Eur Arch Psychiatr Neurol Sci (1989) 238:240–246

European Archives of Psychiatry and Neurological Sciences


# Evaluating the Efficacy of Psychotherapy for Depression: the USA Experience*

**Gerald L. Klerman**

Department of Psychiatry, Cornell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605, USA

**Summary.** New forms of psychotherapy have been developed in North America specifically focused on the treatment of depressed patients, usually "neurotic depressives" treated on an ambulatory basis. The widely studied treatments have been cognitive behavioral therapy and interpersonal therapy (IPT). The theoretical background and empirical basis of IPT is reviewed along with the available evidence for efficacy based on studies of acute treatment and maintenance treatment. The recently completed NIMH multi-center study provides evidence for the overall efficacy of treatment of outpatient depressives, whether by drugs or by brief psychotherapy. Future developments will likely increase the focus of psychotherapy for depression alone and in combination with medication.

**Key words:** Depression – Psychotherapy – Interpersonal psychotherapy – Clinical trials – Outpatients

## Introduction

The decades since World War II have witnessed unprecedented advances in the treatment of depression. These advances have included new psychopharmacological treatments and new forms of psychotherapy.

The new psychopharmacotherapies, particularly imipramine, the prototypic tricyclic antidepressant, and iproniazid, the first monoamine oxidase inhibitor (MAOI) were introduced in the 1950s. Subsequent to the introduction of tricyclics and MAOIs, lithium was used for mania, as were many new antidepressant compounds with unusual chemical structures. Not only have these compounds contributed to improved treatment of depression, but the demonstrated clinical efficacy of these compounds has stimulated basic research on the neurochemistry and neuropharmacology of depression, ushering in the new era of biological psychiatry (Klerman 1986a). Considerable abvances have also been made in the development of new psychotherapies. In clinical practice, the majority of depressed patients receive some form of psychotherapy (Keller et al. 1982).

The *purposes of this paper* are (1) to review recent developments in the psychotherapy for depression, with particular emphasis on interpersonal psychotherapy (IPT); (2) to discuss efforts to evaluate the efficacy of psychotherapy for depression, including the efficacy of IPT and other new psychotherapy for depression; (3) to assess the state of evidence and identify future prospects.

## The Development of Psychotherapies Focused on Depression

For decades, researchers, practitioners, and social critics have debated the usefulness of psychotherapy (Eysenck 1965). Parloff et al. (1978) identified over 200 different types of psychotherapies. Although the weight of evidence for the efficacy of psychotherapy

* Supported in part by grants R-01-MH-43044 and U-01-MH-43077 from the National Institute of Mental Health; Alcohol, Drug Abuse, and Mental Health Administration; Public Health Service; Department of Health and Human Services. Rockville, Maryland, USA

*Offprint requests to:* M. Carlson, New York Hospital – Cornell University Medical College, Payne Whitney Clinic, 525 East 68th Street, New York, NY 10021, USA

Parts of this article were presented on the occasion of the inauguration ceremony of the Department of Psychiatry of the University of Mainz on April 2 and 3, 1987

**Table 1.** New psychotherapies for depression

| Type of psychotherapy | References |
|---|---|
| Cognitive-behavioral therapy (CBT) | Beck et al. (1979) |
| Interpersonal psychotherapy (IPT) | Klerman et al. (1984) |
| Long-term interpersonal psychotherapy | Arieti and Bemporad (1979) |
| Behavioral technique | Lewinsohn et al. (1980)<br>Rehm LP (1976)<br>Hersen (1986) |
| Group psychotherapy | Covi and Lipman (1987) |
| Psychodynamic psychotherapy | Strupp and Binder (1984)<br>Luborsky L (1984) |

is less than for the drug therapies, in a scholarly review of the literature, Glass et al. (1980) summarized over 400 controlled studies of various psychotherapies and discussed the methodological issues in assessing the efficacy of psychotherapy, alone and in comparison with drug therapies (Klerman 1978; Glass et al.1980).

For depressive disorders, in particular, the evidence for the efficacy of psychotherapy is growing, but is not yet as yet conclusive as that for drug therapy. Most of the available research assessing the efficacy of psychotherapy has been conducted using depressed outpatients. Advances in nosology, better specification of treatments, improved scientific designs, and higher standards for conducting clinical trials have resulted in a sufficient number of studies for appraisal of the evidence now to be possible.

As shown in Table 1, a number of new psychotherapies specifically for treatment of outpatients with depression have been developed. Most studies have been conducted with outpatients and have excluded patients who have bipolar or psychotic depression. For the most part, these new psychotherapies have been directed at "neurotic depression" in DSM-II and ICD-9 classifications. Some studies have included comparisons with pharmacotherapy alone or the combination of drugs and psychotherapy. For a number of the treatments [particularly cognitive behavioral therapy (CPT) and IPT] manuals have been developed, which have contributed to their application in systematic studies of outcome and efficacy.

These new psychotherapies have been the subject of extensive reviews and scholarly appraisals, including the application of meta analysis (Lewinsohn 1980; Rush 1982; Strupp and Binder 1984; Hersen 1986; Weissman 1987; Covi and Lipman 1987; Shea et al. 1988). Five treatment approaches have been evaluated: studies using cognitive behavior therapy by Beck and Rush (1979), behavior therapy developed by Rehm (1976), interpersonal psychotherapy tested by Klerman (1974) and Weissman and Lipton 1978, and marital therapy evaluated by Covi and Lipman (1987) and Friedman (1975). The studies supported the efficacy of psychotherapy alone as compared with some control group.

## Interpersonal Psychotherapy

Two forms of IPT have been applied to depression. Arieti and Bemporad (1979) described long-term psychotherapy for severe and mild depressions based on their interpersonal and culturist variation of psychodynamic theory. These techniques have not been defined in a treatment manual and have not been evaluated by systematic controlled studies. At the same time, Klerman et al. (1984) developed a form of short-term IPT which has become manualized. IPT has been the subject of a number of controlled studies.

IPT is a form of brief psychotherapy for ambulatory patients, who have nonpsychotic, nonbipolar forms of depression. The major theoretical sources for IPT derive from the ideas of Adolph Meyer and of Sullivan (1957); Meyer's psychobiological approach to understanding psychiatric disorders placed great emphasis on the patient's adaptation to his/her environment (Darwin 1872). Meyer viewed psychiatric disorders as one expression of the patient's attempt to adapt to that environment. He viewed an individual's response to environmental change as determined by prior experiences, particularly early experiences in the family, and the individual's affiliation with various social groups. Sullivan's writings (1956) linked clinical psychiatry to the emerging social sciences and proposed the interpersonal theory of psychiatry.

The empirical basis for understanding and treating depression with IPT includes: studies of life events associated with the onset of depression, longitudinal studies demonstrating the impairment of depressed patient during the acute depressive phase and following symptomatic recovery. For example, studies by Brown et al. (1975) have demonstrated the role of intimacy and social supports as protections against depression in the face of adverse life stress. Pearlin and Lieberman (1977) and Ilfeld (1977) documented the impact of chronic and social interpersonal stress, particularly marital stress, on the onset of depression. Finally, Bowlby (1969) and Henderson et al. (1978) have emphasized the importance of attachment bonds for normal emotional life and, conversely, that loss of social attachments is associated with the onset of depression and other neurotic disorders.

*Treatment Goals of IPT*

The treatment of depression is seen as involving three possible goals: (1) reduction of symptoms, involving depressive affect and vegetative signs and symptoms, which may derive from psychobiological and/or psychodynamic mechanisms; (2) improvement in social adjustment and interpersonal relations, involving social interactions with other persons which derive from learning based on childhood experiences, concurrent social supports, and/or personal mastery and competence; (3) change in personality, involving enduring traits and behaviors, i.e., the handling of anger and guilt and overall self-esteem, which constitute the person's unique reactions and patterns of functioning and which also may contribute to a predisposition to manifest symptom episodes (Table 1).

IPT aims at the first two goals. Because of the brevity of the treatment, the low level of psychotherapeutic intensity, and the focus on the context of the current depressive episode, no claim is made that IPT will have an impact on the enduring aspects of personality, although personality functioning is assessed and monitored.

*Characteristics of Interpersonal Psychotherapy*

IPT from an interpersonal conceptualization of depression, does not necessarily presume that interpersonal problems "cause" depression. Whatever the cause, however, depression occurs in an interpersonal context. IPT attempts to understand that context and assist the patient to master it. Because of IPT's relatively brief duration, it is not expected to have an impact upon enduring aspects of personality structure, although personality functioning is assessed. While some longer-term psychotherapies have been designed to achieve personality change using the interpersonal approach (Arieti and Bemporad 1978), these treatments have not been assessed in controlled trials.

IPT facilitates recovery from acute depression by relieving depressive symptoms and by helping the patient develop greater mastery in coping with current interpersonal problems. Symptom relief begins with psychoeducational effects helping the patient understand that his/her symptoms are part of a known syndrome, respond to a variety of treatments and have a good prognosis. Psychopharmacological approaches may be used in conjunction with IPT to alleviate symptoms more rapidly.

Treating the depressed patient's problems in interpersonal relations begins with identifying which of four problem areas commonly associated with the onset of depression – grief, role disputes, role transition, or interpersonal deficit – is related to the individual patient's depression. IPT then focuses on the particular interpersonal problem as it relates to the onset of depression (Klerman et al. 1984) (Tables 2, 3).

**Table 2.** Stages in the conduct of IPT

| Stages | Tasks |
|---|---|
| Early | Treatment of depressive symptoms |
| | Review of symptoms |
| | Confirmation of diagnosis |
| | Communication of diagnosis to patient |
| | Evaluation of medication need |
| | Education of patient about depression (epidemiology symptoms, clinical causes, treatments, prognosis) |
| | Legitimation of patient's "sick role" |
| | Assessment of interpersonal relations |
| | Inventory of current relationships |
| | Choice of interpersonal problem area |
| | Therapeutic contract |
| | Statement of goals, diagnosis, problem area |
| | Medication plan |
| | Agreement |
| Middle | Treatment focusing on problem area |
| | Grief reaction |
| | Interpersonal disputes |
| | Role transition |
| | Interpersonal deficits |
| Termination | Issues of loss and dependency |

**Table 3.** Problem areas for IPT for depression

1. Grief
2. Role transition
3. Interpersonal disputes
4. Interpersonal deficits

*IPT Compared with Other Psychotherapies*

The procedures and techniques in many of the different psychotherapies have much in common. Most psychotherapies attempt to help the patient to develop mastery in coping overcoming social isolation and restoring the patient's feeling of competence.

The psychotherapies differ, however, in whether the patient's problems are seen as arising in the far past, the immediate past, or the present. IPT focuses primarily on the patient's present, and it differs from other psychotherapies in its limited duration and its attention to current depressive symptoms and the current depression-related interpersonal context.

IPT is time-limited and not long-term. Considerable research has demonstrated the value of short-term, time-limited psychotherapies (usually once a

week for less than 9–12 months) for most patients' current problems and for most symptom states. While long-term treatment still may be required for changing chronic personality disorders, particularly maladaptive interpersonal and cognitive patterns, and for ameliorating or replacing dysfunctional social skills, evidence for the efficacy of long-term psychotherapy is limited. Long-term treatment also has the potential disadvantage of promoting dependency and reinforcing avoidance behavior. Psychotherapies that are short-term of time-limited aim to minimize these adverse effects.

IPT is focused and not open-ended. In common with other brief psychotherapies, IPT focuses on one or two problem areas in the patient's current interpersonal functioning; the focus is agreed upon by the patient and the psychotherapist after initial evaluation sessions. The topical content of sessions is, therefore, focused and not open-ended.

IPT focuses on current and not past interpersonal relationships. The focus is on the patient's immediate social context just before, and as it has been since, the onset of the current depressive episode. Past depressive episodes, early family relationships, and previous significant relationships and friendship patterns are, however, assessed in order to understand the patient's interpersonal relationships.

IPT is concerned with interpersonal, not intrapsychic, phenomena. In exploring current interpersonal problems with the patient, the psychotherapist may observe the operation of intrapsychic mechanisms such as projection, denial, isolation, undoing, or repression. In IPT, however, the psychotherapist does not work on helping the patient see the current situation as a manifestation of internal conflict. Rather, the psychotherapist explores the patient's current psychiatric behavior in terms of interpersonal relations.

## Establishing the Efficacy of Psychotherapy

Research of the efficacy of psychotherapy has gained increasing prominence in recent decades. This is due to a number of forces; growth in the utilization of mental health services, particularly psychotherapy; the extent of ideological and professional controversies regarding the nature of mental illness and its most effective treatments, and the demonstrated efficacy of psychopharmacology for many of the conditions previously treated exclusively with psychotherapy. These forces have increased the need for scientific evidence of efficacy and have generated discussions and debates as to the most valuable means of generating such evidence.

### *Importance of the Randomized Controlled Trial*

It is now generally agreed that the most valid evidence for the efficacy of any intervention – pharmacological, surgical, radiation, or psychological – comes from randomized controlled clinical trials. This design has been most widely applied to assessment of drugs, but is increasingly being used with other forms of treatment, including surgery and psychotherapy.

Although the experimental basis for the randomized trial goes back to discussions of scientific investigation in the seventeenth century, the first applications in therapeutics did not appear until the 1930s with the development of placebo control trials for cardiac patients. Even so, impetus for increasing application of randomized controlled trials was based upon public and legislative concern as well as upon scientific developments.

In the United States, in 1962, the Kefauver-Harris Amendments to the Food and Drug Act mandated, for the first time, that evidence for efficacy would be required for the approval of the new drug. Today, we take the criteria of safety and efficacy for granted in the health field: however, efficacy was mandated only after hard-fought legislative action. Prior to 1962, evidence for efficacy was not required in the United States for the marketing of new pharmaceutical products; only evidence of purity and safety were required. Interestingly, criteria of safety and efficacy are not included at present in the US Federal statutes for medical procedures other than drugs. For example, these criteria are not required for Medicare or Medicaid reimbursement, which stipulates that they be only "necessary and reasonable". Currently there is a vigorous debate in Washington over proposals that would extend the criteria of efficacy to psychiatric treatment, such as psychotherapy.

When one wishes to evaluate a single treatment, such as a new drug or form of psychotherapy, the minimum acceptable design is a two-group design in which the new treatment is compared with some appropriate control group. In the case of pharmacotherapy, the usual control group is a placebo. In the case of the psychotherapies, however, there remains controversy as to what is the equivalent of the placebo as the control group.

The more satisfactory design for evaluating an individual treatment is a three-group design in which the new treatment is compared with some standard as well as a control group. Thus, in a study of a new antidepressant, it is desirable to compare a new drug with a standard drug (such as imipramine or amitriptyline) and against a placebo. In the case of psychotherapy, where relatively few standard treat-

| | | Psychotherapy | |
|---|---|---|---|
| | | Present | Absent |
| Drug treatment | Present | Combined treatment | Drug alone |
| | Absent | Psychotherapy alone | Absent |

**Fig. 1.** Four-group factorial design for drug-psychotherapy interaction

ments exist, it is often considered useful to compare two forms of psychotherapy against a controlled group. As an example, the NIMH Collaborative Study on the Psychotherapy of Depression is comparing cognitive therapy against interpersonal therapy against psychological management.

When one wishes to evaluate a combined treatment, such as the combination of two drugs (a tricyclic plus a benzodiazepine) or the combination of a drug plus psychotherapy (amitriptyline plus interpersonal therapy), the minimum design is the four-celled design. In the four-celled design, each treatment is evaluated against each other, against a control group and against the combination (Fig. 1).

When one is evaluating the combination of drugs and psychotherapy, a number of additional problems arise from the dynamics of the placebo effect. The usual setting for psychotherapy does not involve pill ingestion. Many observers have argued that even taking an inert pill alters the psychological condition of the psychotherapy, creating changes in expectations, both of the therapist and of the patient.

## Studies of the Efficacy of IPT

There have been a number of studies evaluating the efficacy of IPT.

### *Acute Treatment Study*

In 1973 a 16-week study of the acute treatment of 90 ambulatory depressed patients, both men and women, was initiated, using IPT and amitriptyline, each alone and in combination against a nonscheduled psychotherapy treatment (DiMascio et al. 1979). IPT was administered weekly by experienced psychiatrists. A procedural manual for IPT was developed. By 1973, the SADS-RDC were abailable for making more reliable diagnostic judgments, thereby assuring the selection of a more homogeneous sample of depressed patients.

Patients were assigned randomly to IPT or the control treatment at the beginning of treatment, which was limited to 16 weeks since this was an acute and not a maintenance treatment trial. Patients were assessed one year after treatment had ended to determine any long-term treatment effects. The assessment of outcome was made by a clinical evaluator who was independent of and blind to the treatment the patient was receiving.

In 1980, the results of IPT compared with tricyclic antidepressants alone and in combination for acute depressions were reported. Both active treatments, IPT and the tricyclic, were more effective than the control treatment, but combined treatment was superior to either treatment alone (Weissman and Lipto 1978; DiMascio et al. 1979). In addition, a 1-year follow-up study indicated that the therapeutic benefit was sustained for a majority of the patients. Patients who had received IPT either alone or in combination with drugs were functioning better than patients who had received either drugs alone or the control treatment (Weissman et al. 1979). There remained a fraction of patients in all treatments who relapsed and for whom additional treatment was required.

### *Maintenance Treatment Study*

In 1967, 150 acutely depressed outpatients whose symptoms responded to a tricyclic antidepressant (amitriptyline) were studied long-term (6 months). Afterwards, each patient received 8 months of maintenance treatment with drugs alone, psychotherapy (IPT), alone or in combination. Maintenance drug treatment was found to prevent relapse; psychotherapy alone improved social functioning and interpersonal relations but had no effect on symptomatic relapse. Because of the differential effects of the treatment, the combination of drugs and psychotherapy was the most efficacious (Klerman et al. 1974; Weissman et al. 1974).

Encouraged by these findings, issues of drug-psychotherapy interaction were pursued. Greater specification of the psychotherapeutic techniques was needed as well as careful training of psychotherapists for research. The psychotherapy had been defined in terms of conceptual framework, goals, frequency of contacts, and criteria for therapist suitability. However, the techniques and strategies and actual procedures had not been set out in a procedure manual and there were no training programs.

### *Other Studies*

Other researchers have now extended IPT to other aspects of depression. A long-term period of maintenance (MIPT) is underway at Pittsburgh conducted by Kupfer and Frank to assess the value of drugs and psychotherapy in maintenance treatment of recurrent unipolar depressions. Also, at Pittsburgh, Reynolds

and Frank have modified IPT for use with elderly depressed patients and a study is now underway.

IPT has also been evaluated for the treatment of depression associated with heroin addiction and in the treatment of symptoms of stress and distress in patients seen at a Health Maintenance Organization (Klerman and Weissman 1987).

## The NIMH Collaborative Study of the Outpatient Treatment of Depression

In the mid-1970s, the NIMH, under the leadership of Drs. Parloff and Elkin, designed and initiated a multi-center controlled clinical trial of drugs and psychotherapy in the treatment of depression (Elkin et al. 1985). Two hundred and fifty outpatients were randomly assigned to four treatment conditions: (1) cognitive therapy, (2) interpersonal psychotherapy (IPT), (3) imipramine, and (4) a placebo-clinical management combination. Each patient was treated for 16 weeks. Extensive efforts were made in the selection and training of psychotherapists. Outcome was assessed by a battery of scales which assess symptoms, social functioning and cognition. The initial entry criterion was a score of at least 14 on the 17-item Hamilton Rating Scale for Depression. Of the 239 patients who entered treatment, 68% completed at least 15 weeks and 12 sessions of treatment.

The preliminary findings from three centers (Oklahoma City, Washington, DC, Pittsburgh) were reported (Elkin et al. 1985) at the American Psychiatric Association Annual Meeting, 13 May 1986, in Washington, DC. Overall, the findings showed that all active treatments are superior to placebo in the reduction of symptoms over a 16-week period.

1. There was a highly significant overall improvement. Over two-thirds of the patients were symptom-free at the end of treatment.

2. More patients in the placebo-clinical management condition dropped out or were withdrawn from the study: IPT had the lowest attrition rate.

3. At the end of 12 weeks of treatment, the two psychotherapies and imipramine were equivalent in the reduction of depressive symptoms and in overall patient functioning.

4. The psychopharmacotherapy, imipramine, had rapid initial onset of action, but by 12 weeks, the two psychotherapies had produced almost equivalent improvement.

5. Although may of the less severely depressed patients improved with all treatment conditions, including the placebo-clinical-management conditions, more severely depressed patients treated with placebo-clinical-management did poorly.

6. For the less severely depressed group, there were few differences among the treatments. The criterion of severity used was a score of 20 or more on the Hamilton Rating Scale of Depression. Patients in IPT and in the imipramine groups consistently and significantly had greater improvement than the placebo group on the Hamilton Rating Scale. IPT was significantly superior to placebo for the severely depressed group. For the severely depressed group, IPT did as well as imipramine.

7. Surprisingly, one of the more important predictors of patient response for IPT was the presence of an endogenous depressive symptom picture measured by the Research Diagnostic Criteria following an interview using the Schedule for Affective Disorders (SADS). Endogenous symptoms were also a significant predictor for imipramine; however, this finding for drugs was expected from previous research.

## Conclusion

Given the growing number of studies, there is increased evidence for the efficacy of psychotherapy for depression. Although the full report has not yet been published, the initial reports of the positive findings of the NIMH Collaborative Study are encouraging and have received considerable attention in the popular press.

However, there are a number of limitations to any conclusions regarding the place of psychotherapy in the treatment of depression. All of the studies in the United States have been conducted on ambulatory patients. There are no systematic studies evaluating the efficacy of psychotherapy for hospitalized patients who are usually more severely disabled and often suicidal.

Furthermore, these results should not be interpreted as implying that *all* forms of psychotherapy are effective for depression. One significant feature of recent advances in psychotherapy research is the development of psychotherapies specifically designed for depression and of limited time and brief duration. Just as there are specific forms of medication, there are specific forms of psychotherapy. Just as it would be an error to conclude that all forms of medication are useful for all types of depression, so it would be an error to conclude that all forms of psychotherapy are efficacious for all forms of depression.

These therapeutic advances have contributed to our understanding of the complex interplay of psycho-

social and biological factors in the etiology and pathogenesis of depression, particularly of endogenous depression. For depressed ambulatory outpatients there is a range of effective treatments, including a number of forms of brief psychotherapy and various medications.

A variety of treatments may be suitable for depression. The depressed patient's interest are best served by the availability of scientific tested different psychological as well as pharmacological treatments. The ultimate aim of these studies is to determine which treatments are best for particular subgroups of depressed patients.

The evaluation of treatments in psychiatry is currently in a stage of major activity and considerable progress. The area of evaluation of psychotherapies has been given great impetus by improvements in design and by increasing public attention to mental health problems in general and to the place of psychotherapy and counseling in particular.

## References


Arieti S, Bemporad J (1979) Severe-mild depression: the psychotherapeutic approach. Basic Books, New York

Beck AT, Rush AJ, Shaw BF, Emery G (1979) Cognitive theory of depression. Guilford, New York

Bowlby J (1969) Attachment and loss. Hogarth Press, London

Brown G, Bhrokhain M, Harris T (1975) Social class and psychiatric disturbance among women in an urban population. Sociology 9:225–254

Covi L, Lipman RS (1987) Cognitive behavioral group psychotherapy combined with imipramine in major depression: a pilot study. Psychopharmacol Bul 23:173–176

Darwin C (1872) The expression of the emotions in man and animals. Murray, London

DiMascio A, Weissman MM, Prusoff BA, Neu C, Zwilling M, Klerman GL (1979) Differential symptom reduction by drugs and psychotherapy in acute depression. 1979. Arch Gen Psychiatry 36:1450–1456

Elkin I, Parloff M, Hadley S, Autry J (1985) The NIMH Treatment of Depression Collaborative Research Program: background and research plan. Arch Gen Psychiatry 42: 305–316

Eysenck H (1965) The effects of psychotherapy. Int J Psychiatry 1:99

Friedman AS (1975) Interaction of drug therapy with marital therapy in depressive patients. Arch Gen Psychiatry 32: 619–637

Glass GV, Smith ML, Miller TI (1980) The berits of psychotherapy. Johns Hopkins Press, Baltimore

Henderson S, Byrne DS, Duncan-Jones P, Adcock S, Scott R, Steele GP (1978) Social bonds in the epidemiology of neurosis. Br J Psychiatry 132:463–466

Hersen M (ed) (1986) Pharmacological and behavioral treatment: an integrative approach. Wiley, New York

Ilfeld FW (1977) Current social stressors and symptoms of depression. Am J Psychiatry 134:161–166

Keller MB, Klerman GL, Lavori PW, Fawcett J, Coryell W, Endicott J (1982) Treatment received by depressed patients. JAMA 248:1848–1855

Klerman GL (1974) Depression and adaptation. In: Friedman RJ, Katz MM (eds) Psychology of depression: contemporary theory and research. Winston-Wiley, Washington, DC, pp 127–156

Klerman GL (1978) Drugs and psychotherapy. In: Garfield SL, Bergin AE (eds) Handbook of psychotherapy and behavior change. Wiley, New York

Klerman GL (1983) Psychotherapies and somatic therapies in affective disorders. In: Akiskal H (ed) Psychiatric clinics of North America, vol 6. Saunders, Philadelphia, pp 85–103

Klerman GL, DiMascio A, Weissman MM, Prusoff B, Paykel ES (1974) Treatment of depression by drugs and psychotherapy. Am J Psychiatry 131:186–191

Klerman GL (1986a) Drugs and psychotherapy. In: Garfield SB, Bergen AE (eds) Handbook of psychotherapy and behavior change. Wiley, New York, pp 773–814

Klerman GL (1986b) Historical perspectives on contemporary schools of psychopathology. In: Millon T, Klerman GL (eds) Contemporary directions in Psychopathology: toward the DSM-IV. Guilford Press, New York

Klerman GL, Weissman MM, Rounsaville B, Chevron ES (1984) Interpersonal Psychotherapy for depression. Basic Books, New York

Klerman GL, Weissman MM (1987) Interpersonal psychotherapy (IPT) and drugs in the treatment of depression. Pharmacopsychiatry 20:3–8

Lewinsohn PM (1974) A behavioral approach to depression. In: Friedman RJ, Katz MM (eds) The psychology of depression: contemporary theory and research. Wiley, Washington

Luborsky L (1984) Principles of psychoanalytic psychotherapy. Basic Books, New York

Parloff MB, Wolfe BE, Waskow IE, Hadley S (1978) Assessment of psychosocial treatment of mental disorders: current status and prospects. Institute of Medicine, Washington, DC

Pearlin LI, Lieberman MA (1977) Social sources of emotional distress. In: Simmons R (ed) Research in community and mental health. JAI Press, Greenwich, CT

Rush AJ (1982) Short-term psychotherapies for depression. Guilford Press, New York

Shaw B (1977) A comparison of cognitive therapy and behavior therapy in the treatment of depression. J Consult Clin Psychol 45:543–551

Shea MT, Elkin I, Hirschfeld RMA (1988) Psychotherapeutic treatment of depression. In: Frances AJ, Hales RE (eds) American Psychiatric Association review of psychiatry, vol 7. American Psychiatric Press, Washington DC, pp 235–255

Strupp HH, Binder JL (1984) Psychotherapy in a new key. Basic Books, New York

Sullivan HS (1956) Clinical studies in psychiatry. Norton, New York

Weissman MM (1987) In: Melzer HY (ed) Psychopharmacology: the third generation of progress. Raven Press, New York

Weissman MM (1979) The psychological treatment of depression: research evidence for the efficacy of psychotherapy alone, in comparison, and in combination with pharmacotherapy. Arch Gen Psychiatry 36:1261–1269

Weissman MM, Lipton MA (1978) Psychotherapy and its relevance to the pharmacotherapy of affective disorders: from ideology to evidence. In: DiMascio A, Killam KF (eds) Psychopharmacology: a generation of progress. Raven Press, New York

Weissman MM, Klerman GL, Paykel ES, Prusof B, Hanson B (1974) Treatment effects on the social adjustment of depressed patients. Arch Gen Psychiatry 30:771–778


Received September 2, 1988