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Interpersonal Counseling (IPC) for Depression in Primary Care

MYRNA M. WEISSMAN, Ph.D.[*,#,†], **SIDNEY H. HANKERSON, M.D., MBA**[*,†], **PAMELA SCORZA, ScD, MPH**[*,†], **MARK OLFSON, M.D., MPH**[*,†], **HELENA VERDELI, Ph.D**[‡], **STEVEN SHEA, M.D., MS**[§], **RAFAEL LANTIGUA, MD**[§,≠], and **MILTON WAINBERG, MD**[*,†]

[*] Division of Epidemiology at the New York State Psychiatric Institute

[#] Department of Epidemiology at the Mailman School of Public Health at Columbia University

[†] Department of Psychiatry of the College of Physicians and Surgeons at Columbia University

[‡] Teachers College at Columbia University

[§] Department of Medicine at Columbia University

[≠] Columbia Stroud Center for Geriatric Research and the Associates of Internal Medicine (AIM) Practice

Abstract

Interpersonal Counseling (IPC) comes directly from interpersonal psychotherapy (IPT), an evidenced-based psychotherapy developed by Klerman and Weissman. It [IPC?] is a briefer, more structured version for use primarily in non-mental health settings, such as primary care clinics when treating patients with symptoms of depression. National health-care reform, which will bring previously uninsured persons into care and provide mechanisms to support mental health training of primary care providers, will increase interest in briefer psychotherapy. This paper describes the rationale, development, evidence for efficacy, and basic structure of IPC and also presents an illustrated clinical vignette. The evidence suggests that IPC is efficacious in reducing symptoms of depression; that it can be used by mental health personnel of different levels of training, and that the number of sessions is flexible depending on the context and resources. More clinical trials are needed, especially ones comparing IPC to other types of care used in the delivery of mental health services in primary care.

Keywords

interpersonal psychotherapy; interpersonal counseling; depression; primary care

INTRODUCTION

The implementation of the *Affordable Care Act* brings increasing interest in patient-centered, cost-effective models of care that expand access to mental health services for diverse populations. Broadened eligibility for Medicaid benefits and new subsidies for

Mailing address: *# Diane Goldman Kemper Family Professor of Epidemiology (in Psychiatry), College of Physicians and Surgeons at Columbia University, Chief, Division of Epidemiology, New York State Psychiatric Institute, Unit 24, 1051 Riverside Drive, New York, NY 10032. mmw3@columbia.edu..

private coverage of low and moderate income people will bring large numbers of previously uninsured depressed people into primary care (Garfield et al., 2011). Meeting the mental health care needs of these newly insured individuals will require expanding access to evidence-based, though currently underutilized, approaches to the primary care management of depression. Primary care will remain a major resource for screening and treating depression, especially for patients with low incomes (Cooper et al., 2003; Mojtabai & Olfson, 2008) because of high prevalence, substantial morbidity, and adverse effects of depression on management of chronic medical conditions (Murray et al., 2010; Lerner & Henke, 2008; Wang et al., 2004; Kendler et al., 2009; Olfson et al., 2002; Hankerson et al., 2011; Weissman et al., 2004; Mann et al., 2004; Ormel et al., 2008). Under the traditional model of primary care treatment of depression, primary care physicians often struggle without support to manage the mental health problems of their patients. Their well-intentioned efforts are too often undermined by competing clinical imperatives to treat acute and chronic medical conditions and deliver preventive care. Moreover, primary care physicians in the United States neither have training in psychotherapy nor the time to deliver psychotherapy.

Interpersonal counseling (IPC), a brief, patient-centered approach to managing depression, lowers the burden on primary care physicians by having a mental-health worker located within the primary care setting. Interpersonal counseling is derived directly from interpersonal psychotherapy (IPT), an evidence-based psychotherapy that has undergone numerous efficacy studies, and been translated and adapted for cross-cultural use (Klerman et al., 1984; Weissman et al., 2000, 2007; Markowitz and Weissman, 2012; Barth et al., 2013). This paper describes the rationale for using IPC in primary care, offers alternative models of care, and summarizes the development, evidence of efficacy, and basic structure of IPC. The paper concludes with an illustrative case vignette.

Rationale for Using IPC in Primary Care

Interpersonal Counseling (IPC) is a brief manualized evidence-based treatment for evaluating and triaging patients with depressive symptoms to appropriate levels of care. It fills the gap between screening and referral of patients who may need more sustained care, while offering support, identifying resources and clarifying the psychosocial triggers that may have brought on the depressive episode. Because symptoms of depression are often a transient reaction to life stress, many patients do not require sustained treatment, and the symptoms will remit after 3 to 5 (or even fewer) sessions. Other patients may require watchful waiting, and a small number may require triage to sustained treatment with medication, longer term psychotherapy, or both.

Primary care patients with depression usually receive medication but if given the option, generally prefer to talk to someone about their problems (Vidair et al., 2011 McHugh et al., 2013). Less than 40% of adults entering psychotherapy ever receive more than 3 to 5 sessions. Whether the brevity of treatment episodes is primarily driven by patient preference or economic considerations is unclear, but short treatment is the norm and imposes constraints on the feasibility of traditional psychotherapy approaches in this setting.

Throughout this paper we may refer to IPC as three sessions but the need for flexibility is recognized as will be noted.

The principle underlying IPC is that a systematic, but brief, evaluation, support, and triage may help to allocate a scarce commodity—full outpatient mental health treatment—to those patients who might derive the greatest benefit and for whom it may be most appropriate. This approach can also offer supportive, less intensive interventions to the majority of patients who present with transient depressive symptoms associated with an immediate life stressor. Interpersonal Counseling can be easily taught to psychologists, social workers, or nurses. It can also be taught to persons with little or no background in mental health [treatment], if the personnel are carefully chosen, the procedures are systematically described, and the training appropriately modified.

Alternative Models of Depression Care in Primary Care Settings

In the United States, most treatment for depression of varying degrees of severity occurs in primary care settings (Cooper et al., 2003; Mojtabai & Olfson, 2008), and primary care physicians (PCPs) prescribe the majority of antidepressants, especially to older patients (Mojtabai & Olfson, 2008). However numerous competing demands in primary care limit the time available to adequately assess, diagnose, and treat depression (Rost et al., 2000; Gallo et al., 2005). To address this challenge, several successful strategies for use in primary care have been developed to improve the recognition and management of depression. These range from simple educational programs, to complex (but successful) collaborative care programs that require substantial new resources (Gilbody et al., 2006) and may be difficult to sustain.

Education and training for PCPs, consultation-liaison with mental health specialists, replacement/referral, and collaborative care represent alternative models to the primary care management of depression (Bower & Gilbody, 2005; Gilbody et al., 2006). Training/educational models involve directly training PCPs and other staff members to provide mental health care (Bower & Gilbody, 2005; Gilbody et al., 2003). Such training can take place by using videotapes, written materials, small group teaching sessions (Thompson et al, 2000), intensive practice based seminars (Bower et al., 2006), or educational meetings to disseminate information and practice guidelines (Bower et al., 2006; Andersen & Hawthorne, 1990). The goals of educational models are to improve prescribing of antidepressants or to teach skills in psychotherapy (Bower et al., 2006).

The consultation-liaison model (Bower & Gask, 2002) is a variant of the training model. Consultation-liaison models in primary care involve an ongoing, educational relationship between a mental health specialist, usually a psychiatrist, and a PCP (Bower et al., 2006; Bower & Gask, 2002). When consulted, the mental health specialist supports the PCP in caring for specific patients with depression. This model ensures that as the PCP provides mental health care, the continual PCP–mental health specialist interaction helps improve the PCP's knowledge of mental health care, which, in turn, increases the level of care for patients who are not included in specific consultation discussions (Bower & Gask, 2002).

In replacement/referral, when a PCP identifies a patient with depression, the patient is immediately referred to a mental health specialist for the duration of treatment (Bower & Gilbody, 2005). Primary care settings equipped with on-site mental health professionals utilize this replacement/referral model (Bower & Sibbald, 2000), which requires the highest level of mental health specialist involvement and lowest level of PCP involvement. This model is the one most commonly associated with treatment, including some type of psychotherapy (Bower & Gilbody, 2005; Brown and Schulberg, 1995).

Collaborative care for the treatment of depression, the modality developed by Katon and his colleagues, is the best studied of the modalities mentioned and has the strongest empirical support (Butler et al., 2008; Katon et al., 1995, 1996, 1999). It involves locating a mental health specialist within primary care, establishing simple mental health treatment protocols, providing mental health screenings and education, and conducting ongoing outcome measurement with the assistance of a nurse practitioner or case manager (Bower et al., 2006; Katon & Unutzer, 2006). Depending upon patient preference and depressive symptom severity, case managers may deliver a brief, evidence-based psychotherapy called Problem-Solving Treatment of Primary Care (PST-PC).

A recent meta-analysis of 37 randomized controlled trials of collaborative care in the U.S. and abroad found that such programs significantly improved the quality of depression care, patient and provider satisfaction, and depression outcomes compared with usual primary care (Woltmann et al., 2012). Factors associated with improved depression outcomes included case managers with a specific mental health background and regular, planned supervision. Brief interventions, including telephone follow-up, were also effective (Gilbody et al., 2006). Roy-Byrne (2013) recently described some of the challenges of implementing this model in primary care in the United States, including cost and uncertainty about long term effectiveness (Oosterbaan et al., 2013).

A simpler form of depression management in primary care has been described, which includes five outreach calls for monitoring, support, and feedback to physicians. It has been tested against the same outreach plus the addition of eight telephone sessions of structured CBT for depression and four additional calls for reinforcement. The latter approach, including CBT, had significantly more clinical benefit than monitoring outreach alone (Simon et al., 2000).

These approaches are complementary and are important sources of managing depression in primary care. Within this paradigm, IPC specifically bridges the gap between initial screening, when the diagnostic picture and severity of the patients is unclear, and the subsequent allocation of treatment to match the patients' needs and life circumstances. Interpersonal Counseling is for the most part simpler than these other approaches.

HISTORY OF IPC

In 1983, Klerman and Weissman developed a simplified manual directly derived from IPT; they called it Interpersonal Counseling. Interpersonal Counseling was briefer than IPT, had scripts to follow, and was intended for training professionals with no mental health background in the treatment of primary care patients with depressive symptoms. The first

IPC study focused on training nurses at the Harvard Community Health Plan who did not specialize in mental health care (Klerman et al., 1987).

The manual was updated in the mid-2000s in response to an increasing emphasis in the United States for efficient, accessible, cost-effective models of mental health services and a growing demand for psychosocial approaches to care in developing countries devastated by war and natural disaster. The IPC manual was shortened from 6 to 3 sessions, and the section on termination, which was renamed triage, was made more explicit. The 3 sessions in the manual were based, in part, on the observations that patients in the efficacy studies used, on average, only about 3 sessions; *this was* in keeping with broader mental health service utilization patterns in the United States and was as planned for developing countries without the resources for extended psychotherapy. The updated version of IPC was named Interpersonal Psychotherapy, Evaluation, Support, Triage, or IPT-EST (Weissman & Verdeli, 2012). This name change caused confusion as it seemed unconnected to IPC, and thus appeared to be a new treatment, which was not true. It also appeared to separate these procedures from existing efficacy data. The name IPT-EST has been removed and the revised manual is again called IPC.

The content and structure of IPC has not changed over the years, and there are no substantial differences between IPC and IPT-EST. While the latest version emphasizes three sessions, it allows for flexibility within the context of the setting and resources. (The 2013 updated IPC manual is available from Dr. Weissman at mmw3@columbia.edu.)

TESTING IPC

This is the first review of IPC trials, therefore, efforts were made to include all studies, even if samples were small and not of a randomized controlled design (Table 1 summarizes the IPC clinical trials). These are included with recognition of the tentative nature of the results.

The Klerman and Weissman study at the Harvard Community Health Plan was the first to try IPC. New enrollees in several health centers were screened for depression symptoms using the General Health Questionnaire (GHQ). Individuals with scores of >5, representing mild depressive symptoms, were eligible for the study. All eligible consecutive patients who chose to participate during the study period were assigned to the IPC treatment group. Controls matched on gender and GHQ score were selected from new consecutive enrollees from earlier in the year. The IPC treatment lasted up to six sessions (average 3.4 completed sessions) with internal medicine nurse practitioners lacking psychiatric training, supervised weekly in small groups by two senior psychotherapists. The IPC patient group was assessed after treatment for depression symptoms using the GHQ. The control group was mailed a second GHQ three months from the date of the first GHQ, an interval that approximated the average time between entry and postintervention GHQs in the IPC group. Eighty three percent of the patients in the IPC group remitted as compared to 37% in the control group ($p<0.01$) with remission defined by GHQ scores <5.

Interpersonal Counseling has also been evaluated in hospitalized, medically ill older individuals. Mossey et al. (1996) assessed IPC as a treatment for medically hospitalized patients age 60 years or older who had elevated depressive symptoms but did not meet DSM

criteria for major depression or dysthymia. Seventy-six patients with a geriatric depression scale (GDS) score greater than 10 were recruited. Individuals were randomized into IPC (n=35) or usual care (n=41). Randomization occurred within strata defined by age (60 to 74; 75 to 84; 85 + years) and sex. Two Master's-level psychiatric clinical nurse specialists delivered IPC. Several adaptations of IPC were made to accommodate the needs of the medically ill elderly. Specifically, the number of IPC sessions was increased to 10, session length was extended from 30 minutes to 60 minutes, and IPC sessions were flexibly scheduled from once a week to a schedule that reflected the individual's medical status. In the IPC group, 94% of individuals completed at least one IPC session and 71% had 4 or more sessions. Geriatric depression scale scores were measured at recruitment and three-, six-, and 12-month follow-up. At three months, the IPC treatment group showed greater improvement than the usual treatment group, though this difference was not statistically significant. However, at six months, the IPC group was statistically significantly more likely than the usual care group to have GDS scores less than or equal to 10.

The effectiveness of IPC on decreasing psychological distress following severe physical trauma has also been examined. Holmes (2007) recruited 117 patients with major physical trauma and psychological distress at two major trauma centers for a randomized clinical trial (RCT) examining the impact of IPC and treatment as usual (TAU) on patients' psychiatric symptoms. Interpersonal Counseling was adapted for the patient population and delivered by clinical psychologists. Measures of depressive, anxiety, and post-traumatic symptoms at baseline and 3- and 6-month follow up showed no significant differences between the two treatment conditions for symptom level or psychiatric diagnosis However, patients with a previous history of major depression who were randomized to IPC showed significantly increased levels of depressive symptoms at 6 months. A possible explanation for this symptom elevation could relate to the sustained impact of the physical injury. Thus, for vulnerable patients with a history of previous major depression, lack of physical recovery from the injury impeded successful remission from psychological distress and symptoms with IPC. Holmes noted relatively high attrition rates, with only 58 patients completing the full study.

Badger and colleagues extensively explored the ameliorative role of IPC in patients with cancer. Some of the studies required depressive symptoms as entrance criteria, others did not. Badger et al. (2004, 2005a, 2005b) investigated the impact of IPC on 48 breast cancer patients receiving adjuvant treatment who reported depressive symptoms and fatigue. Patients were recruited from cancer centers, oncology offices, and support groups. Half the patients received IPC, the other half TAU. Three Master's level clinical nurse specialists in psychiatric-mental health nursing who had received additional oncology training collected outcome measures at 6 and 10 weeks. A significant reduction in depressive symptoms, fatigue, and stress, as well as an increase in positive affect, was found for the IPC group. Interpersonal Counseling was associated with better outcomes among women in a long-term marriage who had no past history of depression or cancer.

In a second RCT Badger et al. (2007) examined both 96 breast cancer patients undergoing adjuvant treatment and their supportive partners. Depressive symptoms were not required as inclusion criteria. Patients were randomized into one of three 6-week intervention groups:

1) telephone for both IPC and IPC for partners

2) self-managed exercise and three telephone calls with partners, or

3) an attention-control group that included six weekly telephone calls and six biweekly calls to the partner.

Following up at 6 weeks and 10 weeks post intervention, a decrease in women's depressive symptoms across all groups was evident. Women patients' anxiety symptoms decreased among the IPC and exercise groups, but not the attention control group. Assessment of partners' depressive and anxiety symptoms yielded similar findings; partners reported significantly decreased depressive symptoms, and anxiety symptoms decreased in the IPC and exercise groups but not among the attention control group.

In a third study, Badger et al. (2011, 2013) randomized 71 men with prostate cancer and their intimate or family supportive partners to IPC or health education attention condition (HEAC). Patients were either currently undergoing or had completed treatment for cancer within the last 6 months. Symptoms of distress or depression were not required as entrance criteria. Interpersonal Counseling-trained counselors/research assistants held eight weekly 30-minute sessions. Outcome measures were collected at 1, 8, and 16 weeks, demonstrating superior quality of life (QOL), including improvements in depression, fatigue, social support, social well-being, and spiritual well-being, among cancer patients and their partners/family members for the HEAC group, compared to the IPC intervention group. Advanced age men, active chemotherapy, lower prostate specific functioning, and lower cancer knowledge predicted better outcomes for the HEAC intervention. In contrast, higher education, higher prostate specific functioning, social support, and cancer knowledge showed more favorable outcome and more positive affect for patients receiving IPC.

Finally, Badger et al. (2013) examined 70 Latina women with breast cancer receiving adjuvant treatment and their supportive partners (family members or friends). Symptoms of distress or depression were not required as entrance criteria. This RCT divided patients between IPC and telephone health education (THE) interventions, assessing their progress at 8 and 16 weeks post intervention. Interpersonal Counseling focused on relationships between cancer patient, family members, and health providers. Both interventions provided by master level social workers yielded significant improvements in psychological, physical, social, and spiritual QOL for both Latina breast cancer patients and their supportive partners over 16 weeks, with no significant differences between treatments.

Oranta et al. (2010, 2011a, 2011b) implemented IPC in inpatients with recent myocardial infarctions (MI). Study investigators recruited 103 MI patients from a university hospital in Finland. Patients were first administered the Beck Depression Inventory (BDI) to assess depression symptoms and were then randomized, stratified by depression status (depressed=BDI 2:10, not depressed=BDI <10), to IPC (n=51) or standard care (n=52). In the intervention group, patients had up to six IPC sessions (mean=4.6), with at least the first session occurring in the hospital. Sessions after discharge were conducted by telephone. Interpersonal Counseling was administered by a psychiatric nurse trained for one day its use. Health-related quality of life, measured by the EuroQol-5D, was assessed at study entry, and

at 6 and 18 months after discharge. Depressive symptoms decreased significantly in the IPC group compared with the control group in all age groups. Although IPC did not improve overall health-related QOL at follow up, it was more beneficial for younger MI patients. A statistically significant difference between the non-elderly groups in health-related QOL showed that health-related QOL of patients below 60 years old significantly improved compared to controls.

Preliminary research has also tested IPC for women who experience elevated depressive symptoms after miscarriages. An IPC manual for pregnancy loss was drafted based on the original IPC manual, epidemiological work on miscarriage, and depression and the perinatal bereavement literature. It was tested in an open IPC trial. A psychiatric social worker without prior IPT or IPC training and two IPT-certified psychotherapists provided IPC. A senior IPT therapist audited session tapes and discussed counseling standards with the treating clinicians. A post-intervention assessment with the Hamilton Depression Rating Scale (HAM-D) was scheduled 9 weeks after randomization. In the open trial used for developing the study, Neugebauer et al. (2007) assessed 17 patients with depressive symptoms and medically documented pregnancy loss and found that IPC completers achieved a 52% decrease in depressive symptom scores compared to a 25% decrease among the intention to treat group. Neugebauer et al. (2006) reported findings from 19 women seeking medical care for miscarriage in emergency departments, OBGYN clinics, and private practices in the New York City area in a second study. Women with HAM-D scores >7 who did not have current major depressive disorder were recruited into the study. Eligible women who chose to participate were randomized to IPC (n=10) or treatment as usual (n=9), which consisted of any lay counseling or professional care that the women independently sought. Hamilton depression scores were significantly lower in the IPC than the TAU group at the end of treatment.

A pilot study in Israel examined the impact of two telephone-administered interventions, IPC and supportive counseling, on depression, anxiety, and somatization symptoms as well as the QOL of frequent attenders (FAs) in primary care (Sinai & Lipsitz, 2012). Frequent attenders are believed to have elevated rates of depression, anxiety, and psychological distress as well as lower social functioning and limited social networks, and increased primary care usage. Outcome measures for depression, anxiety and somatization were assessed using the Hebrew version of the Patient Health Questionnaire (PHQ), while QOL was evaluated using the Quality of Life Scale (QOLS). Originally, 159 FAs were randomized to IPC supportive counseling or no treatment. However, only 17 FAs receiving IPC and 16 FAs receiving supportive counseling completed the first telephone session. Only eight completed the full six IPC sessions; eight completed the full supportive counseling sessions, and 17 in the control group responded to the post-12-week evaluation questionnaire. Thus, only the data from those who completed the interventions (n=35) were analyzed in this study, and they showed no differences at baseline. Interpersonal Counseling. Interpersonal Counseling included six 30-minute sessions over 12 weeks focusing on an interpersonal problem that was identified in the initial session. Supportive counseling followed the same contact time as IPC, but had no specific focus. Those receiving no treatment were assessed at baseline and after 12 weeks with the PHQ questionnaire. Overall, results indicated that IPC was significantly superior in decreasing symptoms compared to

the other intervention and controls. Only IPC showed marginal significance in decreasing somatization symptoms compared to supportive counseling and no treatment. Only IPC yielded a reduction in anxiety and depression symptoms, compared to the other treatment arms. Quality of life measurements showed no significant differences between any of the conditions. Health care utilization and costs showed no significant difference pre- to post-intervention change in any of the conditions. Cost of doctor visits, cost of hospitalization, and clinic costs each showed nonsignificant trends of greater reduction in costs for IPC only. There was a marginally significant time × group interaction for number of primary care visits, showing a reduction for IPC only at a trend level.

The first published study to combine IPC with antidepressant medication took place in a general practice setting in Australia (Judd et al., 2001). All patients received medication, venlafaxine-XR, and were randomly allocated to IPC or to usual psychosocial interventions. Patients were enrolled in the study if they were between 18 to 65 years of age and presented with an episode of major depression (as described in the DSM-IV). Doctors in the intervention group received training in IPC with a video and written material. Mood symptoms were assessed using the Beck Depression Inventory (BDI). Twelve IPC patients and 19 patients in the standard treatment group were included in the intention-to-treat analysis of efficacy at 12 weeks. Both treatments produced a statistically significant reduction in BDI scores from baseline, with IPC showing greater improvement evident in recovery.

A recent trial directly comparing IPC to antidepressant medication treatment has just been completed. Menchetti et al (2010, 2013) conducted a multi-center randomized controlled trial in primary care centers in Italy, comparing the effectiveness of IPC to selective serotonin reuptake inhibitors (SSRIs). Patients with depressive symptoms were referred by primary care physicians. Patients were eligible for the study if they met DSM-IV criteria for major depression based on Mini International Neuropsychiatry Interview diagnoses, had a score ≥13 on the 21-item HAM-D, and were in their first or second depressive episode (Sheehan et al., 1998 After baseline assessment, patients were randomly assigned to IPC or to antidepressant treatment. Interpersonal Counseling was adapted to accommodate the patients' needs; the recommended number of sessions was six thirty-minute weekly sessions. Therapists determined whether one or two additional sessions were needed. Eighteen therapists, who were residents in psychiatry or in clinical psychology with at least 2 years of clinical experience, delivered IPC. The therapists attended a 3-day teaching seminar on interpersonal theory's foundations and IPC structure and techniques. Additionally, one study author conducted monthly group supervision sessions. Severity of symptoms was assessed at baseline, 2, 4, 6 months, and 1 year follow-up using the 21-item HAM-D.

Menchetti et al. (2013) reported that the proportion of patients with mild depression who achieved remission (Hamilton score of 7 or less) at 2 months was significantly higher in the IPC than the SSRI group. Interpersonal Counseling and SSRI appeared equally effective in treating moderate to severe depression. Mild depression, low functional impairment, initial first depressive episode, and absence of comorbid anxiety disorders predicted better outcome with IPC. Interpersonal Counseling was feasible, easy to learn, and well suited to

the primary care setting. These results have encouraged investigators working with Menchetti et al. to use IPC in other regions in Italy.

Researchers are currently adapting and testing IPC in lower-resource settings and with less-skilled health workers. Feijo de Mello (personal communication, 2013) is currently evaluating IPC in a Brazilian family health program. Verdeli (personal communication, 2013) is testing it in a stepped-care model within a primary care network of Partners in Health in Haiti, and Ravitz and colleagues (personal communication, 2013) are disseminating it in a nationwide training program in Ethiopia. In these settings, therapists include psychiatric and general medical nurses and community health care workers (Weissman, 2013). Interpersonal Counseling is also being adapted in Edinburgh Scotland as an acute intervention for patients presenting at a crisis service with high levels of self-harm and suicidality (Graham & Lamaigre, personal communications, 2013). The primary aims of IPC in this study are to help identify the social and interpersonal contexts, which are associated with the onset of the acute crisis, reduce the symptoms of distress, and improve interpersonal functioning.

SUMMARY OF TESTING

Thirteen studies have tested IPC. Aside from the large 2010 study by Menchetti et al. (N=300), the sample sizes have been small. The studies found IPC improves depressive symptoms and functioning, the exceptions were the Badger et al. study (2011, 2013) of men with prostate cancer that compared IPC to Health Education attention, and the Holmes et al. study (2007) of psychological distress post major physical trauma. Interestingly, the studies not requiring depressive symptoms or distress as entrance criteria showed weaker findings for IPC (Badger 2007, 2011, 2013). In the Badger et al. (2013) for Latina women with breast cancer comparing IPC to treatment as usual, both groups improved. The most important study in terms of size by Menchetti et al. (2013), which took place in primary care sites, found IPC, as compared to a SSRI regimen alone, achieved greater remission. Clearly more research is needed, including more details as to the adaptations and the training provided. Finally, studies comparing IPC and collaborative care are needed.

DESCRIPTION OF IPC

The IPC manual describes a three-session evaluation, support, and triage intervention for persons with depressive symptoms or suspected major depression. The intervention is designed for use by a variety of disciplines, including primary care physicians, physician assistants, social workers, nurse practitioners, nurses, or counselors. In the United States it is unlikely to be used by primary care physicians because of time constraints. For simplicity's sake, the manual uses the term "therapist" for the health care provider and "patient" for the recipient, recognizing that the brief treatment approach is designed for personnel at differential educational and occupational levels in mental, medical, health, work, educational, and other facilities. The term "therapist" and "patient" should be modified as appropriate to the setting and provider. The therapeutic relationship is supportive and encouraging.

The procedures derive directly from IPT (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman, Markowitz, & Klerman, 2000, 2007), with the language simplified for health providers who are not otherwise trained in mental health. The three sessions can be flexibly scheduled, weekly or more or less frequently depending upon the patient's preferences and clinical need. And, as noted previously, additional sessions can be added. A patient can also choose to have fewer sessions. Sessions are usually 30 to 45 minutes; the first session may be longer. The choice of IPT vs. IPC will depend on level of training of provider, resources available, and severity of patient's illness. In general, IPC is recommended for use in settings that are not specific to mental health care.

The sessions are conceived as supportive evaluation following an initial assessment of elevated depression symptoms. Sessions will involve: (1) clarification of symptoms and diagnosis, (2) delineation of the social and interpersonal context associated with the onset of the symptoms (which fall into one of the four IPT-based problem areas, grief, dispute, life changes, boredom and loneliness), (3) identification of patient resources (e.g., who is there to support the patient), and (4) education for strategies in dealing with problems contributing to the patient's depression. From the very first session, the therapist focuses on clarifying the interpersonal problem and providing basic strategies to manage it.

At the end of the three sessions, the patient and therapist make a decision regarding provision of further services. Depending on the severity of the patient's symptoms at the end of these three sessions, the patient's wishes and social supports, and the availability of mental health care resources, they consider possible triage:

1. For patients with minimal or no symptoms and no functional impairment: no further treatment.
2. For patients who have improved but still have some symptoms and slight functional impairment: unscheduled treatment as needed ("Call me if you need me" or monthly maintenance in person or by telephone.)
3. For patients who have improved but still have moderate symptoms and impairment, as well as those remaining in an episode, not improving, or worsening: regular treatment alone or in combination with other therapies, including group or individual psychotherapy and/or medication. Depending on the service structure, these patients may be referred to mental health specialists.

The manual describes the treatment procedures in detail with scripts and patient handouts to facilitate information gathering and therapeutic discussions. Although the intervention focuses on evaluation and triage, it contains the key elements of IPT, thus making it more than a diagnostic evaluation. These elements encompass the initial phase of IPT. In addition to eliciting the clinical and interpersonal history, there is an educational component about depression. To help the patient clarify the problem and link it to the depressive episodes, the therapist explains how depressive symptoms influence and are influenced by interpersonal situations. The diagnostic focus is on the interpersonal event(s) that triggered the current episode, exploration of the event, and examination of resources for dealing with it.

Outline of the Three Sessions

The manual provides scripts for the procedures. The suggested scripts are shown in bold, and are elaborated upon in the manual. The novice provider will likely use them as presented. The experienced therapist will undoubtedly elaborate on them, but should cover the presented material. Optional handouts help to guide patients in recalling past events and episodes as appropriate (Weissman, 2005).

Session 1

■ Review depressive symptoms with patient (a self-report screening form for symptoms may be used).

■ Review level of impairment and other comorbid symptom (e.g. alcohol abuse, anxiety) with patient.

■ Explain how depression influences and is influenced by co-morbid medical conditions and/or life events.

■ Provide education about depression symptoms using the medical model to reduce guilt (“It’s not your fault”).

■ Give hope (“Your symptoms will improve”).

■ Problem-solve role performance difficulties resulting from current depression (“Who can help you right now?”).

■ Explain the course of evaluation.

■ Explore interpersonal problems associated with the onset of current depressive symptoms (“What was happening when you started feeling sad and your headaches worsened?”).

■ Conduct focused interpersonal inventory.

■ Choose a problem areas on which to focus, and share the plan with the patient.

■ Explain procedures for the next two sessions (i.e. duration and frequency), as well as triage options.

Session 2

■ Review reactions from previous session.

■ Review symptoms and functioning.

■ Briefly present strategies for dealing with problem areas:

- Grief,

- Disputes,

- Transitions (life changes),

- Boredom, loneliness, and isolation.

■ Identify general IPT strategies to help the patient:

- Breaking the social isolation,
- Brainstorming alternative options to deal with the problem,
- Identifying others who can help and advocate for patient,
- Improving communication.

Session 3

■ Review symptoms and functioning.

■ Review progress on problems, discuss the patient's clinical needs and triage preference.

■ Discuss options at termination:

○ No further follow-up;

○ As needed, "Call me as you need me";

○ Maintenance treatment monthly;

○ Refer for medication and/or psychotherapy (individual or group).

Prior to the first session, the therapist may ask the patients to complete an assessment of demographics, symptoms, functioning, treatment history, preferences and obstacles and problems. Depending on the goals and setting, the patient diagnosis may be confirmed by an additional diagnostic assessment. The intervention can be used for patients with depressive symptoms regardless of primary diagnosis.

Case Example

The case example is a composite to preserve confidentiality but represent problems treated by at least one of the authors.

Jennifer Wilson (pseudonym), a 39 year-old woman came to a local primary care clinic seeking antibiotics for an upper respiratory infection. Complaining of sleep problems and loss of energy, she was given a depression screening inventory by her primary care doctor. She endorsed feeling depressed in the context of the recent death of her aunt, who had been a mother figure her. She had an initial score of 19 on the 16-item Quick Inventory of Depressive Symptomatology-Self Report (QIDS-SR 16), in the range of moderate to severe depression (Rush et al., 2003).

Session 1—The IPC therapist reviewed Jennifer's depressive symptoms and explained that she was clinically depressed. He gave her the "sick role" explaining that depression is a medical illness, just like diabetes or high blood pressure. Jennifer was initially reluctant to acknowledge that she was depressed, but after reviewing her symptoms, she informed the therapist, "You're right. I've been really down since my aunt died and it's affecting my work." The therapist praised Jennifer's acknowledgement of her condition and gave her hope that depression is a common illness that can be treated.

The therapist conducted a brief "Interpersonal Inventory," i.e. a review of people who were involved in Jennifer's life and could be resources or problems. This also allowed us to discuss the emotional support available to Jennifer while she was coping with her depressive episode. The two closest people in Jennifer's life were her mother, with whom she had been living for the past two years and had a tenuous relationship, and her cousin, Susan, who had recently moved away from town and whose mother (Jennifer's aunt) had died one month before Jennifer entered treatment. Jennifer's mother was afflicted with several chronic medical conditions, and Jennifer assumed the role of primary care-taker for her mother's. Noting that Jennifer had limited social support, the therapist suggested that Jennifer think of other people with whom she could engage for assistance. Jennifer was able to name several people from her church, one older man in her apartment building, and a work colleague to whom she thought she could reach out. The therapist helped Jennifer develop a plan to engage each of these people.

The therapist explored other potential problem areas as triggers for Jennifer's depressive episode. Jennifer admitted that she was unhappy at work and hoped to go back to graduate school to advance her career opportunities. However, she had limited financial resources and did not feel she could afford to pay for graduate courses at present. As her responsibilities caring for her mother were long-standing, the therapist and Jennifer collaboratively decided to focus on the acute stress of her aunt's death. They framed the treatment focus on grief triggered by the death of her aunt, who had been a major source of support for Jennifer.

Session 2—The therapist briefly reviewed Jennifer's depressive symptoms and level of impairment. Jennifer was still depressed, but she had spent time with two of the people she had identified on her interpersonal inventory. She said both of these interactions had been positive, and she felt somewhat hopeful that she would be able to go out with them again soon.

This session focused on Jennifer discussing in detail the feelings and relationship she had with her deceased aunt. She recalled how her aunt called her every Friday to read a poem to her and to encourage her to have a good weekend. She had hosted Jennifer and her friend for "movie night," a source of great enjoyment for Jennifer. The therapist also gently asked Jennifer what she did not like about her aunt. Jennifer initially brushed this inquiry off, saying that her aunt was "like an angel who had no bad bone in her body." Upon probing, however, Jennifer did admit that her aunt would frequently not deliver on promises. For instance, her aunt had promised to take Jennifer and her cousin to see a Broadway play, but never did. Whenever Jennifer asked about the play, her aunt would harshly chastise Jennifer for "not being grateful for all of her blessings." This chastisement made Jennifer feel extremely guilty. The therapist normalized the mixed feelings Jennifer had for her aunt. This was a cathartic and informative process. At the end of the session, Jennifer said, "I miss my aunt terribly, but there are also parts of me that are glad I don't have to deal with her anymore."

Session 3—At the beginning of the session, Jennifer completed the QIDS-SR. Her score had decreased to a 9. Although she had improved considerably, she still had moderate symptoms. The therapist reviewed her symptoms, and they discussed treatment options

following completion of IPC. Jennifer decided that she wanted to see how she would do and wanted to return in a month. The therapist told Jennifer she could call if she felt worse in the interim. Jennifer continued her contact with her PCP as before, as needed.

CONCLUSION

Interpersonal Counseling is a brief patient-centered approach for evaluating, treating, and triaging patients with depressive symptoms or distress to appropriate levels of care, and for providing support for transient symptoms that may not require additional care. It has primarily been used in medical settings and seems well suited for primary care. It can be readily adapted to telephone use as well as use with the patient primary caretakers and/or significant others. Depression is common among uninsured Americans and we can anticipate an influx of depressed adults and previously uninsured young people in primary care in the next few years. The emerging efficacy data are encouraging and more studies in the United States in primary care are needed. The nature of various adaptations of IPC is not always clear. Interpersonal Counseling is currently not available in training programs in psychiatry, psychology, or social work. IPT training is increasing in these programs, and IPC can readily be used by persons trained in IPT. Health workers are being trained on an *ad hoc* basis in the United States. Several groups in low income countries have trained workers in IPC (Weissman, 2013). Clearly, IPC is a work in progress and this paper reviews where it stands now.

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Table 1

TESTING OF IPC

Authors	Patient Population	Sample	Study Design	Outcome measure	Main findings
Klerman et al. 1987	New HMO plan enrollees with >5 score on the GHQ*	N=128	Non-RCT; Intervention group comprised of all eligible enrollees during study period. Gender and GHQ-score matched controls selected from HMO enrollees and followed naturalistically; outcomes assessed at baseline and 3 months post-intervention.	GHQ	83% of IPC group remitted (GHQ <5) compared to 63% of control group (Chi2= 6.65, p=.01)
Mossey et al. 1996	Medically ill patients aged 60+ with a GDS score >10 not meeting DSM III criteria for MDD or dysthymia.	N=76	RCT; IPC or usual care; outcomes assessed at recruitment and at 3, 6, and 12 months follow-up.	GDS	At 3 months, IPC showed greater improvement than usual care, but not statistically significant. At 6 months, significantly more of the IPC group had GDS scores <11 (60.6% vs 35.1%).
Holmes et al. 2007	Patients with psychological distress post major physical trauma	N=90	RCT; IPC or TAU; outcomes assessed at 3 and 6 months follow up.	BDI HADS PCL AUDIT SF-36	At 6 months, there were no significant differences between IPC and TAU for rates of depressive, anxiety, or post traumatic symptoms, or prevalence of psychiatric disorder. IPC receiving patients with previous MDD had significantly higher depression rates at 6 months.
Badger et al. 2004, 2005a, 2005b	Women with breast cancer, depressive symptoms, and fatigue, and their partners.	N=48	Non-RCT; IPC or TAU; outcomes assessed at 6 and 10 weeks.	CES-D PANAS MFI ICS	IPC: reduced depression, fatigue, and stress over time and increase in positive affect. Women with long-term marriages and no past history of depression or cancer showed most benefit.
Badger et al. 2007	Women with stage I-III breast cancer, and their partners.	N=96	RCT; IPC & IPC for partners, 6-week self-managed exercise protocol & 3 telephone calls to partners, or HEAC group with 6 weekly telephone calls & 6 biweekly telephone calls for partners.	CES-D PANAS MFI ICS	All groups: decrease in depressive symptoms. Reduced anxiety symptoms among IPC and exercise groups, over HEAC. Partners displayed similar findings in depressive and anxiety outcome measures.
Badger et al. 2011, 2013	Men with prostate cancer and their supportive partners.	N=71	RCT; IPC & IPC for partner, or HEAC; outcomes assessed at 1, 8, and 16 weeks follow up by master's level nurses or social workers	CES-D PANAS PSS UCLA Prostate cancer index MFI PSS-FA QOL cancer	HEAC: superior QOL outcomes compared to IPC for patients and their partners. HEAC was associated with better outcomes in elderly men, active chemotherapy, lower prostate specific functioning, lower social support from friends and lower cancer knowledge. IPC improvement was associated with higher education, prostate specific functioning, social

Authors	Patient Population	Sample	Study Design	Outcome measure	Main findings
					support, and cancer knowledge.
Badger et al. 2013	Latina women with breast cancer and their supportive partners.	N=70	RCT; IPC or THE; both telephone delivered outcomes assessed at 8 and 16 weeks follow up by master's level social workers	CES-D PANAS PSS STAI MFI PSS-FA QOL breast cancer	Both interventions lead to significant improvements of QOL for both Latina women and their partners.
Oranta et al. 2010, 2011	Patients with recent myocardial infarctions and depressive symptoms	N=103	RCT; IPC or standard care, stratified by depressed (BDI >9) or not depressed (BDI<10); outcomes assessed at baseline and at 6 and 18 months after discharge.	BDI, Health-related QOL (EuroQol-5D)	Depressive symptoms decreased significantly in the IPC group compared to the control group. Health-related QOL was significantly better for IPC compared to controls <60 years of age.
Neugenbauer et al. 2007	Women with medically documented miscarriage within 18 weeks, presenting with depressive symptoms	N=17	Non RCT Single arm open trial; 9 weeks follow up.	CES-D	52% decrease of depressive symptom scores for treatment completers (n=9) 25% decrease among intention to treat sample (n=17)
Neugebauer et al. 2006	Women seeking medical care for a miscarriage, with HAM-D>7, but who did not meet full criteria for MDD	N=19	RCT; IPC or TAU; outcomes assessed 9 weeks after randomization.	HAM-D	Mean within-subjects HAM-D decline was significantly greater for IPC than TAU.
Sinai & Lipsitz, 2012	Frequent attenders of primary care at large healthcare provider, Israel	N=35	Pilot study; RCT; IPC for FAs*, supportive counseling, or no treatment; 12 weeks treatment duration; outcomes assessed at baseline and at 12 weeks.	Hebrew version PHQ QOLS	IPC showed superiority in reducing somatization (marginal significance), anxiety, and depression symptoms over supportive counseling and no treatment control. No significant differences in QOL across interventions. Medical costs and primary health care visits showed non-significant trends for IPC only in reducing cost and number of visits respectively.
Judd et al. 2001	Primary health care patients aged 18-65 presenting with MDD meeting DSM-IV criteria; IPC administered by PCP	N=31	IPC or standard care; all patients received an antidepressant, venlafaxine-XR; outcomes assessed at baseline and 6 and 12 weeks follow-up.	BDI	Both treatments produced a statistically significant reduction in BDI scores from baseline with greater improvement seen in IPC.
Menchetti et al. 2010, 2013	Adults meeting criteria for MDD based on the MINI, referred from primary care providers	N=300	RCT; IPC versus SSRIs; outcomes assessed at baseline, 2, 4, 6 months, and 1 year follow-up.	HAM-D	Preliminary findings show that the proportion of patients with mild depression who achieved remission at 2 months was significantly higher in IPC compared to SSRIs alone.

*

GHQ: General Health Questionnaire, RCT: Randomized Controlled Trial, DSM III: Diagnostic and Statistical Manual of Mental Disorders Third Edition, MDD: Major Depressive Disorder, GDS: Geriatric Depression Scale, TAU: Treatment as usual, CES-D: Center of Epidemiologic Studies Depression Scale, PANAS: Positive and Negative Affect Schedule, MFI: Multidimensional Fatigue Inventory, ICS: Integrated Cancer Systems, HEAC: Health Education Attention Control, QOL: Quality of Life, PSS: Perceived Stress Scale, PSS-FA: Perceived Social Support from Family, THE: Telephone health Education, STAI: State-Trait Anxiety Inventory, BDI: Beck Depression Inventory, HADS: Hospital Anxiety and depression Scale, PCL: Post-Traumatic Stress Disorder Checklist, AUDIT: Alcohol Use Disorders Identification Test, SF-36: Short Form-36 item quality of life questionnaire, HAM-D: Hamilton Rating Scale for Depression. FAs: Frequent attenders, PHQ: Patient Health Questionnaire, QOLS: Quality of Life Scale, MINI: Mini International Neuropsychiatric Interview, SSRIs: Selective Serotonin Reuptake Inhibitors.