Interpersonal Psychotherapy: Looking to the Future

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Title (SLIDE 1)

• I am so pleased to be here today at the 6th International IPT Conference (SLIDE 2). Thank you, Rosalyn Law, Scott Stuart, Holly Swartz, Paula Ravitz, Laura Mufson, Lena Verdeli, Marc Blom, Mike O’Hara, Michael Robertson, Ellen Frank, and so many others, for all your hard work and ingenuity.
• I am going to give my talk in two parts: The Past very briefly and, Looking to the future.
• I am going to give you my unedited, biased, U.S. centric opinion about what I see is needed to make IPT move to the next level.
• Some of my statements will, be viewed by an international group as peculiar. I hope this is the case as then my statements will reflect only the troubling situation of the U.S.

PAST

IPT was invented by my late husband GLK and myself to test the efficacy of psychotherapy in comparison to and combination with medication in the maintenance treatment of depression. Gerry developed this study to test efficacy of medication for maintenance treatment to prevent relapse of depression. He wanted to add psychotherapy, as a milieu effect, as it was purported to negatively affect medication.

He wanted to mimic clinical practice.

He wanted to use social workers to deliver it.

It should be a supportive psychotherapy except there were not real descriptions of supportive scripts, no manuals. So scripts needed to be written.

He gave me Beck’s partially handwritten and partially typed version to see what he meant about scripts.

He hired me a newly minted SW with no experience to work two days a week to draft the manual and hire experienced social worker to do the therapy. (SLIDE 3)

Gerry was an Associate Professor at Yale and Head of the new Mental Health enter. Gene Paykel and he designed the trial and grant funded by NIMH.

Yale University in a shabby rented space off campus rundown brown stone was our California garage. (SLIDE 4)
High contact, as it was called, in the first clinical trial was based on medical model derived from our experience in the Depression Unit Medication Clinic.

The script was simple and elegant.

Make a diagnosis, educate patient, find out the context of the depression (who is important? what are the supports?) The interpersonal inventory.

Set a time limit

Deal with triggers of depression, grief, disputes, transitions, deficits in the “here and now,”

Write down procedures (The Manual). Train the therapist using the manual.

Determine evidence for efficacy in controlled clinic trial. (SLIDE 5)

Despite all the developments, adaptations for young, old, Brazil, Haiti, Uganda, primary care, group, translations, the core of IPT has remained intact. The medical model, time limits defined, “here and now,” interpersonal inventory, problems. I will get back to that.

In 1984 the first manual was published. (SLIDE 6)

For a brief history (SLIDE 7)

LOOKING TO THE FUTURE (SLIDE 8)

The Organization (ISIPT)

Mission Statement:
- Promoting research and education, professional training
- Setting standards for credentials dissemination, fostering new adaptions
- Worldwide communication
- Developing structures for cross national research, training, dissemination

Committees reflecting these missions:
- Representative of disciplines and regions. Use of Skype and internet

Membership:
- Eligibility
- Mechanism for becoming a member
Benefits of being a member

**Dues:**
Amount
Differences by level of training
Country of Origin

**Dissemination:**
Website: Major tool of communication
General public
Private membership access

**Data Bases:**
Publications (electronic and paper)
Ongoing Research
Manuals and training programs (graduate programs and free standing)
Training materials (profit/not profit)
Fidelity measures
Translations
Pim Cuijper has been the collector of clinical trials. He and his team might be asked to help with a database, but not just for trials but for fidelity to measures, etc.

**Meeting**
Every 2 years for the large international get together seems right but how about regional or local ones annually

**Chapters**
There are Chapters in different countries (Turkey, U.K. Holland).
What is their experience? Who are the chapter? We need a U.S. Chapter
We need to disseminate information from regional chapters.

**A Journal?**
I am ambivalent about having an IPT journal as this will take our research out of the main stream.
On the other hand, it would be very useful to have quick notification about pilot studies, new developments on adaptations, translations, training methods, manuals.

Can the website handle this or do we need another vehicle?

**Training Traditional Graduate School Residency, Counselors, Health Workers (SLIDE 9)**

Who should be trained?

Is this only a U.S. problem?

Despite increasing the evidence for efficacy and calls for psychotherapy by a least likely source (Nature) formal training is minimal (SLIDE 10)

Psychotherapy is described as too expensive, too many manuals, proprietary, not effective, difficult to learn, not available in the U.S.

The major work force for psychotherapy in U.S. is S.W., psychologists, and psychiatrists (SLIDE 11)

Evidenced based psychotherapy is not taught. (SLIDE 12)

We need a committee to delve into this. We need advocacy.

Accreditation is a vehicle for change

This may be a U.S. problem

IPT is increasing in use in developing countries: Haiti, Jordan, Brazil, Gao and decreasing in a resource-rich country like the U.S. (SLIDE 13, 14)

Individual training outside of graduate schools and residency in the U.S. are growing (SLIDE 15)

**Credentials and Certification (SLIDE 16)**

This is a major problem for our field, not just IPT. Anyone can read a manual and call themselves a therapist or can offer a training program and write a certificate.

You can graduate a Ph.D. or M.S.W. program and put up a shingle as an IPT or CBT therapist but have never taken a course or barely read the books.

There are no standards for competency in training programs. There are not continuing certification as is required in medicine.
We need a committee to establish credentials. We need criteria for certification individuals and training programs.

We need to consider training for non-mental health workers.

Much has been done informally

**Research (SLIDE 17)**

- Don’t give up clinical trials and pragmatic effectiveness studies
- Can the organization develop networks to facilitate these studies increase patient recruitment and facilitate training.
- What are the biological psychosocial mechanisms underlying change? What are the changes in brain functioning, hormonal level, cortisol etc. that occur with the process of therapy (using MRI, EEG, Neuropsych Testing, clinical evaluation)
- The call at NIMH is to link change in specific biological features e.g. emotional regulation, working memory to clinical changes and outcomes. e.g. does reduction in disputes lead to change in emotional regulation (measured by cortisol levels or MRI and clinical outcome)?
- Research on fidelity

**Technology, Smart Phones (SIIDE 18)**

Internet, Skype, and cell phones have revolutionized international communication and can be harnessed for training and for research

These tools may eventually be a source of revenue for the organization and also setting standards.

There are numerous possibilities. Training avatars based in use with soldiers who have PTSD in virtual space are a possibility

**Common Elements (SLIDE 19)**

There are over 300 evidence base manuals for mental health and substance abuse disorders

These are 11 advanced psychosocial interventions have been identified by World Health Organization, Mental Health Gap action program, 2010

- Behavioral Activation
- CBT
- Contingency management
- Family counseling
- IPT
Motivational Enhancement
Parent Skills Training for parents of children with behavioral disorders/developmental disorders
Problem-solving counseling
Relaxation Training
Social Skills Training (World Health Organization, Mental Health Gap action program, 2010)

There are different manuals for the same disorders, e.g., CPT, IPT, problem solving for major depression
There are different manuals using the same treatment adapted for different settings, ages, etc.
E.g., IPT for elderly, adolescents, Uganda, primary care, internet, bipolar.

There are specific evidence-based psychotherapies
They have manuals, clinical trials
They are adapted by different ages, cultures, disorders, formats but core remains intact.
If you dismantle the core you no longer have the treatment as the treatment is more than the elements. It is the sequencing of elements.

**Rationale Given for Common Elements (SLIDE 20)**

**Example of Common Elements (SLIDE 21)**

**Summary**
Evidence based psychiatry is rarely taught in psychology, social work, psychiatric residency, counseling.
There are few competency requirements at graduation or ongoing practice
Anyone can call themselves a therapist
A licensed practitioner can call themselves an evidence-based practitioner, but may not have had training or accreditation in the psychotherapy
Access to psychotherapy in the health care system is variable
These are not just IPT problems

**What Would I Like? (SLIDE 22)**
Change accreditation practices in major training programs teaching psychotherapy
Do clinical trials to establish efficacy and effectiveness. Keep IPT honest and therefore evidence based. Don’t dismantle it into element. Instead use modules.

Work Hard – Enjoy yourself- Train the next generation

Build the organization across the world

Make as many adaptations and manuals and trials as you like and need

Write as many books as you like

Develop as many training programs as you need

Remember Gerry and cite him as the inventor (SLIDE 23)

Cite our books where we have laid down the theory, evidence, and procedures (SLIDE 24)

It is his legacy and mine also