

Interpersonal Psychotherapy for Adolescents with Depression: What Has the Research Taught Us So Far?

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Given the high prevalence of depression among adolescents, there is a dire need for efficacious, cost-effective, and accessible treatments for adolescent depression. One type of psychosocial treatment shown to be efficacious in the treatment of adolescents with depression is Interpersonal Psychotherapy (IPT-A). Originally developed and tested for depressed adults and modified for work with adolescents, IPT-A is a time limited, brief psychotherapy based on the premise that depression occurs in the context of interpersonal relationships (Weissman, Markowitz, & Klerman, 2000). Both the time-limited nature and focus on the present, especially social relationships, seem particularly relevant to adolescents and their specific developmental issues, including major life choices in education, work, and the establishment of intimate relationships. Efficacy and effectiveness trials of IPT-A have demonstrated its flexibility and applicability. Nevertheless, more efficacy data is warranted, with larger sample sizes and more diverse populations.

Depression in adolescents is much more prevalent than was once believed, and is currently seen as comparable to adults. This has been demonstrated in epidemiological surveys both nationally (i.e. The National Comorbidity Study [NCS], Kessler, 2006) and in smaller community surveys of adolescents (e.g., Cohen, et al., 1993). It is estimated that the one-year prevalence rate of depression in adolescents is between 1.6% and 8.9% (Angold & Costello, 2001). These rates of depression in youth may reflect an increased prevalence over previous decades. Recent survey results from the NCS also show evidence of increased prevalence of childhood or adolescent onset depression among those born in more recent decades (Kessler, Avenevoli, & Merikangas, 2001). In fact, half of all individuals who have a mental illness during their lifetime report that the onset of disease occurred by age 14 and three fourths report onset by age 24 (Keuhn, 2005). Retrospective assessment among community adults typically indicates that middle to late adolescence is the most common age at onset of first major depression or significant symptoms (e.g., Burke, Burke, Regier, & Rae, 1990). This has also been demonstrated across diverse cultures (Cross-National Collaborative Group, 1992).

Young people who have an untreated mental illness may suffer debilitating symptoms during their most productive years, including problems with educational attainment and career and family building (Kessler, Avenevoli, & Merikangas, 2001). Despite these detrimental consequences, depression in adolescence is largely untreated (Flaherty, Weist, & Warner, 1996). Depressed adolescents are a largely underserved population that faces multiple barriers to receiving treatment (Mufson, Dorta, Olfson,

Weissman, & Hoagwood, 2004). There is a pressing need for more efficacious, cost-effective, and accessible treatments for adolescent depression. This paper will address an attempt to alleviate this problem through the development of a modified Interpersonal Psychotherapy for Depressed Adolescents (IPT-A).

Description of Interpersonal Psychotherapy (IPT)

Interpersonal psychotherapy is a time-limited therapy based on the idea that depression can be treated by focusing on the patient's key interpersonal relationships (Weissman, Markowitz, & Klerman, 2000). Unlike other types of psychotherapy, IPT does not delve into the patient's past to try and determine the cause of the depression. Rather, by focusing on current interpersonal conflicts and improving relationships, IPT alleviates depressive symptoms by reducing current stressors. One of the most important steps in IPT is identifying a primary interpersonal problem area. The four main interpersonal problem areas are grief, interpersonal disputes, role transitions, and interpersonal deficits. During the 16 sessions of IPT, the therapist and patient focus on one, or at most two, of these problem areas as the primary focus of the therapy. In recent years, there has been strong empirical support for IPT's effectiveness in the treatment of depressed adults (de Mello, de Jesus, Balcaltchuk, Verdelli, & Neugebauer, 2005; O'Hara, Stuart, Gorman, & Wenzel, 2000; Talbot, et al., 2005; Weissman, 2007; Weissman, Klerman, Prusoff, Sholomskas, & Padian, 1981).

The Development of Interpersonal Psychotherapy for Depressed Adolescents (IPT-A)

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Because IPT is based on the premise that the onset and perpetuation of depressive episodes occurs in an interpersonal context, its adaptation for adolescents is relevant. IPT addresses issues important to the developmental context of adolescents, such as major life choices in education, work, and establishment of intimate relationships. Furthermore, the time-limited nature of IPT may fit the adolescent's reluctance to seek or stay in treatment. The rationale for an adolescent adaptation to IPT is that improving the adolescent's interpersonal context will help change the course of the depressive episode and result in recovery (Moreau, Mufson, Weissman, & Klerman, 1991).

The initial phase of treatment in IPT-A is very similar to that of IPT; however, there are some key modifications. For example, drug abuse and suicidal behavior, both of which are serious problems with depressed adolescents, are thoroughly evaluated during the initial sessions. Furthermore, in IPT-A the responsible parent plays an integral role in the therapeutic process and is brought into the initial phase of treatment to participate in psychoeducation about depression along with the adolescent. The middle phase of IPT-A focuses on one of the four primary problem areas identified during the interpersonal inventory completed during the initial phase. The main purpose of this phase of therapy is to assist the patient in making the association between depressive symptoms and interpersonal difficulties. Finally, throughout all of the sessions of IPT-A, the issue of termination is raised in order to ensure that the adolescent is aware that the therapy is indeed time-limited. Patients are advised that it is not uncommon for a slight exacerbation of symptoms to occur as therapy comes to an end. The skills acquired during therapy are reviewed during the termination phase, and the availability of an external support system is reiterated. Early signs of depression and possibilities for future treatment, as needed, are discussed in order to ensure that the adolescent knows how to cope if there is a recurrence of depression (Moreau et al., 1991).

Do the Modifications Work?

Initial Trials of IPT in Depressed Adolescents

In order to test the efficacy of IPT-A, phase I and phase II studies were conducted (Mufson et al., 1994). During phase I, modifications to IPT-A were made to the original IPT-A manual based on findings from therapeutic work with five depressed adolescents. In phase-II, 14 depressed adolescents were enrolled in a clinical trial of IPT-A. This study found that depressed adolescents who underwent IPT-A experienced a significant decrease in depressive symptoms along with a significant improvement in overall functioning. In fact, by the end of the study, not one of the adolescents met criteria for a DSM-III-R depressive disorder. While the phase II study indicated the promise of IPT-A as an effective treatment for adolescent depression, a larger randomized controlled study, which would allow IPT-A to be compared to either a control condition or another treat-

ment condition, was needed in order to truly determine efficacy of the therapy.

Recognizing that relapse is common in adolescents with a history of depression (Kovacs et al., 1984, as cited in Mufson & Fairbanks, 1996), the authors set out to determine the clinical status of adolescents one year after the completion of therapy, and attempted to recontact the 14 adolescents who participated in the phase-II trial. Of these adolescents, 10 (7 Hispanic females and 3 African-American females, mean age 17.5) agreed to participate in the follow-up evaluation. At follow-up, 9 of the adolescents met recovery criteria for depression based on both subjective (Beck Depression Inventory, BDI) and objective (Hamilton Rating Scale of Depression, HRSD) measures of depression. In the realm of social functioning, though a trend was found suggesting some difficulties in the "friends" and "dating" dimensions, the overall gains in social adjustment were maintained one year after termination. The results of this study demonstrated that the improvements made during the 12-week trial of IPT-A were maintained during the full year following completion of treatment, suggesting that IPT-A is an effective treatment option for adolescents suffering from depressive disorders. However, there are limitations that must be considered when interpreting these results: 1) by only enrolling Hispanic and African-American females, the sample is not representative of the general population; 2) with such a small sample, there was not enough statistical power to detect potentially significant benefits of IPT; and 3) this trial, as well as the initial open trial, lacked control groups for comparison. Despite these limitations, this study provides important information about IPT-A while stressing the importance of conducting larger clinical trials in depressed adolescents to confirm preliminary findings.

Efficacy of IPT-A

Based on the result of the open clinical trial (Mufson et al., 1994) and the one-year follow-up study (Mufson & Fairbanks, 1996), a randomized clinical trial to test the efficacy of IPT-A was conducted (Mufson, Weissman, Moreau, & Garfinkel, 1999) with 48 clinic-referred adolescents (ages 12-18 years) randomly assigned to either weekly one-hour IPT-A sessions (n=24) or biweekly clinical monitoring (CM) with a therapist (control group, n=24) for 12 weeks. Participants were administered an assessment battery biweekly by a blind independent evaluator to monitor their progress throughout the study. Eligibility criteria for the study included meeting DSM-III-R criteria for a current major depressive episode and having a score of 15 or more on the HRSD. There were no significant baseline differences demographically or on any outcome measures. Although the IPT-A group (in comparison to the control group) reported significantly fewer depressive symptoms at Week 12 on the HRSD (clinician-report), BDI (self-report) results showed no significant differences at the end of the treatment. The investigators of this study defined rates of

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recovery as less than or equal to 6 on the HRSD, and less than or equal to 9 on the BDI. With these criteria, significantly more IPT-A patients (75%) than control patients (46%) met recovery criteria on the HRSD, a result that was significant at the $p=.04$ level.

The results of the randomized controlled trial conducted by Mufson et al. (1999) support the findings of the previous studies of IPT-A (Mufson et al., 1994; Mufson & Fairbanks, 1996), providing further evidence that IPT-A is an efficacious tool in the treatment of depression in adolescents. However, the relatively small sample (24 subjects in each condition) implies the need for replication studies with larger sample sizes in order to confirm these findings. There was also a large drop-out rate in the clinical monitoring group which may have led to skewed results. Furthermore, the sample in this study was predominantly Hispanic females, which is not representative of the general population of depressed adolescents as a whole. Finally, a key limitation with this efficacy trial, as with *all* efficacy trials, is the fact that given the stringent inclusion and exclusion criteria for this study, the results are not necessarily generalizable. In order to remedy this problem, effectiveness trials of IPT-A were conducted.

Effectiveness Trials of IPT-A

Mufson, Dorta, Wickramaratne, Nomura, Olfson, and Weissman (2004) examined the effectiveness of IPT-A compared with treatment as usual (TAU) in school-based mental health clinics in the New York City area. Details of how IPT-A was adapted for the school-based mental health clinics have been published (Mufson, Dorta, Olfson, Weissman, & Hoagwood, 2004). Participants in this 16-week randomized clinical trial were 63 adolescents ages 12-18 (mean age 15) who were referred for mental health intake visits and met DSM-IV criteria for major depressive disorder, dysthymia, depressive disorder not otherwise specified, or adjustment disorder with depressed mood. Patients were randomized to either IPT-A ($n=34$), consisting of 12 sessions during 12-16 weeks, or TAU ($n=29$), defined as whatever psychological treatment the adolescents would have received in their school clinics if the study had not been in place. Though TAU may have varied between schools, it was comparable to supportive individual counseling. Results showed that adolescents who received IPT-A compared with those who received TAU had significantly greater decreases in depressive symptoms both on both the clinician-report (HRSD) and self-report (BDI) at week 12. Overall functioning and social functioning also significantly improved in the IPT-A group at week 12 as compared with the TAU group.

In examining whether research therapy can be applied to community settings, the present study (Mufson, et al., 2004) concluded that interpersonal psychotherapy delivered in school-based health clinics was an effective therapy for adolescent depression. It was also notable that depressed adolescents in the IPT-A group, when compared to the

TAU group, showed significantly more improvement at a faster rate after eight consecutive weekly sessions of IPT-A. Because larger treatment effects occurred in older and more severely depressed adolescents, the authors suggest that this group may benefit more from structured, targeted treatments such as IPT-A. Despite its application to a “real world” setting, this study was limited again by its largely Hispanic female sample from low socioeconomic backgrounds. Other groups must be studied in order to establish the generalizability of these benefits.

Many of the participants in the aforementioned trial had comorbid disorders, in particular, comorbid anxiety disorders. Young, Mufson, and Davies (2006) examined how comorbid anxiety affected the effectiveness of IPT in depressed adolescents within this sample. They found that comorbid anxiety was often indicative of a more severe depression, as evidenced by higher depression scores at baseline. Furthermore, the depressed adolescents with comorbid anxiety had higher depression scores at the end of the study, regardless of treatment group, implying that this combination of depression and anxiety is more difficult to treat. At the same time, a non-significant trend was found suggesting that IPT-A was more effective in treating depression in adolescents with comorbid anxiety compared to TAU. These results suggest that though depressed adolescents with comorbid anxiety tend to have a more severe course of illness than those without comorbid anxiety, IPT-A shows promise as an effective treatment for this difficult-to-treat combination of disorders.

In another study of effectiveness, Rosselló and Bernal (1999) evaluated two treatments—Cognitive Behavior Therapy (CBT) and IPT-A, comparing them with each other and with a wait-list control (WC). This trial consisted of 71 adolescents, ages 13-17, in school grades 5 through 12 who met DSM-III-R criteria for major depressive disorder, dysthymia, or both and who were randomly assigned to either CBT, IPT-A, or WC conditions. CBT and IPT-A treatment conditions consisted of 12 one-hour weekly individual therapy sessions over 12 weeks. The investigators found that both IPT-A and CBT were more effective than the control condition in reducing adolescents’ reports of depressive symptoms. They also found that IPT-A, when compared to CBT, increased self-esteem and social adaptation. Although both IPT-A and CBT were superior to the wait-list control group, participants in the IPT group only benefited in their self-concept and social adaptation significantly more than participants in the wait-list control condition. Limitations again included a small, mostly Hispanic female sample and the use of only self-report measures.

Novice Therapists

Given the fact that most adolescents receive care in community settings such as schools (Mufson et al, 2004) it is important to design a brief yet effective training protocol that is feasible within existing constraints (i.e. training less experienced therapists). Santor and Kusumakar (2001) con-

ducted a trial of IPT-A using “novice” therapists. These therapists were considered novice because they lacked prior experience with IPT, learning about its principles during a 3-day intensive training workshop, followed by weekly supervision sessions during the following year. In this trial, 25 adolescents (ages 12-19 years; 23 females, 2 males) with DSM-IV diagnoses of major depression were recruited via consecutive referrals from outside clinicians. Unlike the samples in other studies (Mufson et al., 1994; Mufson & Fairbanks, 1996; Mufson et al., 1999), all of the participants in this study came from two-parent homes of middle socioeconomic status. Sixty percent of patients also met criteria for a comorbid diagnosis (dysthymia, posttraumatic stress disorder, anorexia nervosa, generalized anxiety disorder, conduct disorder, and/or social phobia). Depression severity was assessed via the BDI (recovery defined as 13 or less) and HRSD (recovery defined as 5 or less), and global functioning was assessed through the Children’s Assessment of Global Functioning (C-GAS).

Results indicated no significant differences in outcome measures as a function of the therapist’s professional background. Santor and Kusumakar (2001) found that 84% of participants displayed a significant decrease in depression as measured by the BDI and HRSD. In fact, at termination, only one of the 25 participants met DSM-IV criteria for depression. Furthermore, based on C-GAS results at termination, over half of the participants displayed a significant improvement in overall functioning. The results of this study provide further evidence that IPT-A is a highly effective mode of treatment for depressed adolescents, while also demonstrating that IPT can easily be implemented in community settings with therapists who have little or no experience with this form of therapy, provided that they receive adequate training and supervision. However, there was no control group in this study and thus no way to tell whether the results could actually be attributed to therapist training and background. Generalizability was again limited by patient demographics, as all patients were mostly females from two-parent, middle-income families.

Group Adaptation

Group therapy is also believed to be an effective treatment for adolescents with depression (Mufson, Gallagher, Dorta, & Young, 2004). It provides immediate opportunities to practice new skills, and it offers adolescents a context to decrease their feelings of isolation. In a group setting, collaboration can also provide adolescents with feelings of empowerment. There are opportunities for role play of communication skills, and room for advice and validation from peers. Thus, the adaptation of IPT-A to a group setting (IPT-AG) seems particularly promising. Furthermore, IPT-AG appears cost-effective (requires less staff for the treatment of more patients) and feasible in various settings including school, community, and primary care clinics (Mufson, Dorta, Wickramaratne, et al., 2004). However, these benefits are also potential limitations in that the indi-

vidual member’s problems may be eclipsed by those of other group members. Mufson, Dorta, Olfson, Weissman & Hoagwood (2004) addressed this potential risk by incorporating individual initial sessions prior to group meetings, at midpoint, and at completion of the group. During these individual sessions, therapists conducted interpersonal inventories and described to the adolescent how his or her issues would be addressed within the group. Nevertheless, in the group setting, attention to each individual’s specific problem(s) is more limited than in individual treatment, as the focus becomes common interpersonal elements among them.

Three pilot groups of four to six adolescents each were conducted to aid in the development of IPT-AG. Of these three groups, one involved a chart review of mostly Latino female patients ages 13-17 of low socioeconomic status. Though measures could not be collected during group meetings, chart reviews were conducted by an independent evaluator. Investigators found that the average attendance for group therapy was 90% (comparable to individual IPT-A studies) and that C-GAS scores increased from baseline to termination (Mufson, Dorta, Olfson, Weissman & Hoagwood, 2004). Future work is necessary to assess the efficacy of the group modality for IPT-A.

Conclusion

The literature review presented in this paper provides evidence for the efficacy, feasibility, and applicability of the adolescent adaptation of IPT (IPT-A). Both IPT-A’s time-limited nature and focus on the present, especially social relationships, seem particularly relevant to adolescents and their specific developmental issues. Additional work has studied IPT-A adaptations in a group modality and with novice therapists, demonstrating the flexibility of IPT-A therapy and its applicability to “real-world” settings. Nevertheless, more efficacy data is warranted, with larger sample sizes and more diverse populations. For example, given that most of the trials of IPT-A were conducted with predominantly Hispanic females of low socioeconomic status, additional studies are required in order to ensure that the original findings can be generalized to the larger overall population of depressed adolescents. Additionally, it would be interesting to see how IPT-A compares to other evidence-based psychotherapies, such as CBT, as well as medications such as selective serotonin reuptake inhibitors (SSRIs) in treating depression. Studies of this nature have been conducted with depressed adults, and it seems appropriate to conduct similar trials with depressed adolescents. The research to date on interpersonal psychotherapy in depressed adolescents has led to many important findings; with further research, more questions regarding the treatment of adolescents with depression will undoubtedly be answered.

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