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ABSTRACT

In an attempt of fill the gap in theoretical and empirical information available for treatment of adolescent depression, interpersonal therapy for adolescents (IPT-A) was developed. Interpersonal psychotherapy (IPT) is a brief, time-limited therapy originally developed for use with adults diagnosed with major depression. Several outcome studies have been completed on the efficacy of IPT-A with adolescents, however these reports have been mainly published in psychiatric journals. This paper attempts to bring these results to counselors who work with adolescents. The rationale for modification of the IPT for adolescents involves the similarities found in research between adolescent and adult mood disorders and the prevalence of depression in adolescents. Studies also show adolescent depression to be associated with significant social and interpersonal difficulties. Many of the problem areas addressed in IPT relate to interpersonal difficulties that correlate with adolescent depression. Promising results are reported from initial empirical investigation into the efficacy of the IPT-A with adolescent depressive disorders. The need for future research is substantiated. (JDM)

Running Head: INTERPERSONAL THEORY

Interpersonal Theory and Depressed Adolescents:

An Overview of Method and Outcome

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Abstract

Interpersonal psychotherapy (IPT) is a brief, time-limited therapy that was originally developed for use with adults diagnosed with major depression. In the last decade, IPT has been modified for use with many different age groups. Interpersonal psychotherapy for adolescents (IPT-A) is one of the modifications that has been developed during the last decade. Several outcome studies have been completed on the efficacy of IPT-A with adolescents diagnosed with major depression. However, those studies and descriptions of IPT-A have been predominantly published in psychiatric journals. No information was found in any counseling journal that directly addressed the use of IPT-A with depressed adolescents. Many counselors may be left with little information about the use of IPT-A with adolescents who are depressed. This paper will provide counselors with a description of the rationale for developing IPT-A, an explanation of IPT-A, and the results of recent outcome studies on the efficacy of IPT-A. Suggestions for future research investigations with IPT-A will also be identified.

Introduction

Interpersonal psychotherapy (IPT) is a brief, time-limited treatment that has been specifically developed and tested for use with adults who have been diagnosed with a depressive disorder (Moreau, Mufson, Weissman, & Klerman, 1991). The goals of IPT treatment include reducing the symptoms related to depression and identifying interpersonal problem areas that are connected with the start of the depression (Moreau et al., 1991). IPT makes no assumptions about the underlying origins of depression, but instead links the onset of depression to one of four interpersonal problem areas frequently associated with the beginning of depression in the adult population (Weissman & Markowitz, 1994). These problem areas are interpersonal deficits, role transitions, interpersonal role disputes, and grief (Weissman & Markowitz, 1994). After identifying interpersonal problem areas, the focus of counseling then becomes working to alleviate and correct problems associated with the identified interpersonal areas (Moreau et al., 1991). IPT theorists believe that discerning the interpersonal problems that contribute to depression and working to alleviate those problems is sufficient for the treatment of depression regardless of other biological or personality factors (Moreau, et al., 1991). IPT therapy emphasizes the current interpersonal relationships and social contexts of the individual (Weissman & Markowitz, 1994). Therefore, IPT attempts to intercede in current interpersonal problems that are contributing to the depression rather than alter pervasive personality characteristics (Weissman & Markowitz, 1994). In the last decade, IPT has been modified for use with a host of different populations (Weissman & Markowtiz, 1994). IPT has been modified for use with elderly persons with depression, depressed individuals with a human immunodeficiency virus diagnosis, dysthymia, bipolar disorder, drug abuse, bulimia, marital disputes, and adolescents who are depressed (Weissman & Markowitz, 1994).

Despite evidence that major depression is prevalent among the adolescent population, little empirical attention has been given to the treatment of this disorder with adolescents (Mufson et al., 1994). In comparison to the outcome studies related to treating adults diagnosed with major depression, there is little information of the same type available for those interested in treating depressed adolescents (Mufson, Weissman, Moreau, Garfinkel, 1999). There have been a few studies that have considered the use of medication with this population, but those studies have failed to demonstrate efficacy and have been criticized for poor research design (Mufson et al., 1999). There has also been some empirical attention paid to the use of individual and group cognitive behavior therapy (CBT) with adolescents who are depressed (Mufson, et al., 1999). However, the empirical information available for the treatment of depressed adolescents is still lacking especially when compared to the information available for treating adults who are depressed (Mufson, et al., 1999).

In attempt to fill the gaps in theoretical and empirical information available for the treatment of adolescent depression, interpersonal therapy for adolescents (IPT-A) was developed. IPT-A has made modifications to IPT to meet the specific developmental and interpersonal needs of adolescents who are depressed (Moreau, et al., 1991). Several empirical investigations into the efficacy of this treatment model with depressed adolescents have already taken place (Mufson et al., 1994; Mufson & Fairbanks, 1996; Mufson et al., 1999; Santor & Kusumakar, 2001). This paper will identify the rationales for the modification of IPT for adolescents with depression, detail the treatment goals and modalities of IPT-A, examine the outcome research that has been conducted to date on IPT-A, and will make recommendations for further research.

Rationales for developing IPT-A

A few rationales for the modification of IPT for adolescents who are depressed have been discussed in the literature on IPT-A (Moreau et al., 1991; Mufson et al., 1994; Santor & Kusumakar, 2001). One of the primary rationales offered for IPT-A involves the similarities found in the research between adolescent and adult mood disorders and the prevalence of depression in adolescents (Moreau, 1991). These similarities have been found in symptomology, family history, and in the courses of mood disorders (Santor and Kusumakar, 2001). Moreover, a study on depressed adults found that the most common age of first onset was during adolescence and young adulthood (Moreau et al., 1991). Prevalence rates for adolescent depression have been reported between 0.4% to 8.4% (Moreau et al., 1991; Birmaher, et al., 1996). Depression in adolescence has symptomology similar to adults (Moreau et al., 1991). Like adults, adolescent depression is linked to significant psychosocial impairment (Moreau et al., 1991). Psychosocial impairment may be evidenced in adolescents by the abuse of drugs and alcohol, antisocial behavior, suicide ideations and attempts, and school dropout (Moreau et al., 1991). Additionally, like adult depression, adolescent depression is also often comorbid with other disorders (Moreau, et al, 1991). Results of outcome studies of IPT with adults have been promising, therefore the rationale is made that a modified version of IPT might also be effective for adolescents based on the common characteristics between adult and adolescent depression (Moreau et al., 1991).

Another rationale that has been offered for the development of IPT-A relates to studies that have shown adolescent depression to be associated with significant social and interpersonal difficulties (Santor and Kusumakar, 2001). IPT theorists believe that IPT-A might be effective for treating adolescents because many of the problem areas addressed in IPT that relate to interpersonal difficulties correlated with adolescent depression (Santor and Kusumakar, 2001).

IPT theorists argue that IPT goals closely mirror the developmental needs of adolescents and therefore, the use of this treatment modality with adolescents may be appropriate (Moreau, et al. 1991).

There are a few other characteristics of the IPT model that have been argued as reasons to modify this method for depressed adolescents (Moreau et al., 1991). First, the short-term nature of this treatment has been identified as potentially useful when working with adolescents who are generally hesitant to be in therapy or to stay in therapy for an extended period of time (Moreau et al., 1991). Also, IPT's focus on current interpersonal issues has been suggested as being effective for work with adolescents who are commonly concerned with dealing with present here and now issues rather than past or future issues (Moreau et al., 1991). IPT's focus on present interpersonal troubles and arguments has been recommended to be appropriate for depressed adolescents who are often times dealing with interpersonal conflicts at home, in school, and with friends (Moreau, et al., 1991). Finally, because adolescence is a catalyst to making decisions related to future career goals, education, and romantic relationships, proponents of IPT theory suggest that IPT is appropriate and well-timed for adolescents who are in need of identifying and overcoming interpersonal problems (Moreau et al., 1991). All of these rationales have led individuals in the field of IPT to develop and test the efficacy of IPT-A with depressed adolescents.

Description of IPT-A

The following section is an overview of an article by Moreau et al. (1991), which discusses the modifications made to IPT for work with depressed adolescents.

Moreau et al., (1991) assert that the goals of IPT-A closely mirror the goals of IPT for depressed adults. Like IPT, IPT- A seeks to identify and change interpersonal problem areas associated with the onset of the adolescent's depression as well as alleviate depressive

symptomology. However, a fifth problem area has been added to IPT-A that meets the developmental concerns and issues of many depressed adolescents. The fifth problem area added is the single-parent family. This problem area was added because of the frequency of single-parent families among depressed adolescents and because of the necessity to address the conflicts can result from a parent's absence in the family.

Moreau et al. (1991) also emphasize that IPT-A has also been designed to meet the specific developmental needs of adolescents. Issues addressed in IPT-A are specific to the concerns and issues that adolescents face. Some of the issues identified in IPT-A include individuating from parents, peer pressures, romantic relationships, experiences with the death of someone that the adolescent was personally close to, and issues of control and authority with parents.

Three treatment phases are identified by Moreau et al. (1991) as a part of the IPT-A model. These phases include the initial, middle, and termination. During the initial phase, the goals are to establish a contract for treatment, deal with the depressive symptomology, and to identify the problem areas that contributed to the onset of the depression. At this time that evaluations for drug abuse and suicidal ideation should be made, because of the high comorbidity of these problems with adolescent depression. Parents may be brought into therapy in the initial sessions to be educated about their child's diagnosis, which should include information about its treatment, course, and prognosis. Contacts between the counselor and the adolescent's school may also be made at this time so that the counselor can educate the adolescent's teachers about the relationship between the adolescent's depression and his or her functioning in school. In order to keep adolescents from withdrawing because of their depression and to keep up the support of the parents, the depressed adolescent is also given the "sick role" In giving the adolescent the sick role the counselor encourages the adolescent to continue participating in all

of their normal activities. However, the counselor also suggests to the adolescent and their parents that the adolescent may not be able to perform in all activities at the level he or she did prior to becoming depressed. The sick role is given to encourage the adolescent to continue participating in his or her normal activities and to prevent parents from becoming overly impatient or critical with the adolescent when they are not performing in these activities like the may have been prior to the depression. During the first four weeks of treatment, the adolescent is encouraged to check in with the therapist by telephone as needed and vice versa. These phone contacts are designed to support and encourage the adolescent in engaging in the therapeutic process, establish trust between the counselor and adolescent, and can also serve to encourage the adolescent's participation in outside activities with his or her recovery by serving as a substitute for counseling sessions. When there is a contract for treatment, when a diagnosis has been given, and when the problem areas have been identified and explained to the client, the initial phase of IPT-A is completed.

Moreau et al. (1991) identify interpersonal problem areas as the focus of the middle phase of IPT-A. The main goal of the middle phase of IPT-A treatment is to associate the interpersonal problem areas that were identified in the initial phase to the depressive symptomology currently being experienced by the adolescent. There are five interpersonal problem areas that may be examined during this time: grief, interpersonal role disputes, role transitions, interpersonal deficits, and single-parent families. The focus of these interpersonal problems areas have been modified to meet the developmental needs and issues of depressed adolescents.

Moreau et al. (1991) emphasize that when working with adolescents who are depressed, issues related to the death of a parent are often the focus of resolving interpersonal problems related to grief. The goals of dealing with grief with adolescents who are depressed have been

modified in the IPT-A model. The goals of dealing with problem area of grief include helping the adolescent deal with atypical grief and helping the adolescent cope with grief to prevent future depression.

Interpersonal role disputes are identified by Moreau et al. (1991) as common to the developmental issues of adolescents and may occur with parents over issues of sexuality, power, finances, and morals. Given the nature of these issues and the frequent involvement of parents in these issues, interpersonal role disputes are treated differently in IPT-A than in IPT. The treatment of role disputes with adolescents often involves bringing in the parents to discuss role disputes and to make negotiations about the relationship.

Moreau et al. (1991) also identify role transitions as another frequent problem area for depressed adolescents. There are some role transitions that are common to the developmental levels of adolescents. Some of the transitions that can prove problematic for adolescents include the initiation of romantic relationships, puberty, parting from parents and family, and the transition into work or higher education. Problems can arise in this area when the adolescent is unable to cope with the role transition or when the parents are unable to handle the new role of their child. If the parents are involved in the adolescent's struggles with role transitions, then they may also be included in some of the counseling sessions. The counselor's function in these sessions would be to help the family adjust to the adolescent's new role and to illicit support and encouragement from the parents in the adolescent's attempts to adjust to his or her new role. Counselors working with adolescents who are experiencing problems with role transitions might also help the adolescent to process his or her old role and feelings associated with it and identify why the transition is necessary.

Moreau et al. (1991) view interpersonal role disputes as being particularly important to address during the adolescent years because these deficits can have a great impact on the adolescent's achievement of developmental tasks. Developmental tasks that can be impacted by the adolescent's interpersonal deficits include making friends, beginning romantic relationships, forming social ties, and making choices about romantic commitment, vocation, and sexuality. Lack of interpersonal skills may lead to adolescent becoming socially isolated from his or her peers, which can initiate low self-esteem and despair. Counselors who are employing the IPT-A model to treat adolescents with problems in this area may use role-plays to help adolescents identify their interpersonal deficits and to help them practice new skills. Asking adolescents to practice new behaviors outside of counseling sessions may also help adolescents to generalize their new skills to other situations.

Moreau et al. (1991) also identify single-parent homes as another common problem are for many depressed adolescents. There are several reasons why an adolescent might be living in a single-parent home. Some of these reasons include divorce, separation, imprisonment, births out of marriage, and the death of a parent. IPT-A has developed six treatment goals for addressing this problem area with adolescents. First, the counselor helps the adolescent recognize the impact that the exit of the parent had on his or her life. Secondly, the counselor helps the adolescent process his or her feelings of bereavement, rejection, desertion, and/or punishment that resulted from the leaving of the parent. Next, the counselor helps the adolescent process his or her hopes for a relationship with the missing parent. Developing an effective relationship with the remaining parent is also a goal when working with adolescents. Also, if possible, the counselor may help the adolescent reestablish a relationship with the absent parent. Finally, the counselor helps the adolescent understand the permanence of the situation.

Moreau et al. (1991) state that the termination should be discussed throughout the counseling process. During the termination session the counselor and adolescent process what has occurred in counseling, discuss possible areas that could cause future problems for the adolescent, and explore problem-solving strategies related to those areas. IPT-A also includes considerations for termination that are specific to working with adolescents. These considerations include terminating work with family members that have been involved in the counseling process and discussing with the family members changes in family interactions that have occurred as a result. Termination in the IPT-A model also includes discussion of symptoms and conflicts within four categories. These categories include symptoms related to the depression, secondary symptoms, areas of conflict that are lasting and represent pervasive personality patterns, and areas of discord between the adolescent and his or her family. The family and adolescent must also be educated about the possibility of a recurrence of symptomology for a short time after counseling has been terminated and indications that suggest future treatment may be warranted for the adolescent.

Additional information about the use of IPT-A with adolescents who are depressed can be found in Interpersonal Psychotherapy for Depressed Adolescents by Laura Mufson, Donna Moreau, Myrna Weissman, and Gerald Klerman.

Outcome Studies

From 1994 to the present, several outcome studies have been completed on the use of IPT-A with depressed adolescents (Mufson et al., 1994; Mufson & Fairbanks, 1996; Mufson et al., 1999; Santor & Kusumakar, 2001). Although the results of these studies have been promising, much more empirical attention needs to be given to this area. The empirical studies that have been done to date have several design flaws that need to be addressed in future research. The ensuing discussion will provide an overview of these studies, their outcomes, and limitations.

Mufson et al. (1994) did a phase I and phase II study of IPT-A with depressed adolescents. The phase I study was a preliminary study designed to try the therapeutic techniques of IPT-A with depressed adolescents and to highlight areas that needed revision based on the results. The population sample for this phase I study was small, consisting of five adolescents who were classified as having major depression, depression not otherwise specified, dysthymic disorder, or adjustment disorder with depressed mood. The diagnoses of these adolescents were made according to the criteria outlined in the *DSM-III-R*. The first author of this study was also the therapist applying the IPT-A treatment to the participants. No assessment measures were used in this phase I study to monitor treatment effects. Instead these cases were evaluated clinically for regularity of appointments, amount of sessions attended, length of therapy, and temperament after the conclusion of therapy. Based on the clinical evaluation of these cases, several modifications were made to the IPT-A treatment model. It was after this study that the authors added the single-parent family as an interpersonal problem area. Counseling sessions were modified to meet the developmental and contextual concerns of adolescents. Discussions of parental and cultural conflicts were therefore added to address issues of concern for adolescents. The length of therapy was shortened from sixteen weeks to twelve weeks and short telephone sessions were also added. Although this study was designed to help the authors make adjustments and changes to the IPT-A treatment manual, there were some design flaws in this initial study. The sample was extremely small and consisted of all female adolescents. Studies designed to solidify the treatment guidelines for a particular therapy should utilize a larger and more diverse population so the uses of the treatment can be generalized to a larger population. This study also used only one therapist. Therefore, it is indistinguishable whether or not the treatment effects were due to the application of the IPT-A treatment or the therapeutic skills of

the therapist. Also, given the demographic makeup of participants, it is unclear if the modifications made to the IPT-A model apply to just the treatment needs of female adolescents, or if the modifications made can be effective when working with a male adolescent.

Moreau et al., (1994) phase II study was designed to test the IPT-A treatment manual in an open clinical trial and to make adjustments to the manual as a result of the clinical trial. Again, this study was small and consisted of fourteen adolescents who met the same diagnoses criteria as in the phase I study. Participants in this clinical trial attended twelve therapy sessions that were conducted by a child psychologist (also the first author of the article). This study did utilize specific assessment measures for evaluating the impact of this therapy on the participants. The results of this study indicated that there was a substantial reduction in depressive symptomology and improvement in the general functioning of the participants. At the conclusion of the study, none of the participants met the criteria of the *DSM-III-R* for any depressive disorder. However, there were some noteworthy limitations to this study. Again, the sample size was small and consisted of mostly female adolescents. There were only two males included in this study. The participants in this study were mostly Hispanic with three participants being of African-American origin. Given the demographic makeup of participants in this study, it is unclear whether or not the treatment effects would be valid for other populations such as Caucasian male adolescents. Another limitation of this study was that the therapy was conducted by only one therapist, which leaves open the question of whether or not the treatment effects were a result of the therapist's skills or the actual IPT-A treatment. Finally, there was no control group in this study. It is not known whether or not the depression would have improved without having any therapeutic treatment.

Mufson and Fairbanks (1996) conducted another study on the effects of IPT-A with depressed adolescents. Unlike the previous two studies, however, this study considered the relapse rates of those adolescents who had previously received IPT-A therapy for their depression. The participants for this study were drawn from the Phase II study discussed earlier. Of the fourteen original participants, only ten elected to participate in this study. All of the participants in this study were female with seven individuals of Hispanic origin and three African-Americans. Assessment measures were used to measure current depressive symptomology and social functioning. The results of this study suggested that the treatment effects from the initial IPT-A therapy were maintained over a one-year period directly following the conclusion of therapy. Although the participants overall impairment appeared to be worse at follow-up, the authors of the study concluded that this finding was probably not valid because of methodological problems. None of the participants in this study had dropped out of school, gotten pregnant, or had problems with the law in the year following the completion of IPT-A therapy. The results of this study also indicated that the participants were experiencing better relations with their families. Like the previous two studies, this study also had limitations. Again, the sample size was small, included no males, and did not represent a variety of cultural backgrounds. Without further research, these treatment effects could not be generalized to adolescents of other demographic backgrounds. Also, because this was a naturalistic follow-up study, there was no control for other treatment the adolescents may have had after the completion of the IPT-A therapy. It is unclear whether or not the results of this study were due to the IPT-A treatment effects or other treatments that may have been utilized in the year following the completion of IPT-A therapy. Finally, there was no control group in this study. Therefore, it is not known

whether or not these findings would have been similar in adolescents who did not receive IPT-A treatment for depression.

Mufson et al. (1999) completed an outcome study of the efficacy of IPT-A therapy with depressed adolescents. There were a total of forty-eight participants included in this study all of which met the *DSM-III-R* criteria for major depressive disorder. Again, the majority of participants in this study were of Hispanic background and were female. However, this study did utilize a control group. The control group received clinical monitoring biweekly for thirty minutes whereas the IPT-A group were seen weekly for twelve weeks. All of the therapists in this study were trained and supervised in the IPT-A treatment method. The results of this study indicated that IPT-A treatment in comparison with clinical monitoring was effective in diminishing depressive symptomology and increasing the social functioning of participants in this study. However, many of the individuals who were assigned to the clinical monitoring group left the study before it was completed. The attrition rate of the clinical monitoring group indicates that IPT-A may be more effective in treating adolescent depression than a biweekly review of the adolescent's symptoms. Participants in the IPT-A group also reported increased abilities to problem solve at the completion of treatment. While the results of this study are promising there are, however, limitations. Although the sample size of this study was much larger than the previous sample sizes in studies of IPT-A, the sample size (N=48) was still relatively small. The participants in this study were again mostly Hispanic, females. Therefore, the results of this study cannot be generalized to adolescents of other demographic backgrounds. This study only considered the use of IPT-A with depressed adolescents, and therefore it is impossible to generalize the results of this study to other adolescents with different diagnoses. This study also used therapists who had received formal training in using the IPT-A treatment

model. Additionally, the therapists in this study were also receiving supervision from individuals who were highly trained in IPT-A themselves. Therefore it is unclear whether or not the results of this study would be found with therapists or counselors who had not received formal training or supervision in IPT-A. There was also a significant attrition rate in the control group, which makes it difficult to compare results to the treatment group with so little individuals left. Moreover, the nature of the control group itself was troublesome. Participants in the treatment group spent more time with their therapists and therefore may have developed a more effective therapeutic relationship than the individuals in the clinical monitoring group. The control group received no therapy, just clinical monitoring. It is unclear whether or not the treatment effects are due to the time spent in therapy and the development of a therapeutic relationship or receiving IPT-A treatment. Finally, social functioning was measured by self-report and therefore is not substantiated by traditional assessment measurements.

One of the more recent studies that has been done on IPT-A considered the use of IPT-A with adolescents who were moderately to severely depressed (Santor & Kusumakar, 2001). Additionally, this study used therapists who did not previously have formal skills or training in using the IPT-A treatment model. Participants in this study included twenty-five adolescents. Of these twenty-five participants, twenty-three were female. All of the participants in this study met the criteria for major depression as outlined in the *DSM-IV*. Nine therapists were used in this study and all completed a three-day instruction seminar on the utilization of the IPT-A treatment protocol. All of the participants in the study received twelve IPT-A treatment sessions with one of the nine therapists. Several assessment measures were used to evaluate participant progress throughout the study. The results of this study suggested that depressive symptomology was significantly reduced and global functioning was increased after the participants received IPT-A

treatment. Therefore, it is suggested that IPT-A treatment might be effective for adolescents who are moderately to severely depressed. This study also indicated that individuals who have had little or no prior experience using the IPT-A method could successfully apply IPT-A therapy. Although the results of this study are promising there are, however, limitations. Again, the participants in this study were predominantly female, which leaves open the question of whether or not these treatment effects would be found in depressed male adolescents who were treated with IPT-A. Also, the participants in this study had comorbid diagnoses, and the treatment effects indicated in this study may be specific to one of the other diagnoses rather than the depression. Because there was no follow-up data collected, it is unclear how long the treatment effects will last. Therefore, this study cannot predict rates of relapse after receiving IPT-A treatment.

Conclusions and Recommendations

IPT was originally developed as a short, time-limited therapy to treat adults diagnosed with major depression (Mufson et al., 1991). However within the last decade, IPT has been adapted for use with many different populations and different clinical diagnoses (Weissman & Markowitz, 1994). IPT-A is one of the modifications that has been made to IPT and is designed to meet the developmental and contextual issues of depressed adolescents (Mufson et al, 1991). Recent empirical investigations of the use of IPT-A with adolescents who are depressed have demonstrated encouraging results (Mufson et al., 1994; Mufson & Fairbanks, 1996; Mufson et al., 1999; Santor & Kusumakar, 2001). However, these participants in these studies have been small and not demographically diverse (Mufson et al., 1994; Mufson & Fairbanks, 1996; Mufson et al., 1999; Santor & Kusumakar, 2001). As a result, the empirical findings of these studies cannot be generalized to populations of depressed adolescents from other demographic

backgrounds. Treatment effects in these studies are also unclear based on research design problems (Mufson et al., 1994; Mufson & Fairbanks, 1996; Mufson et al., 1999; Santor & Kusumakar, 2001). It is difficult to discern whether or not the treatment effects were due to the actual IPT-A treatment or other factors that were inherent in the research design.

The results of the initial empirical investigations into the use of IPT-A with depressed adolescents are encouraging. However, future empirical investigations need to address the limitations of these previous studies if practitioners are to have confidence in the ability of IPT-A to treat depressed adolescents. Future empirical investigations should utilize a larger and more demographically diverse participant sample. Studies that include more males and individuals from other cultural backgrounds are needed if counselors are to have confidence in the use of IPT-A with other adolescents of different demographic backgrounds. Future empirical investigations may also want to further examine whether or not counselors need a great deal of training in IPT-A for it to have successful treatment effects with depressed adolescents. IPT-A also needs to be examined in comparison to other methods of treatment for adolescent depression. Studies that compare IPT-A treatment to pharmaceutical treatment or that examine the use of pharmaceutical treatment along with IPT-A might be helpful in discerning what treatments could be most effective for treating adolescent depression. Additional studies are also needed to investigate the long-term effects of IPT-A treatment with depressed adolescents. This is especially important given data that suggests adolescent depression often leads to depressive episodes in adulthood (Moreau et al., 1991). Finally, many of the studies that have been completed to date on IPT-A have examined its effects with adolescents who are only diagnosed with depressive disorders. Adolescents who had comorbid diagnoses were often times excluded from the studies (Mufson et al., 1994; Mufson & Fairbanks, 1996; Mufson et al., 1999;). Given

that adolescent depression is often comorbid with other clinical diagnoses, additional empirical attention needs to be given to the use of IPT-A with adolescents who have a depressive diagnosis in conjunction with another *DSM-IV* diagnosis.

Given the promising results of initial empirical investigations into the efficacy of IPT-A with adolescent depressive disorders, the need for future research is substantiated. Future research could clarify IPT-A's treatment effects with adolescents of differing demographic backgrounds, compare the efficacy of IPT-A with other treatments for adolescent depression, clarify whether or not IPT-A can be used by novice counselors, and could demonstrate IPT-A's efficacy with adolescents with comorbid diagnoses.

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