Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy

AUTHOR: Holly A Swartz, MD
SECTION EDITOR: Peter P Roy-Byrne, MD
DEPUTY EDITOR: David Solomon, MD

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: **Oct 2023.**
This topic last updated: **Nov 03, 2023.**

INTRODUCTION

Interpersonal Psychotherapy (IPT) is a time-limited psychotherapy for treating depression [1,2]. The therapy focuses upon improving problematic interpersonal relationships or circumstances that are directly related to the current depressive episode. Interpersonal relationships and depressive symptoms appear to affect each other in a reciprocal manner [3-7]. Improvement of interpersonal functioning reduces symptoms, which leads to additional spontaneous improvement of interpersonal functioning, which in turn reduces depressive symptoms further.

IPT was developed in the 1970s as a treatment for depression and for many years was used only by investigators in clinical trials [8]. Demonstrated success in multiple studies eventually led clinicians to discover that IPT is a practical, user-friendly treatment for many different types of depressed patients, including pregnant, postpartum, and primary care patients [9].

Neuroimaging studies using sequential single photon emission computed tomography (SPECT) and positron emission tomography (PET) suggest that successful treatment of major depression with IPT leads to changes in brain function [10,11]. Many of these changes overlap with changes in brain function seen in patients treated with an antidepressant, including regional brain metabolic abnormalities that tended to normalize with treatment.

Clinical guidelines endorse IPT monotherapy for treatment of mild to moderate depression [9,12,13]. In addition, IPT is used to treat other psychiatric illnesses, including bipolar disorder, eating disorders, and anxiety disorders [8].

This topic will review the indications, theoretical foundation, general concepts, and efficacy of IPT for treating depressed adults. Specific IPT interventions and procedures for treating depressed adults are discussed separately, as are other treatments of depression. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Specific interventions and techniques" and "Unipolar major depression in adults: Choosing initial treatment" and "Unipolar depression in adults: Choosing treatment for resistant depression".)

INDICATIONS

IPT is indicated for depressed patients [9,12,13]. The primary goals of treatment are symptom remission and improved interpersonal functioning.

As with all psychotherapies, the patient must have the necessary motivation, interest, and cognitive capacity to participate in treatment and complete assigned tasks.

There are no specific contraindications to IPT. However, patients must be able to tolerate elicitation of strong affects such as sadness and anxiety, which may occur during treatment [13,14]. Psychotic patients are not candidates for most affect-focused psychotherapies, including IPT.

IPT may be used alone or in combination with an antidepressant medication, depending upon symptom severity, as well as past treatment history, patient preference, and cost [15]. Monotherapy with IPT is often used to treat mild to moderate depression. In addition, IPT alone may be helpful for more severely ill patients. However, patients with moderate to severe depression, especially moderate to severe suicidal ideation or moderate to severe neurovegetative symptoms (decreased sleep, appetite, energy, and libido), generally require pharmacotherapy in addition to IPT [9,12,16]. Treating depressive disorders with IPT plus medication is supported by meta-analyses that found combination treatment was superior to medication alone [17,18].

Combining IPT with pharmacotherapy is readily accomplished because IPT is based upon the medical model. (See 'Medical model' below.)

IPT is efficacious for several types of depressed patients, including those who are [9,12,13]:

- Pregnant

- Postpartum
- At risk for postpartum depression
- Mothers with a psychiatrically ill child
- Mothers of infants and toddlers
- At risk for recurrences of depression
- HIV-positive

There is also evidence that IPT is useful for primary care settings and in low- and middle-income countries [9,12,13,19]. (See 'Evidence of efficacy' below.)

THEORETICAL FOUNDATION

The theoretical roots of IPT explain its conceptual approach and distinguish it from other psychotherapies [20].

Interpersonal school of psychoanalysis — IPT is based upon the theoretical framework of the interpersonal school of psychoanalysis, which maintains that relationships are the most basic and important aspect of human experience, rather than drives [20,21]. This school emphasized that interpersonal conflicts and social problems cause depression and other forms of psychopathology, as opposed to the psychoanalytic focus on intra-psychic conflict as the primary cause of depression [22,23]. IPT was also shaped by the belief that psychotherapy for depression should address the patient's social and cultural experiences [24].

This framework is supported by research that suggests a reciprocal link between interpersonal relationships and depressive symptoms. One study found that confiding, supportive interpersonal relationships were protective against depression [5], and other studies have found that relationship distress was associated with higher rates of major depression [25]. Conversely, studies have found that depression was associated with impaired communication and activity within relationships [4], and higher rates of marital discord [6,7].

Attachment theory — IPT also draws upon attachment theory, which states that the relationship between a caregiver and infant is crucial to survival and remains essential throughout life [20,26]. Attachment helps determine whether development is normal. A secure attachment early in life lays the foundation for psychological security and a capacity for healthy intimacy in adult relationships, whereas early disturbances in attachment contribute to the vulnerability to depression and other psychopathology. In addition, differences in early attachment experiences translate into different adult relationship styles. Adult attachment

styles appear to moderate treatment outcomes with IPT. (See 'Predictors of treatment response' below.)

Stress-diathesis model — The stress-diathesis model is utilized in IPT. The model states that depression occurs when patients with a biological vulnerability (diathesis) to the illness experience adverse life events of sufficient severity to provoke the diathesis [27]. Patients are not responsible for causing their illness but can help themselves by actively addressing the recent interpersonal problems that trigger the underlying biologic illness.

GENERAL CONCEPTS

IPT is a time-limited, structured, manual-guided treatment based upon the medical model [2,28]. The therapy emphasizes current relationships and the connection between recent adverse life events and depression. The putative mechanism of action is that mood improves as the patient resolves interpersonal problems due to grief, role disputes, role transitions, and general interpersonal deficits [29].

Medical model — Treatment with IPT occurs within the context of the medical model, which views depression as a clinical syndrome, distinct from the patient's personality [20]. The clinician initially takes a psychiatric history, performs a mental status examination, and diagnoses a current episode of major depression according to criteria from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (table 1) [30]. The explanation of the diagnosis should liken depression to other medical illnesses ("no different than asthma, diabetes or hypertension"). In addition, the clinician should stress that [31]:

- The patient probably has an inherited, biologic vulnerability to depression
- It is not the patient's fault for developing depression ("just like it is not someone's fault for developing asthma")
- Depression does not represent a character flaw

Link between life events and depression — Throughout treatment, the clinician emphasizes the connection between psychosocial stressors and the patient's depression. Therapy focuses upon identifying the interpersonal antecedents of depressive episodes and examining the impact of both positive and negative life events on the patient's symptoms. The basic principle is that the depressive syndrome will improve as interpersonal problems resolve. In addition, the bi-directional nature of the relationship between interpersonal functioning and mood is

highlighted. In an iterative process, improved mood allows patients to more effectively manage interpersonal stressors, which leads to further symptomatic relief.

The clinician does not take the position that life events cause depression per se. Rather, the clinician acknowledges that mood symptoms can contribute to negative interpersonal interactions just as problematic interpersonal events contribute to mood destabilization. As these effects are co-occurring, it is impossible to assign causal roles. From a treatment standpoint, it is important to address both aspects of this dynamic.

IPT and psychodynamic psychotherapy both focus upon relationships and events but differ in several ways. IPT assumes that recent life events are associated with onset and maintenance of the current depressive episode, and that addressing these "here and now" proximal events resolves the depressive episode more rapidly than addressing older "there and then" conflicts [3]. Another difference is that IPT is not aimed at unconscious processes and does not focus upon the transference relationship between the clinician and the patient [20]. (See "Unipolar depression in adults: Psychodynamic psychotherapy".)

Cognitive-behavioral therapy (CBT) also addresses life events and relationships. IPT and CBT are similar in that they are both time-limited, manualized, evidence-based therapies for depression [18,32]. They differ in that IPT focuses primarily on feelings and relationships, whereas CBT emphasizes thoughts and behaviors [33]. In addition, CBT is a highly structured treatment that makes use of handouts and written homework assignments [34]. IPT has an overarching framework, but the sessions themselves are delivered flexibly.

Interpersonal problem areas — There are four categories of interpersonal problems that are identified in IPT as associated with the onset or maintenance of depression: grief (complicated bereavement), role dispute, role transition, and interpersonal deficits [13,20]. Therapy focuses upon the one or two most problematic areas.

Grief — The death or disappearance of an important person that was not adequately resolved results in an abnormal grief reaction that is delayed or prolonged [20]. The goals of treatment consist of helping the patient experience the normal grief process, which includes feeling pain, sadness, and other emotions; letting go of the deceased; and moving on with life by re-establishing social contacts and resuming activities [35].

Losses other than death, such as loss of physical health or the end of a relationship, are categorized as role transition. (See 'Role transition' below.)

Role dispute — A role dispute consists of a conflict with a significant other (spouse, partner, family member, close friend, or coworker) over different expectations about the relationship.

Most often the dispute is with a spouse or romantic partner [20]. The inability to negotiate a compromise leads to an unsatisfying relationship that in turn is associated with the onset or maintenance of the depression. Therapy focuses on helping the patient to understand the nature of the dispute and to develop skills for resolving the dispute.

Role transition — Patients may experience difficulty in coping with a major change in life circumstances. Role transitions occur in many domains, including interpersonal roles (eg, marriage, becoming a parent, or divorce), occupation (eg, graduation from school, leaving one job for another, or retirement), physical health (eg, diagnosis of a serious medical illness), living conditions (eg, moving), or socioeconomic status (eg, financial problems) [35]. The transition is conceptualized as moving from one social role to another social role. The goal of treatment is to establish a realistic view of both the previous role (which is usually idealized) and the new role (which is usually devalued), mourn the loss of the old role, and then to develop better strategies to cope with the new role.

Interpersonal deficits — Interpersonal deficits are marked by pervasive problems starting and maintaining relationships; social isolation; and chronically impoverished, contentious, and unfulfilling relationships. Although many patients seeking IPT treatment have deficits in interpersonal functioning, the interpersonal deficits category is reserved for cases when there is no clear acute interpersonal event associated with the onset or maintenance of the depressive episode. Therapy aims to reduce social isolation by increasing new relationships. Patients with chronic impairment in social functioning, who lack the life events upon which IPT focuses, fare worse in treatment [36].

EVIDENCE OF EFFICACY

Research studies indicate that IPT effectively treats depressed adults.

Psychotherapy trials, like pharmacotherapy trials, are methodologically variable. Some psychotherapy trials are rigorous and specify a priori hypotheses and analytic tests, use active psychotherapy comparators that control for the nonspecific aspects of psychotherapy, use standardized diagnostic criteria and outcome measures, carefully blind outcome ratings, develop manuals for the psychotherapies that are studied and measure adherence, and stratify patients on predetermined risk variables. In less meticulous studies, an increased risk of bias exists because they use open-label designs, less rigorous comparators (eg, treatment as usual or waiting lists), fail to adequately blind outcome ratings, or do not analyze the results by intent-to-treat. Although it is commonly believed that blinding of patients in psychotherapy is less successful compared with pharmacotherapy trials, this has never been studied.

Clinical trials with different control conditions have demonstrated the efficacy of IPT for acute and maintenance treatment of unipolar major depression in specialty mental health and primary care settings [9,12,13]. In addition, a meta-analysis of 11 randomized trials showed that IPT improves functioning in depressed patients [37]. Furthermore, IPT is efficacious for several subgroups of depressed patients, including women in the childbearing years and patients infected with HIV. (See 'Indications' above.)

Depressive syndromes — IPT can effectively treat acute episodes of unipolar major depression. In addition, IPT can delay and prevent recurrent episodes [38-42]. However, patients greater than 70 years of age and patients with dysthymic disorder fare better with an antidepressant than with IPT for acute and maintenance treatment of depression [42-45].

Acute unipolar major depression — The efficacy of IPT for acute unipolar major depression is well established [46]. A meta-analysis of 31 randomized trials (sample size not reported) compared IPT with control conditions such as usual care, waiting list, or pill placebo, and found a significant, clinically moderate to large effect favoring IPT [47]. Treating approximately three patients with IPT yielded a beneficial response in one additional patient that would not have occurred with the control condition (number needed to treat of three). A subsequent series of meta-analyses also found that IPT was superior to usual care, waiting list, or pill placebo [48].

In addition, meta-analyses of randomized trials have found that IPT works at least as well as other psychotherapies for treating acute major depression [18,47,49]. As an example, a network meta-analysis identified 331 randomized trials that studied different psychotherapies in patients with depressive disorders (n >34,000) [48]. The psychotherapies included IPT (35 trials), behavioral activation, cognitive-behavioral therapy (CBT), problem-solving therapy, psychodynamic psychotherapy, and supportive therapy. The analysis compared the efficacy of each therapy with each of the other therapies, by using results from direct comparisons between the therapies as well as indirectly comparing therapies through their relative effect with a common comparator (eg, usual care or waiting list). The benefit of IPT was comparable to that of each other therapy, including CBT. Additional information about the efficacy of IPT compared with other psychotherapies is discussed separately. (See "Unipolar major depression in adults: Choosing initial treatment", section on 'Selecting a specific psychotherapy'.)

The benefit of IPT for acute depression also appears to be comparable to pharmacotherapy. In a meta-analysis of 16 randomized trials (number of patients not specified) that compared IPT with antidepressant medication, the benefit was comparable for the two groups [47].

However, adding IPT to drug therapy does not provide any advantage over drug therapy alone. A meta-analysis of 10 randomized trials (number of patients not specified) compared IPT plus

antidepressants with antidepressants alone, and found that the benefit was comparable for the two groups [47].

Recurrent unipolar major depression — Major depression often recurs. For patients who have recovered from an episode of depression, randomized trials indicate that maintenance IPT can efficaciously delay and prevent recurrences of major depression. As an example, a systematic review identified seven randomized trials (number of patients not reported) and conducted of a series of meta-analyses that evaluated the efficacy of once-monthly IPT in patients who recovered from depression [47]. The primary findings were as follows:

- Recurrence was less likely in patients who received IPT plus pill placebo compared with pill placebo alone (odds ratio 0.5, 95% CI 0.3-0.9)
- Recurrence was less likely in patients who received IPT plus antidepressant compared with antidepressant alone (odds ratio 0.3, 95% CI 0.1-0.8)
- Recurrence was comparable for patients who received IPT plus pill placebo and patients who received antidepressant alone (odds ratio 1.7, 95% CI 0.5-5.5)

However, the benefit of maintenance IPT may be less robust for patients age 70 years and older [42].

Monthly sessions of maintenance IPT seem to be as effective as more frequently scheduled sessions for preventing recurrences in patients who have recovered from an episode of major depression [50]. A randomized trial enrolled 131 patients who had recovered from an episode of recurrent major depression (with IPT monotherapy or IPT plus a selective serotonin reuptake inhibitor), and assigned them to maintenance treatment with weekly, twice monthly, or monthly sessions of IPT monotherapy. Time to recurrence was comparable for the three groups.

Dysthymic disorder — IPT has been adapted for patients with dysthymic disorder, which is marked by dysphoria for at least two years and other symptoms including disturbed appetite, sleep, or energy [51]. In addition, patients typically describe impoverished interpersonal relationships in the context of hopelessness and low self-esteem. The central feature of IPT adapted for dysthymia is that patients learn to view their illness as a mood disorder (treatable state) rather than a core feature of their personality (immutable trait), and to develop new, healthy interpersonal relationships [8]. The clinical manifestations and diagnosis of dysthymic disorder are discussed separately. (See "Unipolar depression in adults: Assessment and diagnosis", section on 'Persistent depressive disorder (dysthymia)'.)

Two studies indicate that IPT is less efficacious than sertraline for treating symptoms of dysthymia, and that augmenting sertraline with IPT provides no added benefit [43,44]. However, IPT may help reduce costs of health care and social services, and reduce time lost from work. It is not known whether IPT is more effective than no treatment or a less intense treatment.

- A randomized trial assigned 94 patients with dysthymic disorder to 16 weeks of treatment with IPT adapted for dysthymia (IPT-D), brief supportive therapy, sertraline, or sertraline plus IPT-D [43]. Response (≥50 percent improvement in baseline depression rating scale scores) occurred in fewer patients who received IPT-D alone or brief supportive therapy, compared with patients who received sertraline alone or sertraline plus IPT-D (35 and 31 versus 58 and 57 percent).

- A randomized trial assigned 707 primary care patients with dysthymic disorder to sertraline, IPT (not adapted specifically for dysthymia), or sertraline plus IPT [44]. Patients received sertraline for up to 2 years and up to 12 sessions of IPT over a 6 month period. Response (≥ 40 percent improvement in baseline depression rating scale scores) at 6 months occurred in fewer patients who received IPT alone compared with patients who received sertraline alone or sertraline plus IPT (47 versus 60 and 58 percent). IPT alone was also inferior at the two year assessment. However, total costs for health care services, social services, and lost wages over two years were lower in patients who received IPT alone, compared with the other two treatments.

Minor depression — The efficacy of IPT for minor depression (also called “other specified depressive disorder, depressive episode with insufficient symptoms”) is discussed separately. (See "Unipolar minor depression in adults: Management", section on 'Evidence of efficacy'.)

Depressed patients with medical comorbidities — IPT may be efficacious for some depressed patients with a comorbid nonpsychiatric medical illness. Depressed patients infected with HIV benefitted from IPT, but depressed patients with coronary heart disease did not [52,53]. In addition, patients with irritable bowel syndrome (depression status was not considered) responded to IPT, suggesting depressed patients with irritable bowel syndrome may also respond to IPT [54].

Depression and HIV-seropositivity — Multiple randomized trials indicate that IPT can be efficacious for depressed patients who are HIV positive. The therapy is modified to address concerns about physical illness, death, grief, and social stigma associated with HIV and the acquired immunodeficiency syndrome (AIDS) [52]:

- One trial randomly assigned 79 patients with major depression or dysthymia and an HIV-AIDS diagnosis to either 6 sessions of telephone-delivered IPT or usual care [55].

Symptoms of depression decreased more in patients who received IPT compared to usual care.

- A nine-week trial compared telephone based IPT with usual care in HIV positive patients with depression (n = 132) who resided in rural settings [56]. IPT consisted of nine weekly, one-hour sessions administered one-to-one for one hour via telephone. Response (reduction of baseline depressive symptoms ≥50 percent) was greater with telephone based IPT than standard care (22 versus 4 percent of patients). In addition, the benefit of telephone IPT persisted at the eight-month follow-up assessment [57].

- A three-month trial enrolled 256 HIV-positive women from sub-Saharan Africa, who had experienced intimate partner/gender-based violence and met criteria for both unipolar major depression disorder and posttraumatic stress disorder (PTSD) [19]. All patients received usual care and were randomly assigned to either 12 sessions of IPT or a waitlist control condition. Improvement of major depression (no longer meeting diagnostic criteria) occurred in more patients who received adjunctive IPT (67 versus 42 percent). In addition, improvement of PTSD occurred in more patients who were assigned to IPT rather than the waitlist, and disability was reduced with IPT.

Depression and coronary heart disease — A randomized trial with 284 patients found that IPT was no better than clinical management (nonspecific support) for treatment of comorbid major depression and coronary heart disease [53].

Depressed patients in different settings — IPT has been transported from specialty mental health clinics and demonstrated efficacy for treating depression in primary care settings, community settings, and low- and middle-income countries. In addition, IPT has been adapted for delivery online and by telephone. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Specific interventions and techniques", section on 'Format'.)

Primary care settings — A trial randomly assigned 276 primary care patients with unipolar major depression to 20 sessions of IPT, nortriptyline, or the primary care physician's usual treatment [58]. All treatments were administered over an eight-month period in the primary care clinic, and IPT was administered by mental health specialists. IPT and nortriptyline each led to greater improvement compared with usual care. In addition, recovery occurred in more patients treated with IPT or nortriptyline, compared with usual care (46 and 48 versus 18 percent). Other studies have successfully used IPT in primary care settings [59].

Community settings — The initial studies that found IPT can treat major depression were conducted in academic settings. Subsequently, multiple studies have demonstrated that IPT can be effective in routine practice settings [60]:

- A two-month study randomly assigned 182 patients with unipolar major depression, who were treated in a community mental health center, to IPT, CBT, or a waiting list control condition [61]. Psychotherapy included weekly sessions, each lasting 45 minutes. IPT and CBT were superior to the waiting list, and the benefit of the two active treatments was comparable.

- A study randomly assigned 96 patients with unipolar major depression, treated in a community setting, to 14 sessions of IPT or CBT [62]. Improvement, defined as reduction from baseline on the Beck Depression Inventory-II depression rating scale >8 points, was comparable with IPT and CBT (53 and 51 percent of patients).

Low- and middle-income countries — IPT was adapted and successfully used within a group therapy format for treatment of major depression in rural Uganda, where an HIV epidemic has occurred. IPT groups met for 16 weekly sessions, each lasting 90 minutes, and were single-sex in composition to facilitate disclosure and accommodate local attitudes and customs [63]. The basic structure of IPT was retained but simplified so that groups could be led by non-clinicians. Investigators randomly assigned 30 villages (341 patients with self-identified depression) to group IPT plus usual care or usual care alone. Improvement of depressive symptoms and psychosocial functioning was greater among patients treated with group IPT, and fewer patients who received group IPT met criteria for major depression, compared with the control group (7 versus 55 percent) [64]. The benefits of IPT persisted at six-month follow-up, such that the rate of major depression was lower in the IPT group compared with the control group (12 versus 55 percent) [65].

In addition, IPT was efficacious in sub-Saharan Africa for HIV-positive women, who developed both unipolar major depression and PTSD in the context of intimate partner/gender-based violence [19]. (See 'Depression and HIV-seropositivity' above.)

Depression in adolescent and older patients — IPT has demonstrated success in treating adolescent patients. However, the results with older patients are mixed. Bereavement-related major depression in older patients appears to be better treated with pharmacotherapy than with IPT [45]. Maintenance treatment with IPT appears to prevent depressive recurrences in patients age 60 to 69 years, but not in patients age 70 years and older [41,42].

Depressed adolescents — IPT has been successfully adapted for depressed adolescents (IPT-A) to address their specific interpersonal issues, including separation from parents, autonomy in relationship to parents, peer pressure, dyadic interpersonal relationships, death of a friend or a relative, and single-parent families [66]. An overview of IPT-A, including evidence supporting

its use, is discussed separately (See "Pediatric unipolar depression: Psychotherapy", section on 'Interpersonal psychotherapy for adolescents'.)

Older patients — The benefits of IPT appear to dissipate in patients age 70 years and older and appear to be maximally effective when combined with pharmacotherapy.

- A randomized trial enrolled 80 patients age 50 years and older, with acute bereavement-related major depression, and assigned them one of four treatments, each lasting 16 weeks [45]. The rate of remission with placebo plus IPT was 29 percent, placebo plus medication visits 45 percent, nortriptyline plus medication visits 56 percent, and IPT plus nortriptyline 69 percent.

- A randomized trial assigned 124 patients with unipolar major depression, who partially responded to six weeks of treatment with escitalopram, to augmentation with either IPT or depression care management (nonspecific psychoeducation and supportive treatment) [67]. Patients were age 60 years and older. Remission rates for escitalopram with IPT and with depression care management were similar (58 versus 45 percent).

- Randomized trials found that patients age 60 to 69 years benefited from IPT as maintenance treatment to prevent recurrence of major depression, but that patients age 70 years and older did not [41,42]. (See 'Depressive syndromes' above.)

Women in the childbearing years — IPT is efficacious for several different populations of depressed women in their childbearing years, including women who are pregnant, postpartum, have had a miscarriage, or have a psychiatrically ill child [68-73]. IPT also appears to prevent postpartum depression in women who are at risk for the disorder [74]. However, it is not known whether IPT has greater utility in women compared with men [75].

Pregnancy and parenthood involve role transitions. Treating depressed, pregnant or postpartum women with IPT usually involves examining the psychological changes associated with pregnancy, one's capabilities as a parent, and changes in relationships with one's spouse and other family members [8].

Management of depression during pregnancy is discussed separately. (See "Severe antenatal unipolar major depression: Choosing treatment".)

Depression during pregnancy — IPT is beneficial for pregnant patients with major depression. (See "Mild to moderate episodes of antenatal unipolar major depression: Choosing treatment", section on 'Overview'.)

Depression following perinatal loss — IPT may be effective for perinatal loss, such as miscarriage, stillbirth (late fetal death), or early neonatal death. A 20 week randomized trial compared group IPT with group CBT in 50 women who experienced perinatal loss (primarily miscarriage or stillbirth) within the preceding 18 months and met criteria for major depression [76]. Each treatment included 14 sessions; IPT was adapted for perinatal loss, but CBT was not. Although time to recovery was comparable for the two groups, there was a trend for greater improvement with IPT than CBT, and treatment satisfaction was greater with IPT.

Postpartum depression — IPT has demonstrated efficacy in preventing and treating postpartum depression. (See "Postpartum unipolar depression: Prevention" and "Mild to moderate postpartum unipolar major depression: Treatment", section on 'Evidence of efficacy'.)

Mothers of children with psychiatric disorders — For depressed mothers who have a psychiatrically ill child, IPT for the mother appears to relieve depressive symptoms in both the mother and child. A randomized trial compared IPT (nine sessions) with usual care for treatment of unipolar major depression in 47 mothers with a child receiving psychiatric treatment [68]. IPT was modified to include some behavioral strategies and motivational interviewing. Maternal baseline depression and psychosocial functioning rating scale scores improved more with IPT than usual care, and treatment gains persisted at the nine-month follow-up. In addition, child depression and functioning scores were better in the offspring of mothers assigned to IPT, compared with the offspring of mothers assigned to treatment as usual.

However, it does not appear that IPT is superior to other psychotherapies for depressed mothers who have a psychiatrically ill child. A subsequent, three-month randomized trial by the same group of investigators compared IPT with supportive psychotherapy for treating unipolar major depression in 168 mothers with a child diagnosed with a depressive or anxiety disorder; each treatment included nine sessions [77]. Improvement of maternal depression in both groups was comparable. Nevertheless, mothers preferred IPT over supportive psychotherapy, and children of mothers assigned to supportive psychotherapy had more outpatient mental health visits and were more likely to receive antidepressant medication [77].

Mothers of children age zero to five years — IPT can be efficacious for mothers of young children:

- A randomized trial assigned 80 immigrant Latin American mothers, with limited English language skills and children age zero to three years, to 11 sessions of nurse-delivered, in-home IPT (plus 5 follow-up booster sessions) or to usual care [78]. Depressive symptoms

decreased more in patients who received IPT compared with usual care. In addition, the child's aggression decreased more in mothers who received IPT.

- A three-month trial compared IPT with usual care in racial/ethnic minority mothers (n = 119), who screened positive for clinically significant depressive syndromes and had children age three to five years who were enrolled in a program promoting school readiness [79]. IPT was administered in a 12-session group format, with each session lasting 90 minutes; usual care consisted of a referral to mental services. Improvement of depressive symptoms was greater with IPT, and the benefit persisted six months posttreatment.

Low-income mothers — Based upon randomized trials, IPT is beneficial for economically-disadvantaged, depressed mothers [80]. As an example, a 14-week trial compared IPT (14 individual weekly sessions, each lasting one hour) with usual care in mothers of 12 month old infants; the mothers were at or below the United States poverty line and suffered from unipolar major depression [81]. After adjusting for history of trauma and treatment nonadherence, symptomatic improvement at the eight-month posttreatment follow-up was greater with IPT than usual care.

Other trials have also demonstrated the efficacy of IPT in treating low-income mothers [78,79]. (See 'Mothers of children age zero to five years' above.)

Infertile women — IPT may be helpful for depressed infertile women. A 12-week randomized trial compared weekly sessions of IPT with supportive psychotherapy in 31 women with unipolar major depression who were infertile for at least one year and undergoing fertility treatment [82]. Response (reduction of baseline depression ≥50 percent) occurred in more patients treated with IPT than the active control (73 [11/15] versus 38 [6/16] percent).

Women with childhood sexual abuse — IPT can treat major depression in women with a history of childhood sexual abuse; however, it is not clear if IPT is superior to other psychotherapies, due to conflicting results across two randomized trials by the same group of investigators. Each trial enrolled women with unipolar major depression who were sexually abused before age 18 years, and most patients were receiving antidepressants at study onset:

- One 36-week trial compared IPT with usual care psychotherapy (eg, supportive psychotherapy) in 70 patients; both groups received 16 sessions of psychotherapy [60]. Improvement of depression was superior with IPT, and adherence to pharmacotherapy was nearly two times greater with IPT than usual care psychotherapy. In addition, improvement of shame and posttraumatic stress disorder symptoms was better with IPT.

- A subsequent randomized trial lasting 32 weeks compared IPT with usual care psychotherapy in 161 patients; both groups received 16 sessions of psychotherapy [83]. Remission of major depression was comparable with IPT and usual care psychotherapy (45 and 36 percent of patients), as was adherence with pharmacotherapy. However, improvement of posttraumatic stress disorder symptoms was better with IPT.

Incarcerated women — A small observational study suggests that IPT may be useful for incarcerated depressed women who have a substance use disorder [84].

PREDICTORS OF TREATMENT RESPONSE

Response to IPT may be greater with an increased number of therapy sessions per week. In addition, response to IPT is associated with fewer comorbid anxiety symptoms [85,86], less social impairment [36], single or separated marital status [87], the presence of obsessive-compulsive personality traits [87], lower levels of attachment avoidance and attachment anxiety [88-90], and normal pretreatment electroencephalogram (EEG) sleep profiles [91]. Among African Americans, three studies have found that IPT is associated with better outcomes compared with alternative treatments [92]. However, none of these factors is consistently associated with response to IPT across multiple studies, and are likely to have little predictive power for any specific patient [92].

Session frequency — An increased number of therapy sessions per week may initially improve outcomes with IPT. One trial enrolled 102 patients with unipolar major depression or persistent depressive disorder (dysthymia), and randomly assigned them to 16 sessions of IPT given twice per week or to 16 sessions given weekly [93]. Clinically significant improvement occurred in nearly two times as many patients with twice weekly sessions (33.3 versus 17.6 percent). However, at the two-year follow-up, the advantage of twice weekly (versus weekly) sessions was no longer evident [94].

Depression severity — Higher baseline severity of depression is generally a non-specific predictor of worse outcomes for depressed patients [95]. It is also a moderator of treatment response such that lower severity is associated with better response to either placebo or less intense treatment [96].

IPT has been successfully used in more severely depressed patients [36]. However, it is not clear whether IPT is superior to cognitive-behavioral therapy (CBT) for more severely depressed patients. In one randomized trial, high baseline depression severity predicted superior response to either IPT or imipramine, but not CBT, compared with placebo plus clinical management

[36,39]. In a subsequent randomized trial, CBT was more effective than IPT for severe depression [97].

Anxiety — Anxiety occurs often in depressed patients, and comorbid anxiety consistently predicts worse outcomes for depressed patients treated with IPT [85,86]. In 134 women treated for recurrent major depression with IPT, the probability of remission was two-fold less in patients with higher levels of baseline somatic anxiety (eg, dry mouth, indigestion, belching, palpitations, headache, sighing, and sweating; odds ratio 2.0, 95% CI 1.1-3.6) [85]. Another study of 61 women with recurrent depression found that remission occurred in fewer patients with a lifetime history of clinically meaningful anxiety symptoms compared to patients with no such history (43 versus 68 percent) [86]. In response to these observations, a modified form of IPT for patients with depression and comorbid anxiety symptoms has been developed, which includes some CBT techniques [98]. This treatment needs to be evaluated.

Psychosocial functioning and personality — In a randomized trial, less social impairment predicted superior response to IPT [36]. Although it might be expected that poor interpersonal functioning in a depressed patient would be an indication to prescribe IPT, it seems that one must have a moderately intact level of interpersonal functioning in order for IPT to take hold. In other words, the clinician must have "something to work with."

A randomized trial assigned 177 patients with unipolar major depression to 16 weeks of IPT or CBT [99]. Comorbid personality disorder adversely affected outcome with IPT but not CBT. A different randomized trial found that IPT was more effective than CBT for depressed patients with obsessive-compulsive personality traits, whereas CBT was more effective than IPT for patients with avoidant personality traits [87].

Attachment style — It is hypothesized that there are two types or dimensions of adult attachment [88]. Attachment anxiety refers to levels of anxiety about rejection by others. Attachment avoidance refers to levels of discomfort with closeness and intimacy.

Response to treatment of depression with IPT is better in patients with lower levels of attachment avoidance and attachment anxiety [88-90]. A randomized trial compared IPT with CBT (16 to 20 weekly sessions of either psychotherapy) in 56 patients with major depression, and found that patients with greater levels of attachment avoidance were less likely to remit with IPT [88]. A second study found that among depressed patients who remitted with IPT, higher levels attachment anxiety and attachment avoidance were associated with a longer time to clinical stabilization [89]. A case series of 145 depressed patients treated with IPT found that there was less attachment anxiety and attachment avoidance among patients who remitted, compared with patients who did not remit [90].

Relationship adjustment — In an open-label study of patients with major depression (n = 95) who were treated with IPT, decreases in dyadic adjustment (ie, decreases in satisfaction with one's partner) during therapy were associated with better depression outcomes [100]. In discussing this paradoxical finding, the investigators hypothesized that the ability to identify maladaptive problems in relationships was potentially helpful in IPT, allowing patients to shift the blame from themselves ("something is wrong with me") to a more adaptive focus on addressing relationship difficulties in therapy.

Sleep EEG profiles — Pretreatment sleep parameters may be associated with response to IPT. In a prospective observational study of 91 patients treated for major depression with IPT, remission occurred in more patients with normal pretreatment EEG sleep profiles compared with abnormal profiles (58 versus 37 percent) [91].

OTHER RESOURCES

Additional resources that are available to learn more about using IPT include treatment manuals and a professional organization. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Specific interventions and techniques", section on 'Other resources'.)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders".)

SUMMARY

- **Indications** – Interpersonal Psychotherapy (IPT) is indicated for depressed patients. Monotherapy with IPT is often used to treat mild to moderate depression. Patients with moderate to severe depression, especially moderate to severe suicidal ideation or moderate to severe neurovegetative symptoms (decreased sleep, appetite, energy, and libido), generally require pharmacotherapy in addition to IPT. Combining IPT with pharmacotherapy is readily accomplished because IPT is based upon the medical model. (See 'Indications' above.)

- **Theoretical foundation** – The theoretical foundation of IPT includes the principle that relationships are the most important aspect of human experience. In addition, IPT draws upon the theory that the relationship between a caregiver and infant is crucial to survival

and helps determine whether development is normal. IPT also applies a model which states that depression occurs when patients with a biological vulnerability to the illness experience adverse life events of sufficient severity. (See 'Theoretical foundation' above.)

- **General concepts** – IPT is a time-limited, structured, manual-guided treatment based upon the medical model. The therapy emphasizes current relationships and the connection between recent adverse life events and depression. The putative mechanism of action is that mood improves as the patient resolves interpersonal problems due to grief, role disputes, role transitions, and interpersonal deficits. (See 'General concepts' above.)

- **Evidence of efficacy**

  - **Depressive syndromes** – IPT works at least as well as other psychotherapies. IPT also delays and prevents recurrent episodes in patients less than 70 years old. However, older patients and patients with dysthymic disorder fare better with an antidepressant than with IPT. (See 'Evidence of efficacy' above and 'Depressive syndromes' above.)

  - **Medical comorbidities** – Some depressed patients with a comorbid nonpsychiatric medical illness may respond to IPT. Depressed patients infected with HIV benefitted from IPT, but depressed patients with coronary heart disease did not. (See 'Depressed patients with medical comorbidities' above.)

  - **Across different settings** – IPT has been transported from specialty mental health clinics and demonstrated efficacy for treating depression in primary care settings, community settings, and low- and middle-income countries. (See 'Depressed patients in different settings' above.)

  - **Adolescents and older patients** – IPT has demonstrated success in treating adolescent patients. However, the results with older patients are mixed. Acute episodes of bereavement-related major depression in older patients appear to be better treated with pharmacotherapy than with IPT. Maintenance treatment with IPT appears to prevent depressive recurrences in patients age 60 to 69 years, but not in patients age 70 years and older. (See 'Depression in adolescent and older patients' above.)

  - **Women of childbearing age** – IPT is efficacious for several different populations of depressed women in their childbearing years, including women who are pregnant, postpartum, have had a miscarriage, have a psychiatrically ill child, are economically disadvantaged, or have a history of sexual abuse. IPT also appears to prevent postpartum depression in women who are at risk for the disorder. (See 'Women in the childbearing years' above.)

- **Predictors of response** – Response to IPT may initially be greater with an increased number of sessions per week. In addition, response is associated with fewer comorbid anxiety symptoms, less social impairment, single or separated marital status, the presence of obsessive-compulsive personality traits, and lower levels of attachment avoidance and attachment anxiety. In addition, IPT has been successfully used in more severely depressed patients. (See 'Predictors of treatment response' above.)

Topic 15675 Version 24.0

→