A Group Adaptation of Interpersonal Psychotherapy for Depressed Adolescents

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This paper presents an overview of the adaptation of Interpersonal Psychotherapy for depressed adolescents (IPT-A) to be delivered in a group format (IPT-AG) for the treatment of depressed, nonbipolar outpatient adolescents. The model has been modified to address the challenges of working with several adolescents in a group context. It takes advantage of the group as a laboratory environment for experimenting with new ways of communicating and interacting with others. The IPT-AG manual, described in this paper, provides guidelines for working with multiple interpersonal issues and keeping the group discussion relevant to the group as a whole. These adaptations are discussed in the context of the interpersonal framework with respect to each phase of treatment. Preliminary data about the feasibility and acceptability of conducting IPT-AG are discussed.

Depression is one of the most commonly diagnosed disorders among adolescents with a conservative prevalence rate by age 18 of 1.6% to 8.9% (1). The impact of depression on adolescent development is considerable in terms of disrupted academic progress as well as impairments in social, career, and identity development. Specific impairments can include school failure, substance abuse, suicide attempts, and antisocial behavior (2). Depressed adolescents are a largely underserved population that faces multiple barriers to receiving treatment. There is a pressing need for more efficacious, cost-effective, and accessible treatments for adolescent depression. This paper presents a time-limited group treatment for adolescent depression. While two psychosocial treatments (3, 4) have been shown to be efficacious for treating adolescent depression, only one has been

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adapted for use in a group modality (5). It is important to know if IPT-A also can be efficacious if delivered in a more cost-effective group modality that provides an ideal context for adolescents to practice interpersonal skills and interact with peers with similar difficulties. This paper presents our group adaptation of IPT-A.

TREATMENTS FOR ADOLESCENT DEPRESSION

Two types of psychosocial treatments have been shown to be efficacious for the treatment of adolescent depression: cognitive-behavior therapy (CBT) and interpersonal psychotherapy (IPT-A). CBT has demonstrated efficacy as an individual (3) and group therapy treatment (5–7). Interpersonal psychotherapy has been demonstrated to be efficacious as an individual psychotherapy for depressed adolescents (4, 8). Medication, specifically selective serotonin reuptake inhibitors (9–12), also has been shown to be efficacious in treating adolescent depression.

Interpersonal Psychotherapy

Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) is a time-limited (12 session) individual weekly intervention adapted from interpersonal psychotherapy for depressed adults (13). The goals of IPT-A are to decrease depressive symptoms and improve interpersonal functioning by improving communication and other interpersonal skills. IPT-A posits that, regardless of etiology, depression occurs in an interpersonal context. Interpersonal problems can play a critical role in the development and sequelae of adolescent depression (14, 15). IPT-A has been efficacious for adolescents in part because it focuses on those issues most important to this developmental stage. Improving the interpersonal context will help change the course of the depressive episode and result in recovery. Interpersonal difficulties are conceptualized as fitting into one or two of four problem areas: grief, interpersonal role disputes, role transitions, and interpersonal deficits. The therapeutic focus is on the current interpersonal issues rather than intrapsychic events. The techniques most commonly used in IPT-A include psychoeducation, encouragement of affect expression, communication analysis, role playing, and interpersonal problem-solving.

Group Psychotherapy

Although there is a relative paucity of randomized controlled trials of group interventions to treat adolescent depression (16), group therapy is often believed to be an effective treatment. Group therapy puts the adolescent in contact with peers who can provide support for each other,

and provides immediate opportunities to practice new skills. Specific group-therapy goals can include: (a) enabling group members to perceive the similarity of their needs, (b) generating alternative solutions to particular conflicts, (c) learning more effective social skills, and (d) increasing awareness of others' needs and feelings (17). These goals are consistent with the goals of interpersonal psychotherapy.

Rationale for Adapting IPT-A as a Group Treatment (IPT-AG)

The impetus for adapting IPT-A as a group treatment arose from our clinical experience witnessing adolescents' struggles to practice new communication and problem-solving skills on their own between sessions. Their frequent queries about whether other adolescents had similar problems also led to the possibility of bringing these adolescents together to decrease their isolation with their difficulties. Group therapy offers an immediate context in which the adolescents could see that they are not alone in their experience and together can practice new interpersonal interactions. In individual therapy, the patient is dependent upon the therapist to motivate and encourage more active engagement in problem-solving and the therapist has only the patient to generate possible solutions to the presenting problems. In contrast, group therapy provides the patient with peers who have similar difficulties and who may be empowered by the collaborative effort of the group. More specifically, group therapy allows its members to realistically role play different communication skills, obtain validation of their experiences and receive advice from peers on what to do.

Another important reason to adapt IPT-A for group is the potential cost-effectiveness of treating adolescents in a group and its feasibility in other settings such as school-based health clinics, community mental health, and primary care clinics. School-based health clinics and mental health clinics in general are understaffed for the patients' needs. Group therapy allows staff and clinics to meet the needs of more patients without additional personnel or more clinical hours. If IPT-AG proves to be efficacious and acceptable to depressed adolescents, it will provide an important treatment option to overburdened staff and clinics, particularly in underserved settings.

Wilfley and colleagues discuss in their book, *Interpersonal Psychotherapy for Group* (18), that the challenge in adapting IPT to a group format is to maintain the intensive focus on an individual member's problem area while simultaneously creating relevance for other group members. This therapeutic process allows the group members to obtain therapeutic

benefit from exploration of someone else's problem, not just their own. Each group member receives individual attention and also gains from discussion of others' difficulties. We have tried to maintain this balance by (a) including individual initial sessions prior to the group, at midpoint and completion of the group; (b) conducting the interpersonal inventory during the initial individual sessions; and (c) explicitly stating how the adolescents' own issues will be addressed sufficiently within the group. These group strategies are discussed more fully within the core of the manual.

The purpose of this paper is to describe the specific modifications of IPT-A for application in a group setting with depressed adolescents (IPT-AG). We provide a general overview of the main tenets and procedures for the treatment intervention.

DESCRIPTION OF IPT-AG

Developing the Manual

To facilitate the development of the manual, three pilot groups of IPT-AG were conducted with groups of depressed Latino and African American adolescents seeking treatment at a university hospital. Members carried diagnoses of adjustment disorder with depressed mood, major depression, dysthymia, and depression disorder not otherwise specified. Each group had four to six adolescents although a maximum of eight could be included in the group. Experienced clinical psychologists trained in IPT-A conducted the therapy sessions. The psychologists were supervised by two of the authors (LM and TG) and sessions were videotaped. These experiences served as the basis for adapting the manual for IPT-AG to be used to train therapists and to standardize the treatment to allow replication and refinement in ongoing and future studies. For the pilot groups described in this paper, no formal adherence measures were administered, however, all sessions were videotaped and reviewed in weekly supervision to ensure adherence to the treatment manual. Adherence measures have been created for use in the pilot clinical trial. This paper summarizes the manual to date (19). The modification for group should be read in conjunction with the manual for individual treatment of depressed adolescents (20).

Treatment Goals

The primary goals of group interpersonal psychotherapy for depressed adolescents (IPT-AG) are: (a) to reduce depressive symptoms, (b) to improve interpersonal functioning, and (c) to increase adolescent and parental understanding of the nature of depression in adolescence. A

central component of the treatment is educating the adolescents as well as their parents/families that they have an illness that affects functioning in major life arenas. Additional goals for the group format are to increase the adolescents' experience with positive social interaction, reduce social isolation, and increase positive resolution of interpersonal difficulties in a supportive group setting.

Frequency and Timing of Sessions

The group intervention protocol differs in several ways from that of the individual treatment. The group intervention consists of a combination of individual and group therapy sessions over 14 weeks. The treatment begins with two intensive 90-minute pre-group individual sessions with parent and adolescent, followed by twelve 90-minute group therapy sessions. The rationale for the pre-group sessions is that the work of the initial phase needs to be done in an individual format in order to obtain sufficient background information on the particular adolescent's depressive syndrome and significant relationships. Middle phase work (understanding the problem area, learning and practicing skills needed to improve the identified relationship) takes place largely in the group setting, as does the work of termination. Treatment, also includes one mid-treatment family collateral session with each adolescent and parent and culminates with a family collateral exit session with each adolescent and parent.

Parent Involvement

If possible, parents are involved throughout the duration of treatment to facilitate achievement of the treatment goals. In the two pre-group sessions, the parent participates in order to learn about depression and how it affects his/her child, to give input on the history of the problem, to review the treatment parameters, and to obtain parental commitment to support the adolescent's participation in the intervention.

During the middle phase of treatment, it is hoped that the parent will support the adolescent's attempts at new ways to communicate and problem-solve interpersonal situations. To encourage the delivery of support, the parent(s) is asked to participate in a collateral session with the adolescent and therapist to review progress to date and revise or refocus specific treatment goals for the remaining sessions of the group. In addition, if the adolescent appears to be having difficulty implementing new strategies and skills at home, the mid-group session provides an opportunity for the adolescent to practice newly identified skills with his or her parent in a supportive setting. The goal of the interaction is to help facilitate a change in the quality and style of their interactions at home if

that is the identified problem area, or to support the adolescent's work in another identified area.

The parent is invited back for another session with the adolescent and therapist at the conclusion of treatment. The goal of this session is to review the adolescent's progress and current clinical status, and to discuss the need for further treatment, the possibility of future episodes and how to manage them. The number of collateral sessions is limited because clinical experience suggests that adolescents frequently prefer to work individually. They are more resistant to significant parental involvement, such as in family therapy, as often are parents. Our experiences suggest that much of the work can be accomplished by working with the adolescents in the group and asking them to apply these skills at home with collateral sessions to help facilitate the work at home with the family.

PREGROUP INDIVIDUAL MEETINGS

Pregroup Meeting 1

The work of the initial four-session phase of the individual IPT-A treatment is conducted in the initial two 90 minute pregroup individual sessions of the group IPT-A treatment. The tasks for the first pregroup session are: (a) confirming the depression diagnosis, (b) educating both the adolescent and the parent/caretaker about the nature of depression and possible treatments, (c) assigning the limited sick role, and (d) beginning the interpersonal inventory. The therapist should begin this first pregroup session with a brief meeting with both the adolescent and caretaker. The therapist should explain the goals of this phase of treatment and explore areas of concern for the parent and adolescent, while also paying attention to patterns of interaction.

Introduction and Psychoeducation about Depression

After confirming the depressive diagnosis and identifying the adolescent's specific symptoms, the therapist provides the adolescent and parent with basic information about depression, including symptoms and their sequelae, prevalence, prognosis, and treatment options. The therapist teaches the adolescent to rate his/her depression using a 1–10 depression rating scale so that therapist and adolescent will be able to monitor changes in mood associated with interpersonal events or changes.

Limited Sick Role

The therapist must also give the adolescent a limited sick role that encourages the adolescent to try to maintain a predepression level of activity while acknowledging how difficult this may be to achieve. It is

conceptualized in the same manner as in the individual treatment (21). The limited sick role lessens daily life pressures during the initial phase of treatment. There is an important secondary benefit to assigning a limited sick role specific to work with depressed adolescents. Parents often misinterpret symptoms of clinical depression to be character flaws. It can be a great relief for parents to learn that decreased school performance is due to a medical illness and its associated symptom of decreased energy and concentration rather than laziness. Parents are asked to encourage the adolescent's attendance at school, while understanding that decreased performance stems from depression, not oppositional behavior. The adolescent and parent are told that the adolescent's performance of these activities will improve as his/her mood improves.

After completing this discussion, the therapist should then proceed with the adolescent alone to conduct the tasks of the initial phase, inviting the parent back briefly at the end of the first pregroup meeting.

Interpersonal Inventory

The next step in this initial 90-minute pregroup meeting is beginning the interpersonal inventory. An interpersonal inventory is a clinical interviewing process in which the therapist and patient review the patient's significant relationships, looking for strengths as well as problems, adaptive and/or maladaptive communication and problem-solving skills. The interpersonal inventory links relationship events and behaviors to depressive symptoms and identifies relationships in need of improvement. The most significant relationships are examined for positive and negative aspects, desired changes in the relationships, and disputes, losses, and transitions within the relationships that may be related to the depressed mood. Strengths and positive relationships are identified as a foundation upon which to build new interpersonal skills.

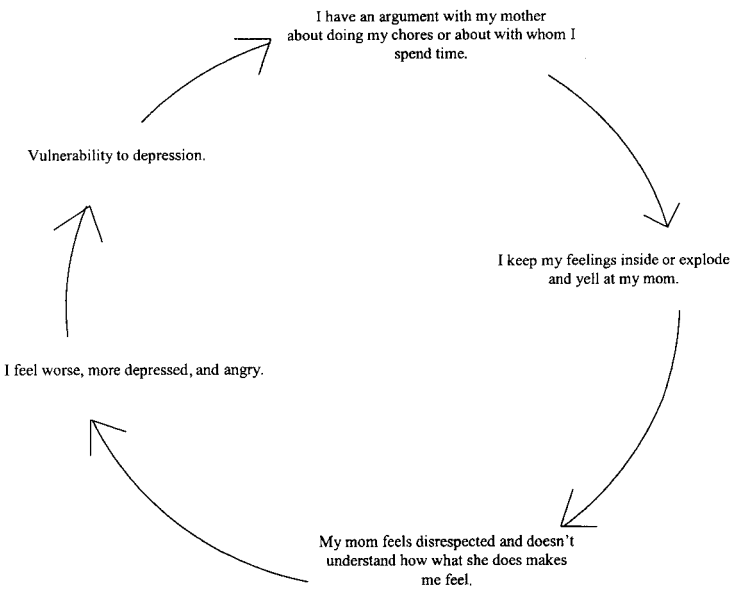
At the end of the first pregroup session, the therapist meets with the parent and adolescent to: (a) describe the adolescent's depressive symptoms with special attention to suicidal ideation to ensure awareness of any suicidal thoughts that need monitoring while participating in the group, and (b) arrange a meeting to finish the interpersonal inventory. Adolescents are included in the group if they have passive ideation without intent or plan. In such cases, parents are alerted to the ideation and the seriousness of the adolescents' depression and home precautions are reviewed. Parents also are instructed to contact the therapists at any time if they feel their adolescent appears to be feeling worse. Group goals and therapist expectations for the adolescent and parent are presented briefly

for the first time and are reviewed again at the conclusion of the second pregroup meeting. Before ending this session, the therapist establishes an emergency contingency plan with the parent and adolescent, should the depression worsen. This plan stipulates that the adolescent must inform a responsible adult of the increased depression, and that the adolescent and adult will contact the therapist to determine what emergent action, if any, is needed. In the event that the therapist cannot be contacted, the adolescent and adult should proceed directly to an emergency room for further evaluation.

Between the first and second pre group meetings, the therapist creates a tentative depression circle (see Figure 1) that describes the specific interpersonal events precipitating depression along with the adolescent's interpersonal responses that signal his/her depression. This is an effective interpersonal template for each adolescent's depression. The adolescent's goal in group will be to change this maladaptive interpersonal pattern using specific interpersonal skills. The therapist also creates an initial depressive portrait that presents the adolescent with an individualized constellation of depressive symptoms that is used to track the depression throughout the course of the group. Special attention is paid to hallmark

Figure 1

JOYCE'S CIRCLE OF DEPRESSION.



symptoms, which first indicated the emergence of a depressive disorder rather than a transient sad or angry mood.

PreGroup Meeting 2

The tasks of the second pregroup session are: (a) completing the interpersonal inventory, (b) setting a treatment contract, and (c) reviewing the tentative depressive circle. The therapist will have formalized a depressive circle for the adolescent and examined how the adolescent's response to interpersonal events maintains a depressive state. The therapist highlights common themes or problems in the adolescent's relationships, and together with the adolescent chooses one of four interpersonal problem areas that will be the focus of treatment. The four problem areas are: grief, interpersonal role disputes, role transitions, and interpersonal deficits. Briefly, the problem areas focus on issues of: (a) loss due to death of a loved one, (b) conflict in significant relationships due to problems in understanding their roles in the relationship and/or difficulties communicating in the relationship, (c) problems in transitioning from an old role to a new role and social circumstance that creates difficulties for the adolescent and/or his/her family, and (d) problems in increasing one's support system and developing new relationships to decrease social isolation. A detailed discussion of the problem areas is beyond the scope of this paper, but can be found in the IPT-A manual (20). Finally, when possible, the therapist meets briefly with both parent and adolescent to review facts about depression, to assess whether they are adhering to the limited sick role, and to educate them about rules and expectations for group. The therapist may share the adolescent's interpersonal problem area with the parent after first obtaining the adolescent's consent to do so. While it is not required to involve the parent in the second pregroup session, positive parental engagement in treatment may facilitate the adolescent's involvement and ability to make changes in his significant relationships.

THE GROUP INTERVENTION

It is beneficial for the therapists to be aware of the general phases of group therapy (engagement, differentiation, and termination) so they will be able to assist the adolescents in understanding the feelings and concerns they may have at different stages of the group, as well as to modulate the process to insure development of a healthy cohesive group. To prepare for the group, the therapists emphasize that the focus on each individual's specific problems will be more limited than in individual treatment, and that the focus will be on the common interpersonal elements of their

difficulties and the strategies that will help them both individually and as a group. The stages of group process have been described in detail elsewhere (21) and have been specifically related to the work of interpersonal psychotherapy by Wilfley and her colleagues (18).

INITIAL PHASE (SESSIONS 1–4)

There are several important tasks to be accomplished in the initial group session: group introductions, discussion of adolescents' use of the group to learn and practice skills with peers, and collaborative establishment of group rules. Group rules specifically deal with such issues as confidentiality, socializing outside the group, mutual respect for group members, how to give and use feedback in the group, time commitment to the group, and rules regarding lateness or canceling of sessions. Agreement about the group rules is crucial in establishing the necessary atmosphere of trust and confidentiality needed for the interpersonal work of the group that is to follow. Lastly, all group notebooks, used to track progress during the course of treatment, are distributed to members and an overview of general session structure is provided.

Patient notebooks play an important role in group IPT-A: They contain cue cards with helpful prompts for adolescents to use during role play as well as each adolescent's depressive portraits and circles. Notebooks are the focus of an icebreaker activity during group session 1, as adolescents are given the opportunity to personalize them. They also are used to record intergroup interpersonal assignments for adolescents to practice between group meetings. Group members are encouraged to refer to their notebooks for help in identifying how their maladaptive responses to interpersonal events are linked with depressive feelings, such as sad mood, anhedonia, and irritability.

During the initial sessions, adolescents learn that each group will have a similar structure. Meetings begin with a reminder of remaining sessions and a brief check-in to track their depressive mood and symptoms using the depression rating scale provided in patients' notebooks. To review depressive symptoms, group leaders collect the adolescents' completed depression rating scales, and compare and contrast members' depressive symptoms, monitoring any worsening of symptoms that might need to be addressed. This is followed by a review of each member's problem area with attention to difficulties encountered during the previous week and highlighting commonalities among the group members. Each group ends with a summary of the main discussion points for that session and with preparation for the next week.

Once initial group tasks are accomplished, typically during the first group session and part of the second, the group shifts to an IPT-A focus. Subsequent group sessions concentrate on discussion of depressive portraits (individualized symptom lists) and depression circles (functional analysis of identified problem area(s)). This process allows adolescents to identify common elements of both their depression and relationship difficulties.

Specific tasks for group session two are: (a) re-introduce group members, (b) address any questions from previous week, (c) review group rules, (d) review depressive portraits and symptom checklists, and (e) begin discussions of interpersonal issues demonstrating communication analysis techniques. The therapists use the session to begin to demonstrate ways to dissect an interpersonal event, targeting communication breakdowns that have occurred and brainstorming different communication and/or problem-solving strategies to use. The precipitating event is always explicitly linked with depressive symptoms.

By session three, the group's weekly routine is established and remains constant until the final phase of treatment. After discussing symptoms and depression ratings and a brief week in review, each member presents a difficult interpersonal situation. Group leaders and members clarify interpersonal difficulties and identify ways in which the event could have happened differently. Members explore how this new interaction might feel for the targeted group member as well as themselves. New strategies are practiced and discussed as to how they might produce more favorable outcomes for many group members.

If an adolescent reports suicidal ideation during the group session, the group is immediately assured that the group leaders will manage the situation. One of the group leaders meets with the adolescent immediately following the group to assess level of suicidality and to determine whether the adolescent can safely return home. If the suicidal ideation is ongoing but passive and the adolescent strongly feels no action will be taken, the adolescent is typically referred for adjunctive individual therapy or medication. If there are safety concerns, the adolescent is withdrawn from participation in the group and is referred to a more intensive level of care, such as crisis intervention and possible hospitalization. The remaining group members are helped to understand and process any such events.

Therapist Tasks

Throughout the initial phase of group IPT-A, it is essential that group leaders work hard to identify and highlight areas of common experience

among group members, while at the same time pointing out differences. By careful attention to this developmental group process, leaders help to assure a cohesive and tolerant group climate, effectively setting the stage for the middle or *work* phase of treatment.

MIDDLE PHASE (SESSIONS 5–9)

The main goals for the middle phase of the treatment are to identify and to practice using new interpersonal skills and strategies which, when used successfully, will result in decreased depressed mood and improved relationships. The therapist must also continue to monitor depressive symptoms while increasing hopefulness that change will occur. By the middle phase of treatment, group members likely will have achieved a solid comfort level with each other and the group rhythm will be established. They have learned to recognize the ways in which they differ and to tolerate differences (work phase of group development).

It is the therapists' job to help each adolescent maintain focus on a manageable identified problem and, if necessary, expand the adolescent's focus to include a second problem area. The strategies used for this phase of treatment include: (a) facilitating the appropriate level of self-disclosure to assist in changing the behaviors/communications, (b) connecting individual members' situations to those of others in the group, (c) identifying and practicing new interpersonal skills within and outside of the group between sessions, and (d) encouraging observation of behavior within and outside of the group. The group leaders strive to keep morale and motivation high. Since groups consist of adolescents with different problem areas, the leaders' therapeutic work must emphasize generalizable interpersonal and communication strategies and skills, applying these to members' multiple specific problem areas. A challenge of the middle phase is ensuring that members have equal airtime, and not allowing more talkative adolescents to dominate to the exclusion of the other group members. It is equally challenging to address multiple problem areas in adolescents for whom this is necessary. During this phase, it remains important to continue to link the change in depression symptoms to adolescents' management of interpersonal events.

For a complete description of problem areas and strategies, the reader is referred to *Interpersonal Psychotherapy for Depressed Adolescents* (20). The problem areas are addressed similarly in the group modality as in the individual treatment except for the problem area of grief. Pathological grief can be difficult to treat in a heterogeneous group. Death of a loved one during adolescence can catapult the affected adolescent into a new

developmental phase that includes acute awareness of mortality, a developmental phenomenon uncommon to most adolescents. It is possible that this premature recognition of mortality can serve to separate the affected adolescent from peers in a way that is difficult to reconcile in a group setting and which may actually interfere with group cohesion, thus possibly precluding the working through of this problem area. Thus, it is advised to have a separate group for bereaved adolescents.

The "Work" of the Middle Phase

The bulk of the middle phase of the treatment is characterized by work on a selected focal area or areas. The group becomes an in-vivo interpersonal lab where adolescents can practice sharing their feelings in a constructive manner and hear feedback about themselves in a safe and supportive environment. Therapists must provide clarification and elucidation of conflicts by conducting a microanalysis of communication, while at the same time providing reassurance and support for the adolescents' tentative forays into new and more adaptive interpersonal styles. IPT-AG therapists continue to teach the adolescents specific interpersonal skills that can be applied to the different problem areas. Examples of skills include finding the right time to initiate an important discussion or negotiation, expression and communication of feelings in a positive constructive way, positive listening to others, learning to see another's perspective, and learning to negotiate and develop a compromise solution. The practice of these interpersonal skills in the group is aided by the use of visual cue cards with catchy slogans, such as "Strike while the iron is cold!," "Use 'I' statements!," etc. By using cue cards that are included in the IPT-AG notebooks, group leaders help adolescents to identify critical aspects of conflict resolution, such as timing and empathy. Throughout the life of the group, adolescents are encouraged to refer to their notebooks while doing role plays. Adolescents are given either the role of coach or participant. Coaches are instructed to hold up pertinent cue cards to help participants remember what approach may be most productive in the role-playing situation. To achieve greater interpersonal efficacy, adolescents are taught to use tactful guidance when coaching each other. In addition, adolescents learn increased empathy by giving each other direct, supportive feedback on maladaptive interpersonal styles.

It is often easier for adolescents to accept constructive, positive and, more importantly, negative feedback from each other than from a group leader. Developmentally, adolescents are still willing to accept adult influence but are increasingly gravitating towards peers for advice and

support. The opportunity to learn from both adults and peers is what can make IPT-AG so appealing to adolescents. Tactful questions posed by group leaders to the group at large as well as group leaders offering individual adolescents specific feedback and skills-training guide the adolescent in this process of interpersonal learning.

TERMINATION PHASE (SESSIONS 10–12)

The approaching end of treatment should not come as a surprise to the adolescents in the group. The group leaders should have discussed the length of treatment in the initial and middle phase, to serve as both a reminder of the time-limited nature of the relationship as well as a motivator to work hard for a finite period of time. Final group sessions are designed to give adolescents a chance to discuss their feelings about ending their relationships with the therapists, as well as about ending or changing the nature of their relationships with each other. The goal is to focus on bolstering their acquisition and successful use of new interpersonal strategies both within and outside the group.

The therapists emphasize the development of competence and independence rather than fostering a more dependent relationship. Group exercises are designed to give the adolescents the sense that they have acquired a skill they can apply successfully now and that they can continue to use in their interpersonal repertoire long after treatment has ended. Group members are helped to anticipate normal sadness (as opposed to depression) at the end of what, hopefully, has been a nurturing and supportive interpersonal growth experience.

Negotiating what the group members' relationship will be with each other posttreatment is a task unique to group therapy and the decision may vary with the different personalities of the group. It is an important opportunity for adolescents to practice ending relationships in a positive, self-affirming way rather than in an avoidant, self-destructive manner. The therapists' job is to help the adolescents recognize and weigh the benefits and risks of whatever decision they make about future contact and to allow the opportunity for group members to voice their concerns. The group's conclusion provides another opportunity for practicing effective communication and understanding the perspective of others in negotiating a resolution to an interpersonal issue.

Finally, the adolescents are encouraged to say a farewell to the therapists and fellow members. To recognize their hard work, the adolescents are given a certificate honoring their efforts and accomplishments in the group. Group members take their notebooks with them, to chart the

progress made in group, to help them remember hallmark symptoms of depression, to identify possible future episodes of depression before the impairment is too severe, and to provide a visual reminder of how to more adaptively negotiate interpersonal events.

Postgroup Interview Meeting

In the final postgroup individual meeting, the therapist reviews the adolescent's progress and discusses whether more work remains to be done in continuing treatment. Initially, this information is discussed with the adolescent and therapist alone, then with the adolescent's consent the parent is invited into the session. The therapist reviews progress made in group, solicits the parent's impression of gains made and discusses the need for continued treatment if this is indicated. The therapist also prepares the parent to tolerate the adolescent's possible sadness following the group's ending and educates the parent regarding the differences between normal sadness and the onset of another depressive episode. Each adolescent's "hallmark" depressive symptoms (symptoms which may be an early warning of an incipient depressive episode) are reviewed for a final time with the adolescent and parent, and plans are made to schedule a "booster session" if necessary. To date, research on booster sessions (3, 22, 23) has not demonstrated efficacy in preventing relapse. These studies conducted quarterly booster sessions (4 times a year) that may not be sufficiently frequent to have a preventative effect. More frequent boosters might be more beneficial. One study that provided six months of CBT continuation treatment did show a significantly lower relapse rate than CBT without the continuation phase (24). More research is needed on this question.

PRELIMINARY RESEARCH ON IPT-AG

Three pilot groups of four to six adolescents each were conducted to aid in the adaptation of the individual treatment manual for the conduct of the group and to provide preliminary information on the acceptability and feasibility of conducting IPT-AG. A chart-review study was conducted on one of the three groups. The patients ranged in age from 13 to 17 years and were Latino females from a low socioeconomic status urban community. For this particular group, six depressed female adolescents had been recruited from a hospital outpatient clinic. In order to be eligible for this group, members were required to be in adjunctive individual therapy. Measures were not collected during the group. A subsequent chart review of progress notes was conducted by an independent evaluator to determine

the effects of the group on depressive symptoms, as well as global functioning over the course of treatment. Five of the six charts were available for review by the independent evaluator. The average attendance rate for the group therapy was 90%. The attendance rate is similar to what has been found in studies of individual IPT-A (4, 25). We hypothesize that the structure, short-term nature, and interpersonal focus of IPT-AG is well received by adolescents and leads to increased attendance. Four of the six adolescents had perfect attendance. The adolescents reported an average of 6.5 symptoms of depression at baseline and 2 at termination on a DSM-IV depression symptom checklist. The mean initial Children's Global Assessment Scale (C-GAS) score was 49, increasing to a mean of 68 at termination. All of the adolescents attended school regularly, and there were no reports of pregnancy, involvement with the police or school failure. As a result of this chart review and the experience conducting two other groups, IPT-AG appears to be a feasible and acceptable treatment for depressed adolescents. Although it is unclear whether the clinical improvement in the pilot group was due to the group intervention or adjunctive therapy, the attendance rate suggests feasibility and acceptability of IPT-AG and the need for further investigation.

FUTURE WORK

While the manual has been delineated as described above, further work is needed to assess the efficacy of the group modality for depressed adolescents. Using these present modifications, we are currently conducting a pilot controlled clinical trial comparing the feasibility and efficacy of individual IPT-A to IPT-AG for the treatment of adolescents with a range of depressive disorders including major depression, dysthymia, adjustment disorder with depressed mood, and depressive disorder not otherwise specified. Results of this pilot trial will be used to make final modifications of the manual and to design a larger study if the results support the use of the group modality. As mental health dollars are shrinking, the development of an effective brief group therapy model for treating depressed adolescents could provide significant public health benefits to an underserved population.

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