was used to treat differing types of depression. Findings and critique of this study follow:

- **IPT as an 'acute' treatment**

Among the 13 studies reviewed by de Mello and colleagues, six found IPT efficacious for 'acute treatment' – however it's argued that this conclusion should not be relied upon since the studies failed to use credible 'control' conditions for psychotherapy research (requiring provision by the therapist of non-specific ingredients such as support and empathy), but instead used such measures as waiting lists, clinical management and placebo tablets.

- **IPT compared to antidepressants**

No significant difference was found between IPT and antidepressants as an acute or long-term treatment, but IPT was found to be slightly better at preventing recurrence of depression than antidepressants. However this appears an erroneous conclusion since it actually contradicts two of the studies on which it was based. Reasons for the error may be the difficulty of comparing studies with wide differences in treatment duration, in adherence to a particular therapy, and in response rates associated with different treatments.

- **IPT compared to Cognitive Behavioural Therapy (CBT)?**

No significant difference in remission rates were found when comparing IPT and CBT. However, two individual studies point to possible advantages in IPT over CBT for specific sub-groups of depressed people – particularly those with ‘reactive’ disorders. One looked at depressed Puerto Rican adolescents where IPT was thought to be superior in terms of self-concept, social adaptation and functional performance, and more in line with Puerto Rican cultural values favouring family over the individual. Another study looked at HIV seropositive people and concluded IPT better than CBT in connecting life events to mood episodes.

3. Clinical factors influencing how well people respond to IPT

The authors cite several studies identifying clinical factors that could influence how well people respond to IPT, including the particular sub-type of depression they have, how severe or chronic it is, their age, social functioning, personality style, comorbidity and adherence to treatment.

They conclude:

- For people with endogenous (biological) depression, IPT alone is not effective but it is effective for those with ‘situational’ depression. Patients with neurobiological disturbances appear less responsive to IPT.
- IPT appears particularly good for both antenatal and postnatal depression.
- IPT is probably less effective for more ‘severe’ or chronic depression.
- IPT was found particularly promising for treating depression in adolescents.
- There is also evidence favouring IPT as a treatment for older depressed patients.
- IPT seems to work better for people with a higher, rather than lower, initial level of social adjustment.
- The two unique characteristics of IPT – the Interpersonal Inventory and focusing on interpersonal problem areas – have not yet been found to have any effects on depression symptoms or social functioning.
- IPT is less likely to benefit people with perfectionist tendencies but more likely to benefit those who believe they can influence their own life (rather than be controlled by external events).
- Those with co-morbid conditions are less likely to respond to IPT.
- The quality of the IPT received could impact how well IPT works.

The authors conclude that the original boundaries for IPT have expanded beyond their therapeutic credibility and that, as for other therapies, there is a need to define its specific advantages for individual treatments. Progress depends on identifying when drugs and various types of psychotherapies are most useful.

(Black Dog Institute – September 2006)