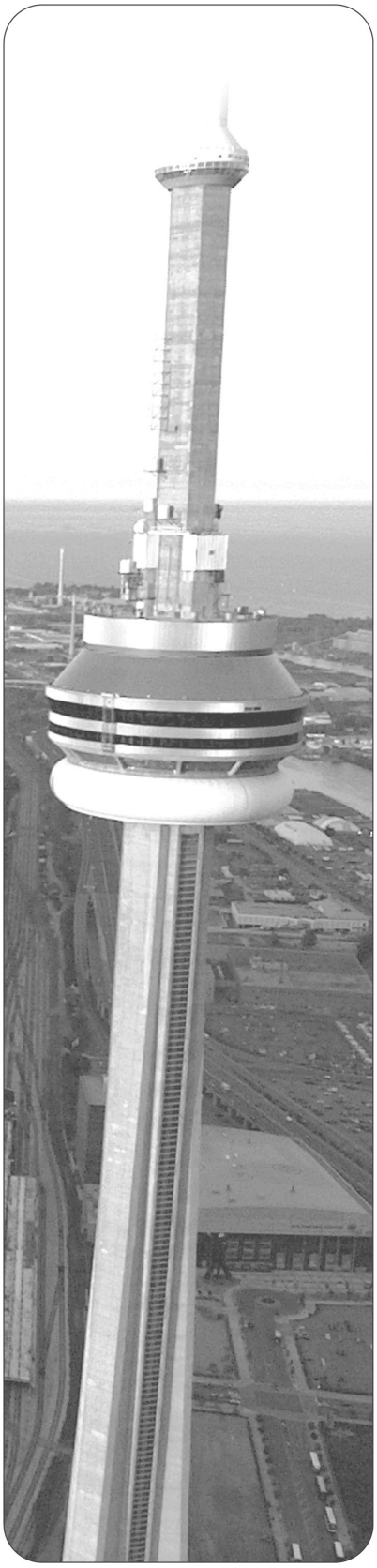
Second International Conference on

Interpersonal Psychotherapy:
Extending the Reach of IPT

Scientific Program

November 13-14, 2006

Essex Ballroom
Sheraton Centre Toronto Hotel
123 Queen Street West



Hosted by:

- The Centre for Addiction and Mental Health, Toronto
- The Department of Psychiatry, Faculty of Medicine, University of Toronto

Co-Sponsored by:

- The International Society of Interpersonal Psychotherapy
- Mount Sinai Hospital, Toronto, Canada

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Welcome and Overview

Dear Participant,

Welcome to the 2nd International Interpersonal Psychotherapy Conference. University of Toronto is pleased to welcome the International Society of Interpersonal Psychotherapy and host this gathering of international IPT clinicians, researchers and educators.

The theme of this year's conference, "Extending the Reach of IPT," is related to the innovations, development, and dissemination of IPT. The first day of the conference is devoted to two IPT workshops – a didactic and interactive introductory workshop that utilizes standardized patients for demonstration and practicing of therapeutic techniques and a concurrent advanced trainers' retreat that will focus on knowledge translation and the teaching of this evidence based therapy through application of best practices in education. The subsequent two day scientific meeting includes presentations by clinical research experts who have successfully overcome barriers to dissemination and adapted IPT for community-based settings and with populations with co-morbidity and more severe symptom profiles.

This year's keynote address is by Dr. Myrna Weissman, one of the founding clinical research pioneers of IPT, who along with the late Dr. Gerald Klerman authored the seminal IPT manual. She will highlight the gap between research and clinical practice and the need for more effective dissemination. Presentations of IPT innovations, adaptations and new research along with "ask the experts" mini-workshop sessions with clinical research experts in modifications of IPT for differing patient populations will be featured. Rapid communication and poster sessions of research, clinical and educational initiatives include presentations by young investigators and community clinicians. The symposium on neurobiological correlates of psychotherapy treatment outcome present differing approaches to understand associated biological and psychological mechanisms. As well, there will be presentations on clinical approaches to optimize outcome through sequencing or combining of psychotherapy and pharmacotherapy.

40 presenters, 10 countries, 200 participants – a shared interest, IPT. We hope the conference will spark interest, encourage dialogue, provide opportunities to network, inspire learning and catalyze new initiatives.

Paula Ravitz MD FRCPC
Conference Chair, 2nd International IPT Conference

Conference Objectives

By attending this conference, participants will have the opportunity through interactive workshops, symposia and poster sessions to:

1. Describe the clinical conditions to which IPT is applicable
2. Discuss efficacy and effectiveness data supporting IPT for various patient populations
3. Recognize issues relevant to dissemination and knowledge translation of evidence-based psychotherapy
4. Understand neurobiological correlates of treatment outcome
5. Understand principles of combining and sequencing pharmacotherapy and psychotherapy to optimize response

PROGRAM: Monday, November 13th

Each presentation will be followed by a five-minute question period.

7:45 Registration and Continental Breakfast ..... Essex Foyer

8:30 Overview of the Day
& Introductions: Paula Ravitz ..... Essex Ballroom
Ivan Silver, MD, Associate Dean, Continuing Education, University of Toronto
Don Wasylenki, MD, Chair, Department of Psychiatry, University of Toronto
David Kupfer, MD, Chair, Department of Psychiatry, University of Pittsburgh

8:45 **Symposium I** ..... Essex Ballroom

Extending the Reach of IPT

Chair: Holly Swartz (USA)
Discussant: John Markowitz (USA)

A Role for IPT in the Treatment of Bipolar Disorders
Ellen Frank (USA)
The challenges of effectiveness studies and therapist training in the community
Laura Mufson (USA)

Question and Answer Period

10:30 Refreshment Break and Exhibits ..... Essex Foyer

10:45 **Keynote Address** ..... Essex Ballroom

Bridging the Gap between Research and the Clinical Practice of Interpersonal Psychotherapy

Myrna Weissman (USA)

11:45 Lunch ..... on your own

12:00 **Ask the Experts Mini-Workshop** ..... Windsor West
(Enrollment for this workshop is limited. Please sign-up at the registration desk prior to the start of the session.)

Using IPT in Elders: Pragmatic Advice and Shared Experiences
Mark Miller and Gregory Hinrichsen (USA)

1:00 **Symposium II** ..... Essex Ballroom

Translating Knowledge into Practice

Chair: Laura Mufson (USA)
Discussant: Chris Freeman (UK)

Taking It To The Streets: Bringing IPT-A to the Real World
Elizabeth Hall (Canada)
Lorraine Hathaway (Canada)
An Italian Experience with IPT
Mario Miniati (Italy)
Group IPT with Depressed Adolescents in Northern Uganda
Helena Verdeli (USA)
IPT Training Across Scotland: The Doing Well by People with Depression Project
Roslyn Law (Scotland)

Question and Answer Period

2:30 Refreshment Break and Exhibits ..... Essex Foyer

2:45 **Rapid Communications Sessions**

(two concurrently) ..... Windsor West

A1. Issues And Challenges In Integrating Interpersonal Psychotherapy Into Psychiatry Departments
Heather A. Flynn, Jonathan Lichtmacher, and Scott Stuart (U.S.)

A2. Ipt-TAAPP (Toronto Addis Ababa Psychiatry Project): Teaching Ipt In Ethiopia
Dawit Wondimagegn, Menelik Desta, Atelay Alem, and Paula Ravitz (Ethiopia, Canada)

A3. IPTt Training In An Outpatient Child And Adolescent Mental Health Treatment Setting
Cindy Goodman Stulberg and Dr. Jennifer Steadman (Canada)

A4. Video Vignettes Illustrate Incorporating Caregivers Into the IPT Process In Late Life Depression with Cognitive Impairment
Mark D. Miller (U.S.)

B1. Group IPT For Women Prisoners With Comorbid Depression And Substance Use
Jennifer Johnson and Caron Zlotnick (U.S.)

B2. IPT-G Treatment For Severe And Chronic Social Phobia In An Inpatient Setting
Gun Elinor Abrahamsen and Randi Ramstad (Norway)

B3. An Adaptation Of Interpersonal Psychotherapy For Depression Within Primary Care (Ipt-B)
Patricia Graham (U.K.)

B4. Culturally Relevant Brief Interpersonal Psychotherapy For Perinatal Depression
Nancy Grote, Holly Swartz, Sharon Geibel, and Ellen Frank (U.S.)

4:30 **Poster Session &**
Wine & Cheese Reception ..... Long Bar/Churchill Room
(until 6:00 pm)

Join your colleagues for a relaxed and interactive review and discussion of each other's work

7:30 **CN Tower Dinner Reception – Horizon's Café** (until 10:30 pm)

Enjoy the view of cosmopolitan Toronto from atop the world's tallest freestanding structure and share a wonderful meal with friends and colleagues.
Shuttle bus will be provided - details at registration desk

PROGRAM: Tuesday, November 14

Each presentation will be followed by a five-minute question period.

7:45 Registration, Continental Breakfast and Exhibits ..... Essex Foyer

8:30 Overview of the Day: Holly Swartz ..... Essex Ballroom
Introductions:
Molyn Leszcz MD, Psychiatrist-in-Chief, Mount Sinai Hospital
Zindel Segal MD, Morgan Firestone Chair of Psychotherapy, University of Toronto

8:45 **Symposium III** ..... Essex Ballroom

Neurobiological Correlates of Treatment Outcome

Chair: David Kupfer (USA)
Stress, Depression, and Interpersonal Psychotherapy:
Extending the Reach of Research on IPT Process and Outcome
Jill Cyranowski (USA) -
Brain Blood Flow and Dopamine D2/D3 Receptor Imaging of IPT
Elizabeth Martin and Stephen Martin (UK)
Paths To Recovery: Differential Brain Effects of Medication and Psychotherapy
Helen Mayberg (USA)

Question and Answer Period

10:30 Refreshment Break and Exhibits ..... Essex Foyer

10:45 **Parallel Interactive "Ask the Experts" Workshops**
Session I (by pre-enrollment)

Workshops are repeated in Session II at 4:40 pm

1. **Group IPT for Eating Disorders** ..... Conference Room F
   Marian Tanofsky-Kraff (USA), Rob Welch (USA),
2. **IPT for Bipolar Disorder: Interpersonal Social Rhythms Therapy** ..... Conference Room G
   Ellen Frank (USA), Sue Luty (New Zealand)
3. **IPT for Adolescent Depression** ..... Conference Room H
   Kathy Clougherty (USA), Laura Mufson (USA)
4. **IPT for Patients with Trauma** ..... Essex Ballroom
   Janice Krupnick (USA), John Markowitz (USA),
   Roslyn Law (Scotland)
5. **IPT for Postpartum Depression** ..... Windsor West
   Rebecca Reay (Australia), Scott Stuart (USA)

12:15 Lunch ..... on your own

1:15 **Symposium IV** ..... Essex Ballroom

Treatment Considerations: Selecting, Sequencing or Combining Psychotherapy and Psychopharmacology

Chair: Sagar Parikh (Canada)

Treatment of Chronic Depression: Combining IPT and Cognitive Behavioural Therapy in a Group Format
Marc Blom (The Netherlands)
Concurrent and Sequential Combinations of Psychotherapy and Medication for Mood Disorders: State of the literature circa 2006
Michael Thase (USA)

Trevor Young (Canada) -

Question and Answer Period

2:45 Refreshment Break and Exhibits

3:00 **Symposium V** ..... Essex Ballroom

Innovations & Adaptations of IPT

Chair and Discussant: Sue Luty (New Zealand)

Preliminary Findings from a Randomized, Controlled Trial of Enhanced Brief Interpersonal Psychotherapy for Depressed Mothers Whose Children Are Receiving Psychiatric Treatment
Holly Swartz (USA) -
The CREATE Trial
Francois L'Esperance (Canada)
Personality and the Prediction of Response in Major Depressive Disorder: A Randomized Control Trial Comparing Interpersonal Therapy and Pharmacotherapy
R. Michael Bagby (Canada) -
Defining the Psychotherapies: The Case of IPT
Scott Stuart (USA) -

Question and Answer Period

4:40 **Parallel Interactive "Ask the Experts" Workshop Session II** .....

Workshop Session I topics repeated (please pre-enroll as seating is limited for each session)

1. **Group IPT Eating Disorders** ..... Conference Room F
   Marian Tanofsky-Kraff (USA), Rob Welch (USA)
2. **IPT for Bipolar Disorder: Interpersonal Social Rhythms Therapy** ..... Conference Room G
   Ellen Frank (USA), Sue Luty (New Zealand)
3. **IPT for Adolescent Depression** ..... Conference Room H
   Kathy Clougherty (USA)
4. **IPT for Patients with Trauma** ..... Essex Ballroom
   Janice Krupnick (USA), John Markowitz (USA),
   Roslyn Law (Scotland)
5. **IPT for Postpartum Depression** ..... Windsor West
   Rebecca Reay (Australia), Scott Stuart (USA)

6:00 Evaluation & Adjournment ..... Essex Ballroom

Accreditation

This program meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for Mainpro-M1 credits (see daily credit count below).

This educational event is approved as an Accredited Group Learning Activity under Section 1 of the Framework of CPD options for the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada (see daily count below).

The Continuing Education Office, Faculty of Medicine, University of Toronto designates this educational activity for category 1 credits toward the AMA Physician's Recognition Award (see daily count below). Each physician should claim only those credits that he/she actually spent in the activity.

Members of the American Academy of Family Physicians are eligible to receive Prescribed hours for attendance at this meeting due to reciprocal agreement with the College of Family Physicians of Canada (see daily count below).

European Accreditation Council for Continuing Medical Education (EACCME). As a result of a reciprocal agreement between the EACCME and the AMA, European registrants may claim AMA Category 1 credits as equivalent.

Canadian Psychological Association Continuing Education Sponsor Review Committee has approved this educational activity for 20 continuing education credits. Please note that participants must attend all 20 hours in order to obtain full credit.

Credit count by event/day:

Day 1	ISIPT Introductory Workshop, Sunday, November 12th	6.5 credits
Day 1	Trainers' and Advanced Practitioners' Retreat, Sunday, November 12th	3.5 credits
Day 2	Monday, November 13th	6 credits
Day 3	Tuesday, November 14th	7.5 credits

Letters of Accreditation or Attendance

Letters of attendance/accreditation are distributed at the end of the program. If you are leaving earlier, you may request your letter from us at that time. We do not routinely mail out accreditation letters. Should you forget to pick up your letter at the conference, please contact the CE office.

Disclosure

Speakers have been requested to disclose to the audience any real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of this program.

Kathy Clougherty – Consultant: RFMH, New York State Psychiatric Institute
Mark Miller – Grant/Research Support: Various, NIMH Grants; Consultant: GSK; Speakers' Bureau: GSK, Forest Labs, Wyeth
Laura Mufson – Financial/Material Support: Guilford Publications (book on IPT-A; royalties)
Holly Swartz – Grant/Research Support: NIMH, NARSAD; Consultant: Novartis; Speakers' Bureau: BMS, Pfizer; Financial/Material Support: AstraZeneca
Myrna Weissman – Grant/Research Support: NIMH, Macy, GlaxoSmithKline, Lilly, NARSAD, NIDA; Financial/Material Support: book royalties
Trevor Young – Speakers' Bureau: Eli Lilly

At time of print, no other speakers or faculty have indicated any conflicts of interest.

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Mount Sinai Hospital, Toronto, Ontario

Mark Your Calendar

For future IPT workshops, see the International Society of IPT web-site: www.interpersonalpsychotherapy.org

"Achieving and Sustaining Psychotherapy Effectiveness" Mount Sinai Psychotherapy Institute (MSPI) Workshop and University of Toronto CE Psychotherapy Certficate Program with individualized psychotherapy supervision in modality specific approaches, including IPT. Next workshop begins March 2007. For further information, contact: Jwan@mtsinai.on.ca

Centre for Addiction & Mental Health (CAMH) and University of Toronto CE ***IPT Summer Institute***, August 2007. For further information contact: Genevieve_Poulin@camh.net

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University of Pittsburgh School of Medicine

Extending the Reach of IPT: A Role for IPT in the Treatment of Bipolar Disorders?

Interpersonal and social rhythm therapy was conceived in a single day, actually in a single flash of recognition on July 14, 1990. For several years prior, colleagues at Western Psychiatric Institute and Clinic and in the MacArthur Foundation research network on the psychobiology depression had been theorizing about the relationship between *social zeitgebers* and unipolar disorder; however, by 1990 it had become apparent that this theory might be even more applicable to bipolar disorder. The treatment we then developed, interpersonal and social rhythm therapy, built on the essential components of interpersonal psychotherapy: but added a large behavior modification component focused on the social rhythms or routines of the patient's life.

We had argued in papers published in the late 1980's (Ehlers, Frank, & Kupfer, 1988; Ehlers, Kupfer, Frank, & Monk, 1993) that the major mood disorders reflected, among other things, a disturbance in the circadian system. Further, we said that external social factors like the time we need to be at work or the time the family normally has dinner help to set the body's clock. We had also argued that changes or interferences in these social routines, which we termed *zeitstörers* (or time disturbers), could disrupt the body's clock and destroy the body's naturally synchronized rhythms. We concluded that, in those individuals who were vulnerable to mood disorders, the loss of social *zeitgebers* (timekeepers) or the appearance of *zeitstörers* (disrupters) could lead to the onset of illness episodes (depression or mania). And, conversely, preventing disruption of circadian rhythms could prevent new episodes of illness.

To create IPSRT, we adapted some of the scheduling and monitoring techniques of cognitive therapy, refashioning them for the purpose of helping patients to establish and maintain regular social rhythms. Such efforts fit very naturally with three of the four traditional IPT problem areas: resolving an unresolved grief experience, negotiating a transition in a major life role, and resolving a role dispute with a significant other. The addition of a new problem area, that we termed 'grief for the lost healthy self,' was aimed at increasing acceptance of the illness and improving treatment adherence in a patient population for whom these are difficult issues.

Thus, IPSRT became a treatment that sought to improve on the outcomes usually obtained with pharmacotherapy alone for bipolar disorder by integrating efforts to regularize social rhythms (in the hope of protecting the patient's circadian system from disruption) with efforts to improve the quality of patients' interpersonal relationships and social role functioning. Data from two clinical trials demonstrating the capacity of IPSRT to do this will be presented. Finally, future directions describing how we are now extending the reach of IPSRT itself will be discussed.

Laura Mufson, Ph.D.
Columbia University College of Physicians and Surgeons

New York State Psychiatric Institute
New York, New York

IPT-A: The challenges of effectiveness studies and therapist training in the community

Abstract

IPT-A is a brief psychotherapy for depressed adolescents (Mufson, Dorta, Moreau, & Weissman, 2004) that was originally developed to treat adults suffering from depression (Weissman, Markowitz & Klerman, 2000). Over the years, the study of IPT-A has moved from University-based hospital clinics to various community settings including schools, school-based health clinics and community mental health centers. Extending the reach of IPT-A includes extending the application of IPT-A to new settings, different types of clinicians, and to new treatment formats. IPT-A also is being extended to new disorders and populations, but those are not the focus of this presentation. IPT- A, in its efficacy studies, was typically delivered by expert clinicians who trained for significant periods of time before participating in the clinical trials. In the newer effectiveness settings, IPT-A is now being delivered by community clinicians with varying backgrounds who were already employees of the selected setting rather than hired as an expert for the study. Clinicians receive brief didactics in IPT-A then immediately begin treatment with supervision, a less costly and time-consuming model necessary in many community settings. There are many influences of delivery of treatment in clinical practice such as patient volume, clinical characteristics, and financial arrangements that affect the transportability of treatments from the lab to the community. To meet the needs of a more heterogeneous population, IPT-A has been adapted to other formats including a group intervention model (IPT-AG) and a preventive group intervention model (IPT-AST). Preliminary results are promising for both of these new formats, but more studies are needed and are currently underway.

Moving treatments into the community creates challenges to the traditional models for training clinicians used in efficacy trials. The labor intensive models no longer work and less time-consuming models are being implemented, but there is a gap in our knowledge of the effectiveness of these training models for achieving IPT-A adherence and competence in the most cost-effective manner. The field is making great strides to increase the effectiveness of IPT-A to heterogeneous populations, real world clinicians, and to settings in which the consumer is likely to experience fewer barriers to receiving care. However, the next step is to identify the most effective training models for achieving adherence and competence as we continue to extend our reach into more diverse communities.

Myrna Weissman, PhD
Columbia University College of Physicians and Surgeons
Chief, Division of Clinical and Genetic Epidemiology

Bridging the Gap Between Research and Clinical Practice of Psychotherapy

Approximately 3% of the US population receives psychotherapy each year from psychiatrists, psychologists, or social workers. A modest number of psychotherapies are evidence-based therapy (EBT) in that they have been defined in manuals and found efficacious in at least 2 controlled clinical trials with random assignment, that include a control condition of psychotherapy, placebo, pill, or other treatment and samples of sufficient power with well-characterized patients. Few practitioners use any EBT, including IPT.

I will present results from a national survey of a probability sample of all accredited psychiatric resident, psychology and social work training programs in the US, to determine the state of training in evidence and non-evidence based psychotherapy. The results show a considerable gap between research evidence for psychotherapy and clinical training. Steps to rectify this gap and the role the International Society can play in IPT will be discussed.

Mark D. Miller M.D. and Greg Hinrichsen Ph.D.

Ask The Experts Mini-Workshop
Using IPT in Elders: Pragmatic Advice and Shared Experiences

This session is intended for anyone currently using or contemplating the use of IPT with elderly patients. The discussants will begin by describing the way in which IPT is utilized in their respective institutions and also put forth their opinions about ways in which IPT might be utilized more fully in geriatric settings. Case vignettes from participants , special problems and institutional support issues for training are all possible directions for digression. It is hoped that this meeting will serve as the nidus for a work group of clinicians and researchers internationally who are specifically interested in geriatric issues.

Elizabeth Baerg Hall, M.D., FRCPC
Gayle Read, MSW

Taking it to the Streets: Bringing IPT-A to the Real World

This presentation will outline a knowledge translation project to train community mental health clinicians in British Columbia in IPT-A. Through a collaborative project undertaken by the Ministry of Child and Family Development (MCFD) and BC Children's Hospital Mood and Anxiety Disorders Clinic, community mental health therapists were randomly assigned to traditional IPT-A training (audiotaped sessions reviewed weekly by an IPT-A expert) or a more cost efficient group supervision model (no audiotape review). Treatment audiotapes of both groups were reviewed for adherence to the model by external raters. Slated for completion in 2007, the project contains a self-sustaining model where some community practitioners will be trained as supervisors able to provide IPT-A consultation to a number of their colleagues.

In addition to the challenges inherent in disseminating IPT-A in community mental health clinics, this project also has the added features of having the expert consultants situated across the continent (Columbia University) from the training clinicians. As well, although funding for the project comes entirely from the government via the MCFD, the project is administered and coordinated by the University of British Columbia through the BC Children's Hospital. Working across complex bureaucracies requires continued awareness of and respect for knowledge translation caveats. Using Schoenwald and Hoagwood's (2001) framework for comparing conditions in research and real world settings, the challenges and successes of the project will be reviewed.

Mario Miniati, M.D.
Department of Psychiatry, Neurobiology, Pharmacology and Biotechnology
University of Pisa, Italy

Translating Knowledge into Practice: An Italian Experience with IPT

A number of studies have demonstrated the efficacy of Interpersonal Psychotherapy either alone or in combination with pharmacological treatment, in major depression, bipolar disorder and several other psychiatric disorders. Nonetheless, when knowledge derived from controlled studies on IPT is applied to clinical practice, some problems may occur, especially in non-English-speaking countries. For example, in Italy, the translation of the IPT manual has been available since 1989. However, no specific training procedures for Italian community practitioners have been established, and few clinicians in Italy have even attended a formal training course in IPT, usually conducted by U.S.therapists, with several difficulties due to different languages and backgrounds. According to our knowledge, a standardized experience in IPT training for Italian psychiatrists was applied for the first time in 2001. The Psychiatric Clinic of Pisa was the Italian center participating in a two-step research study involving IPT. Four candidates for IPT training were selected at Pisa. Candidates were M.D. psychiatrists, with excellent clinical experience in pharmacological treatment of mood disorders, and a strong motivation to learn an approach to patient's problem different from those they were used to. Selected clinicians were not psychotherapists. Two of them were completing a course in Cognitive Behavioral Therapy (CBT); the remaining two did not have any experience with psychotherapy at all.

Their one year of training in IPT encompassed 4 different steps: 1) familiarization with the basic techniques, strategies and goals of IPT, using the manual as a guide. During this phase, clinicians were asked to learn the basic theory of IPT, and to make an effort to integrate their *'previous'* experience in managing patient's symptoms with the *'new'* interpersonal approach to problematic areas related to depression; 2) participation in a series of intensive didactic seminars, with an Italian clinician expert in IPT (Paolo Scocco, Department of Mental Health, Padua, Italy), already trained by Ellen Frank (from Western Psychiatric Institute and Clinic of the University of Pittsburgh). Objectives of the seminars were: to discuss clinical cases, to learn how to recognize the main focus of IPT treatment, and to decide how to manage current depressive symptoms with IPT; 3) treatment, under supervision, of at least 2 patients with a current major depressive episode. The supervision was structured via e-mail, and telephone: sessions were audio-taped, sent to the Italian supervisor (Paolo Scocco), and discussed every week, in order to provide immediate feedback to the trainee. If necessary, Ellen Frank was also available by e-mail and telephone for comments on specific problems; 4) finally, group sessions headed by a senior clinician of the Psychiatric Clinic of Pisa, with a solid background in IPT and other psychotherapies (Isa Corradi) were weekly scheduled with the aim to compare the different individual experiences. Our first contact with IPT was enthusiastic, and after 4 years, our impression of this *'Italian Translation into Practice'* of IPT is still largely positive. According to our experience, IPT is a powerful tool even when the therapist has a neuro-biological or a pharmacological background. The *'imprinting'* from the supervisor is critical, and to have an Italian-speaking supervisor (Paolo Scocco), assisted side-by-side by an English-speaking supervisor who is fluent in the second language (Ellen Frank) was probably the key point of our training. Learning interpersonal psychotherapy long-distance, with audio-taped or video-taped session is possible and fruitful. As a matter of fact, the 4 selected psychiatrists completed the training, and they are currently performing as psychotherapists in their usual clinical practice, as well as in the multi-site research project, involving the University of Pittsburgh, and the University of Pisa. Moreover, given that IPT has not yet been integrated into most psychiatric residency or clinical psychology training programs, this group has promoted courses dedicated to residents in Psychiatry of the University of Pisa, and individual face-to-face supervision.

Lena Verdeli, Ph.D
Kathleen Clougherty, M.S.W

Presentation: Group IPT with Depressed Adolescents in Northern Uganda"

Ethnographic research in adolescents in internally displaced persons' (IDP) camps in Northern Uganda, an area ravaged by civil war, showed significant depression expressed in local syndromes. Group IPT, which has shown efficacy for depressed adults in South Uganda, was adapted for this population and tested in a randomized clinical trial. Three hundred and four adolescents aged 14-17 years and living in two IDP camps met study criteria and were randomized to either group IPT, a Creative Play (CP) intervention (to control for non-specific group effects), or a wait list control group. Both active interventions were manualized and lasted for 16 weeks. Adolescents in the group IPT condition showed significant improvement in their depression compared with controls. No effect was observed in the CP group. No intervention had an impact on functioning. The results of the trial and the adaptations to IPT will be discussed.

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Rapid Communications Sessions – Oral Abstracts

A1

ISSUES AND CHALLENGES IN INTEGRATING INTERPERSONAL PSYCHOTHERAPY INTO PSYCHIATRY DEPARTMENTS Heather A. Flynn, Jonathan Lichtmacher, Scott Stuart (University of Michigan, University of California San Francisco, University of Iowa)

Objectives
Psychiatry departments vary widely in their integration of Interpersonal Psychotherapy (IPT) into training and clinical programs. This presentation will highlight key issues and challenges faced by faculty developing IPT programs at three psychiatry departments in the US: The University of Iowa, the University of Michigan, and University of California San Francisco.

Methods
The discussion will emphasize educational and organizational issues faced including the importance of department and faculty leadership, philosophical / cultural obstacles, and logistical issues. A brief overview of the three IPT program models will be presented, followed by a summary of the unique and shared issues and challenges that have been confronted. The role of resident training in light of the National Psychiatry Training Council Task Force will be discussed. The second half of the presentation will be devoted to audience discussion of relevant experiences in learning, teaching or otherwise incorporating IPT into academic psychiatry departments.

Results
It is hoped that residents, faculty, and clinicians from a variety of disciplines and at all levels of IPT experience will participate.

Conclusions
Based on the discussion, a set of recommendations on how to meet challenges will be outlined.

A2

IPT-TAAPP (TORONTO ADDIS ABABA PSYCHIATRY PROJECT): TEACHING IPT IN ETHIOPIA Dawit Wondimagegn, Menelik Desta, Atelay Alem, Paula Ravitz (Addis Ababa University, University of Toronto)

Objectives
The Toronto Addis Ababa Psychiatric Project (TAAPP) was established by Addis Ababa University and the University of Toronto to develop psychiatric residency training in Ethiopia. IPT-TAAPP was a month long intensive course for psychiatry residents in Interpersonal Psychotherapy (IPT) conducted at Addis Ababa University. The goals of this educational project were to transfer knowledge, and establish the clinical relevance and feasibility of IPT in Ethiopia.

Methods
IPT-TAAPP focused on skills acquisition and principles of IPT derived from the seminal IPT manual (Weissman, Markowitz, Klerman 2000), along with the IPT adaptations created for adolescent depressed patients (Mufson 2004) and rural Uganda (Bolton et al; Verdeli, Clougherty et al.). The curriculum was delivered through readings, workshops, didactic, and bedside teaching with the residents in their clinical settings. A key task was to culturally and structurally adapt IPT to the Ethiopian context. To facilitate the transfer of knowledge to practice, we also created laminated pocket cards summarizing IPT practice principles that could be used as quick reminders to trainees in order to further reinforce learning.

Results
IPT-TAAPP established the clinical relevance and feasibility of IPT in Ethiopia as an effective therapeutic adjunct with a diverse group of psychiatric patients.

Conclusions
Further research is needed in knowledge translation/dissemination efforts such as this project, to determine whether they lead to sustained changes in practice and improved patient outcomes. As well, outcome research is needed to examine IPT adaptations for settings in which there are high service demands and cultural diversity.

A3

IPT TRAINING IN AN OUTPATIENT CHILD AND ADOLESCENT MENTAL HEALTH TREATMENT SETTING Cindy Goodman Stulberg, Dr. Jennifer Steadman (Institute for Interpersonal Psychotherapy, Private Practice, Toronto, Ontario, former clinical director, Child Psychiatrist, Child and Adolescent Crisis Program, Southlake Regional Health Centre, Newmarket, Ontario)

Objectives
1. Participants will be able to identify the structure required and the steps to provide training and supervision

to clinicians learning IPT in an outpatient counseling program.

2. Participants will be able to identify the pros and cons of providing group supervision in learning IPT

Methods
Presentation will consist of a brief overview of the didactic training provided and then an indepth description of the group supervision process provided to a multidisciplinary group of clinicians working with depressed adolescents and their families. An experienced psychiatrist who was clinical director of an outpatient child and adolescent program will present her training experience of learning and implementing IPT. A specific case, representative of the complex client population treated, will be provided.

Results
The psychiatrist, experienced by anyone's standards but a rank newcomer to IPT will hightlight efforts to stay on model, describe gathering the interpersonal inventory and describe the structured, non-judgemental aspects of IPT. Clinicians had positive experiences learning and delivering the model, receiving group supervision and saw significant improvement in client and client's family's interpersonal functioning and decrease in depressive symptoms.

Conclusions
IPT training and supervision is a practical viable model to be taught to clinicians in an outpatient mental health treatment setting. In underfunded child and adolescent mental health settings, with lengthy waiting lists,it is imperative that effective evidence based,time limited treatments be available to our clients and clincians.

A4

VIDEO VIGNETTES ILLUSTRATE INCORPORATING CAREGIVERS INTO THE IPT PROCESS IN LATE LIFE DEPRESSION WITH COGNITIVE IMPAIRMENT MARK D. MILLER M.D. (Westtern Psychiatric institute and Clinic, Univeristy of Pittsburgh)

Objectives
Although IPT has shown utility in treating late life depression , working with depressed elders who also have cognitive impairment presents the additional challenges of impaired recall, impaired insight, and executive dysfunction.

Methods
In our group's experience in the MTLLD-II study, we frequently found role conflicts between the afflicted patient and caregivng family members who did not realize how much the reduction in cognitive capacity, exacerbated by depression, was impairing the patient's overall functioning. Some caregiver's responses bordered on being abusive. IPT intervention for the patient, by necessity, required us to engage, educate, confront and sometimes model more appropriate reponses for caregivers who were not "getting the big picture".

Results
This unique interface raised such issues as whether one or two patients were being engaged; and how to explore ways in which caregivers coud learn to help the IPT therapist between sessions by being advocates, reinforcers or coaches to help the patient to compensate for lost abilities due to cognitive decline in addition to depression.
Video vignettes will be used to illustrate clinical examples and attendee discussion is encouraged.

Conclusions
IPT remains a user friendly treatment for depressed elders, however, with the prevalent co-morbidity of cognitive impairment, modifications of IPT are needed that include techniques for incorporating caregiving family members to increase the utility of IPT for this special population as illustrated in the clinical video vignettes.

B1

GROUP IPT FOR WOMEN PRISONERS WITH COMORBID DEPRESSION AND SUBSTANCE USE
Jennifer Johnson, Caron Zlotnick (Brown University, Providence, RI)

Objectives
Research on treatments for incarcerated women with co-occurring depressive disorder (DD) and substance use disorder (SUD) is needed. Female offenders have high incidences of both DD and SUD, and DDs increase the risk of suicide and decrease the likelihood of recovery from SUDs in an already vulnerable

population. IPT addresses the interpersonal difficulties and inadequate social supports that underlie many DDs and SUDs in women prisoners. This study provides a preliminary test of the efficacy of group IPT for DD, depressive symptoms, and social support among female offenders with SUDs.

Methods
Participants (N = 25) in this open trial met the following inclusion criteria: (1) current enrollment in prison SUD treatment, (2) current major depressive or dysthymic disorder, and (3) SUD one month prior to incarceration. Women with bipolar or psychotic disorders were excluded. Women attended 24 group sessions over 8 weeks.

Results
Intent-to-treat analyses showed that 72% of the women no longer met SCID criteria for any depressive disorder post-treatment. Two-tailed paired t-tests showed significant improvement on the following measures from pre-treatment to post-treatment: Hamilton Rating Scale for Depression ($p < .001$), Beck Depression Inventory ($p < .001$), and the Multidimensional Scale of Perceived Social Support ($p < .01$).

Conclusions
Results of this open trial of IPT for women prisoners with DD and SUD are very encouraging, especially given the high prevalence of antisocial and borderline personality disorders in our sample. A randomized clinical trial with post-release SUD assessment and 3-month follow-up is currently underway

B2

IPT-G TREATMENT FOR SEVERE AND CHRONIC SOCIAL PHOBIA IN AN INPATIENT SETTING
Gun Elinor Abrahamsen, Randi Ramstad (Modum Bad, Vikersund, Modum Bad,Vikersund)

Objectives
Modum Bad is a Norwegian psychiatric hospital that gives a variation of treatments for different psychiatric illnesses.

We would like to give a short presentation of how we have adapted the IPT-G model for patients with severe and chronic social phobia. Additionally, we want to give some information about research that have been done at Modum Bad comparing IPT treatment with CBT treatment for patients diagnosed with social phobia.

Methods
We have practiced the IPT-G model on patients with social phobia for over five years, and our clinical experiences are quite good. APD is seen as a common personality disorder among our patients and the drop out risk is often a problem in treating these patients.

Results
We have found that using the IPT-G format, and focusing on attachment issues, in the initial phase lower the drop out rate. In the last seven social phobic groups all patients have completed the ten weeks treatment.

Conclusions
The comparative study between CBT and IPT-G treatment for social phobia is soon to be completed. However, results are so far good for both treatment conditions. Further results have shown that the effect of both the IPT-G and the CBT treatment is significant at a one-year follow up.

B3

AN ADAPTATION OF INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSION WITHIN PRIMARY CARE (IPT-B) Patricia Graham (University of Edinburgh and Fife Primary Care)

Objectives
This study was an attempt to extend previous findings that mildly and moderately depressed patients show equivalent, strongly positive outcome, regardless of whether they received 8 or 16 sessions of either cognitive-behavioural or psychodynamic-interpersonal psychotherapy (Shapiro et al. 1994) through

the employment of an adapted version of Interpersonal Psychotherapy for Depression (IPT: Klerman, Weissman, Rounsaville and Chevron, 1984).

Methods
IPT was firstly adapted to IPT-Brief, applied to a single N pilot case-study and then applied as the intervention arm in a randomised 2-group experimental versus control pretest-posttest design: IPT-B versus waiting list control group.

Results
1. IPT-B leads to a reduction of symptoms of depression at a rate higher than that occurring with the passage of time.
2. Initial severity of depression predicts reliable change and severity of outcome.
3. IPT-B does not lead to an improvement in the quality of interpersonal relationships over the short duration of treatment or two-month follow-up.
4. Severely depressed patients exhibit greater improvement.

5. Greatest change demonstrated through self-report, whereby 73% of IPT-B patients made clinically significant change by 2 month follow up.
6. The economic evaluation demonstrated the relative cost effectiveness of IPT-B compared to estimated standard clinical practice of CBT.

Conclusions
1. IPT can be adapted to be a briefer model of IPT-B.
2. IPT-B can be employed with patients who present to their GP (in Primary Care in the UK) with a primary diagnosis of major depressive disorder.

B4

CULTURALLY RELEVANT BRIEF INTERPERSONAL PSYCHOTHERAPY FOR PERINATAL DEPRESSION Nancy Grote, Holly Swartz, Sharon Geibel, Ellen Frank (School of Social Work, University of Pittsburgh, Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center)

Objectives
Maternal depression during infancy has deleterious effects on infant and child well-being and on the mother's and father's mental health. Depression during pregnancy has been repeatedly demonstrated to be one of the strongest predictors of postpartum depression. The overall aim of this randomized pilot study was to investigate the effects of using Brief Interpersonal Psychotherapy (IPT-B)to treat antenatal depression in pregnant, low-income women who attended an Ob/Gyn outpatient clinic in a large hospital. In addition, IPT-B was enhanced to make it culturally relevant to women disadvantaged by race and/or poverty.

Methods
53 African American and White women on low-incomes, who met criteria for depression, were randomly assigned to 8 sessions of IPT-B (n=25) or to a referral to treatment-as-usual at a mental health clinic near the Ob/Gyn clinic (n=28). Participants were assessed before and after treatment on depressive symptoms, anxiety symptoms, and social functioning.

Results
Of the 25 women in the IPT-B condition, 21 out of 25 (84%), compared to none of the women in TAU condition, attended at least 4 IPT-B treatment sessions. After acute treatment,women in the IPT-B group displayed a significant reduction in depressive and anxiety symptoms and an improvement in social functioning, compared to those in the TAU group.
Conclusions
Findings suggest that IPT-B may not only ameliorate antenatal depression in women disadvantaged by race and/or poverty, but also improve their social functioning.
Jill Cyranowski, Ph.D.

Stress, Depression, and Interpersonal Psychotherapy:
Extending the Reach of Research on IPT Process and Outcome

Depression and the stress response share common physiologic processes, including perturbations in peripheral markers of both hypothalamic-pituitary-adrenal (HPA) and sympathetic-adrenal-medullary (SAM) axis activity. It has been argued that close, supportive relationships buffer the effects of life stress on physiologic stress responses and ultimate health outcomes. Yet, among depressed individuals close relationships may become strained and may amplify, rather than buffer, both subjective and physiologic responses to life stress.

IPT provides an ideal platform from which to study relationships among stress, depression, and interpersonal function over time. To date, little IPT-based process research has examined potential links among interpersonal function, subjective assessments of perceived stress, and peripheral markers of HPA and SAM activity over time or with IPT treatment. The current talk will present a series of pilot studies developed to integrate methods drawn from the field of mind-body medicine to evaluate subjective stress perception and peripheral markers of stress physiology among samples of depressed and never-depressed women.

In the first study, we examined stress-related cardiovascular responses among depressed and never-depressed women as part of two laboratory-based tasks: a speech stress and relationship-focused guided imagery task. As would be expected via the "stress-buffering" theory of close relationships, never-depressed women who first completed a relationship-focused imagery task displayed consistent reductions in diastolic and systolic blood pressure prior to, during and following a subsequent speech stress. In contrast, depressed women displayed an opposite pattern of results. Specifically, depressed women who completed the relationship-focused imagery task prior to the speech stress displayed consistent elevations in both systolic and diastolic blood pressure prior to, during and following the subsequent speech stress. These findings are discussed in the context of understanding both current relationship difficulties and adult attachment patterns among currently-depressed and never-depressed women.

In the second study, we examined stress profiles among a sample of depressed mothers of psychiatrically ill children randomly assigned to receive either referral for treatment as usual (TAU) or a motivationally-enhanced form of brief IPT (M-IPT-B) developed by H. Swartz and colleagues. For comparison purposes, we evaluated similar stress profiles among a sample of age-matched never-depressed mothers. As a preliminary examination of diurnal cortisol secretion, mothers provided saliva samples five times a day for two days, both during the early phase of treatment and during post-treatment follow-up evaluation. In addition, mothers engaged in a clinic-based speech stress task, in which they were asked to: (a) discuss their child and their relationship with their child in open-ended fashion, and (b) discuss a recent interpersonal conflict with their child. Subjective evaluations of current mood state and peripheral markers of stress reactivity were obtained at resting baseline, following the speech task, and during recovery. Results will be discussed in the context of obtained differences in rates of early childhood trauma reported between the depressed and never-depressed women. Finally, general methodological issues and areas for future research will be reviewed and discussed.

Elizabeth Martin
Stephen Martin

Brain Blood Flow and Dopamine D2/D3 Receptor Imaging of Interpersonal Psychotherapy
1. Clinical findings of Mirtazapine and Mirtazapine and IPT for Treatment Resistant Depression

20 DSM-IV patients with major depressive disorder were randomised to Mirtazapine 30mg-45mg or the same dose of Mirtazapine with Interpersonal Psychotherapy received weekly for the first 16 weeks then monthly for the rest of the year. Binded ratings were done at week 0, 16, 26 and 52. The IPT group showed significant clinical improvement compared ot baseline at each follow-up and by week 26 the IPT group had a significant improvement compared to the Mirtazapine group lasting to week 52. This was a small trial showing the need for further large scale research in IPT and Treatment Resistant Depression.

2. Functional Neuroimaging with IPT
We reported central cingulate and basal ganglia blood flow increase with IPT compared to basal ganglia blood flow increase with Venlafaxine, whilst patients improved with mild to moderate depression.

1. In the above treatment resistant depression study patients had IBZM SPECT images done at week 0 and week 6 to investigate the quantitiy of Dopamine D2/D3 receptors in their basal ganglia. There was no dfference between treatment groups or from baseline to any point in follow-up in Dopamine D2/D3 receptor density with IPT and Mirtazapine compared to Mirtazapine only.
Patients who were agitated failed to improve clinically in both groups and had relatively high Dopamine D2 and D3 counts in the striatum throughout. Agitation may need further medication for Treatment Resistant Depression to improve. There is scope for new low dose antipsychotic research augmenting IPT in this respect.

Helen Mayberg, MD

Paths to Recovery: Differential Brain Effects of Medication and Psychotherapy

Requisite brain changes underlying antidepressant response and clinical remission are the object of intense study. Pre-clinical studies of medications emphasize a bottom-up chain of events including aminergic reuptake inhibition and associated presynaptic autoregulatory desensitization, up- and down-regulation of multiple post-synaptic receptor sites, and receptor-mediated second messenger, and neurotrophic intracellular signaling effects in the brainstem, hippocampus, hypothalamus and their neocortical afferents. In contrast, theoretical models of cognitive behavioral therapy (CBT) action implicate 'top-down' mechanisms and primarily cortical targets, as the intervention focuses on modifying attention and memory functions involved in the mediation of depression-relevant explicit cognitions, affective bias and maladaptive information processing. We have identified differential brain changes measured with FDG PET associated with depression remission in patients treated with pharmacotherapy (SSRI) or CBT respectively, consistent with preclinical and theoretical evidence of complementary but distinct modes of action. Furthermore two brain subtypes have been characterized prior to treatment using these PET techniques that correlate with differential outcome to these two treatments. These types of imaging studies lay foundation for future studies of direct measures of brain functioning in the development of new algorithms for first-line clinical management of depressed patients.

Marc B.J. Blom

Psychiatrist and Head of the Department of Mood Disorders
PsyQ, Den Haag, the Netherlands.

Title: Treatment of chronic depression: Combining interpersonal psychotherapy and cognitive behavioural therapy in a group format.

Introduction: Chronic depression is very common in secondary care centres. Treatment resistance is common and standard outpatient treatment is not enough for most patients. It is estimated that about 20% of depressed patients will develop chronic forms of depression. Comorbidity with other disorders, especially anxiety disorders and axis II pathology among this group is often the rule. Standard treatment such as medication and/or psychotherapy is only of benefit for a minority of patients.

Method: In an earlier study we (Blom et al, submitted for publication) we treated 193 patients with IPT, medication or the combination. Of those patients with a index episode > 12 months, only 5% remitted. With this in mind we have designed a intensive treatment aimed at combating chronic depression. The treatment consists of IPT, cognitive therapy and standard farmacotherapy. Running therapy, help in structuring daily life and psycho-education is also part of the program. It is an open group with a standard duration of 16 weeks. Patients come in three days a week to follow the program.
Pre-and post scores on the SCL-90 and QIDS will be presented.

Results: Significant reductions on both depression scores and total psychiatric symptomatology were found. This form of intensive outpatient treatment seems very promising for many patients for whom other treatments don't seem to work.

Michael Thase

Concurrent and sequential combinations of psychotherapy and medication for mood disorders: State of the literature circa 2006

Objectives: At the conclusion of this lecture, the participant will

1. be familiar with the evidence supporting the use of combined treatment for depressive and bipolar disorders;
2. be able to identify the indications for which combined treatment is strongly recommended as the approach of first choice, and
3. be able to discussed the strategies suggested to improve the efficiency of combined treatment.

Differential therapeutic models of mood disorders have too often followed the false dichotomy between mind and brain, with psychotherapy recommended for milder, more stress-related disorders and pharmacotherapy recommended for bipolar and more severe nonbipolar depressions. Recent advances in neurosciences provide a compelling basis for more integrative models of targeted and additive interventions for patients with a wide range of mood disorders. This presentation will review the evidence from controlled studies of psychotherapy and pharmacotherapy combinations for, emphasizing additive effects for patients with severe, recurrent, chronic, and/or complicated mood disorders, whether unipolar or bipolar. The presentation will also review evidence from several studies of sequential pharmacotherapy/psychotherapy combinations.

Holly A. Swartz, M.D.
Allan Zuckoff, Ph.D.
M. Katherine Shear, M.D.
M. A. Dana Fleming, R.N.
Ellen Frank, Ph.D.

Preliminary Findings from a Randomized, Controlled Trial of Enhanced Brief Interpersonal Psychotherapy for Depressed Mothers Whose Children Are Receiving Psychiatric Treatment

INTRODUCTION: Major depression affects one out of five women during her lifetime. Depressed mothers with psychiatrically ill children represent an especially vulnerable population.[1] Challenged by the demands of caring for ill children, these mothers often put their own needs last, and, consequently, their depressions remains untreated. This population is especially difficult to engage in treatment. We developed a 9-session intervention, an Engagement Session based on principles of motivational interviewing followed by 8 sessions of brief interpersonal psychotherapy designed to increase maternal participation in their own psychotherapy, resolve symptoms of maternal depression, and enhance relationships with their ill children (IPT-MOMS).[2] We describe initial findings from a randomized controlled trial of IPT-MOMS for depressed mothers whose children are receiving psychiatric treatment. **METHODS**: Mothers were recruited from pediatric mental health clinics where their offspring (ages 6-18) were receiving psychiatric treatment. Forty-seven mothers meeting DSM-IV criteria for major depressive disorder were randomly assigned to either IPT-MOMS (n=26) or treatment as usual (TAU; n=21), stratified by clinic location. Both mothers and their children were assessed at baseline, 14 weeks, and 6-months. **RESULTS**: At 14 week follow-up, mothers assigned to IPT-MOMS had significantly lower depression scores on the 17-item Hamilton Rating Scale for Depression and on the Beck Depression Inventory compared to mothers assigned to TAU. Mothers assigned to IPT-MOMS also had significantly lower scores on the severity subscale of the Clinical Global Impressions instrument and significantly higher levels of functioning as measured by the Global Assessment Scale relative to mothers assigned to TAU (for all, $p<0.05$). These differences persisted at 6 month follow-up. Children of mothers assigned to IPT-MOMS did not differ from children of mothers assigned to TAU on any outcome variable at 14 weeks. At 6-month follow-up, however, children of mothers assigned to IPT-MOMS had significantly lower depression scores on the Child Depression Inventory and significantly lower levels of impairment on the Columbia Impairment Scale compared to children of mothers assigned to TAU (for both, $p<0.05$). **CONCLUSIONS**: These findings suggest that the differential impact of IPT-MOMS is seen relatively quickly in mothers, but that child improvement lags. The authors speculate that changes in maternal symptoms and functioning may mediate child outcomes. Additional studies are needed to formally evaluate this hypothesis.

François Lespérance, MD, Nancy Frasure-Smith, PhD, Diana Koszycki, PhD, Marc-André Laliberté, MD, Louis T. van Zyl, MD, Brian Baker, MBChB, John Robert Swenson, MD, Kayhan Ghatavi, MD, Beth L. Abramson, MD, Paul Dorian, MD, Marie-Claude Guertin, PhD

The CREATE Trial: a 2 by 2 Factorial Randomized Trial of Citalopram and Interpersonal Psychotherapy for Major Depression in Patients with Coronary Artery Disease

The primary aim of the CREATE study(Canadian cardiac randomized evaluation of antidepressant and psychotherapy efficacy) was to determine the efficacy of citalopram compared to matched placebo, and interpersonal psychotherapy(IPT) compared to clinical management(CM) in reducing depressive symptoms in 284 outpatients with major depressive disorder (MDD) and coronary artery disease (CAD) from 9 Canadian centers. Eligibility criteria included current unipolar MDD of minimum 4 weeks duration, a score of at least 20 on the 24 item Hamilton Depression Rating Scale (HAM-D) at baseline, a history of angioplasty, bypass surgery or myocardial infarction with currently stable CAD. Subjects were randomized both to 20-40mg citalopram or placebo and to 12 weekly sessions of CM or IPT. IPT was delivered by trained IPT therapists. Trained psychologists assessed the primary outcome, the HAM-D by telephone. The secondary outcome was the Beck Depression Inventory(BDI-II). This study randomized 284 patients of which > 83% of those assigned to interpersonal psychotherapy(IPT) or clinical management(CM) completed all 12 weekly sessions. 75% were male and 43% had previously had a major depressive episode. 94% completed the final Hamilton Depression scale(HAM-D). Mean duration of sessions was 48 minutes for IPT and 20 minutes for CM. Over 12 weeks Citalopram reduced depressive symptoms more than placebo. The HAM-D difference was 3.3 points (96.7% CI, .80 to 5.85; P =.005) with an effect already apparent by 6 weeks. Pre-planned subgroup analyses showed that citalopram was more efficacious for recurrent depression than for first episodes of MDD. In contrast, there was no additional benefit of adding IPT to CM(HAM-D difference -2.3 points; 98.3% CI, -4.78 to .27; P =.06), favoring CM over IPT in lowering depressive symptoms. Subgroup analysis suggested that CM was more efficacious in lowering depression compared to IPT for those subjects with low levels of functional performace and social support. Citalopram can be considered as a first line treatment of MDD in patients with CAD. So far there is no evidence that any form of psychotherapy is superior to regular CM for these patients.

R. Michael Bagby, Carolina McBride, Lena C. Quilty
Centre for Addiction and Mental Health
University of Toronto

Personality and the Prediction of Response in Major Depressive Disorder: A Randomized Control Trial Comparing Interpersonal Therapy and Pharmacotherapy

Objective: Major Depressive Disorder (MDD) is among the most common of mental disorders and is associated with immense personal suffering and societal cost. While a number of interventions have demonstrated efficacy in the treatment of MDD, a substantial proportion of individuals do not remit in response to the treatment they are offered. Personality traits may provide a way in which to understand this variability in response rates, and to optimize treatment success through the identification of which patients are more likely to respond best to which treatments. The objective of this investigation was to determine if the personality traits of a comprehensive taxonomy of personality are predictors of response to either interpersonal therapy (IPT) or pharmacotherapy (PHT). **Method:** Eighty-six participants diagnosed with MDD were randomized to receive either IPT or PHT over 16-20 weeks. Participants completed the Hamilton Rating Scale for Depression and the Revised NEO Personality Inventory prior to and following treatment. **Results:** Five personality traits -- Neuroticism, Angry Hostility, Depression, Impulsiveness, and Straightforwardness -- were able to distinguish differential response rate to IPT or PHT. **Conclusions:** Participants did not response equally to the treatments provided; indeed, personality traits predicted differential response to IPT versus PHT. The assessment of patient personality traits may assist in the selection and subsequent optimization of treatment response for depressed patients.

Scott Stuart, M.D.
Professor of Psychiatry and Psychology
University of Iowa, Department of Psychiatry

Defining the Psychotherapies: The Case of IPT

All psychotherapies share common elements; many have similar goals, such as remission of symptoms or improvement in social functioning. As a result, there is often confusion about what the “core” or defining elements of a particular therapy are, and what elements distinguish it from other approaches. This issue is critical because empirical testing of a treatment, and subsequent modifications of that treatment, rest on describing it precisely.

In this presentation, a potential method of categorizing psychotherapeutic approaches using the concepts of theory, targets, tactics, and techniques will be discussed. IPT will be used as a case example, and modifications of IPT will be discussed in this context.