Interpersonal Psychotherapy (IPT) for depressed adults: Specific interventions and techniques

AUTHOR: Holly A Swartz, MD
SECTION EDITOR: Peter P Roy-Byrne, MD
DEPUTY EDITOR: David Solomon, MD

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INTRODUCTION

Interpersonal Psychotherapy (IPT) is a time-limited psychotherapy for treating depression [1,2]. The therapy focuses upon improving problematic interpersonal relationships or circumstances that are directly related to the current depressive episode. Interpersonal relationships and depressive symptoms appear to affect each other in a reciprocal manner [3-7]. Improvement of interpersonal functioning reduces symptoms, which leads to additional spontaneous improvement of interpersonal functioning, which in turn reduces depressive symptoms further.

IPT was developed in the 1970s as a treatment for depression and for many years was used only by investigators in clinical trials [8]. Demonstrated success in multiple studies eventually led clinicians to conclude that IPT is a practical, user-friendly treatment for many different types of depressed patients, including pregnant, postpartum, or primary care patients [9].

Neuroimaging studies using sequential single photon emission computed tomography (SPECT) and positron emission tomography (PET) suggest that successful treatment of major depression with IPT leads to changes in brain function [10,11]. Many of these changes overlap with changes in brain function seen in patients treated with an antidepressant, including regional brain metabolic abnormalities that tended to normalize with treatment.

Clinical guidelines suggest IPT monotherapy for treatment of mild to moderate depression [9,12,13]. In addition, IPT is used to treat other psychiatric illnesses, including bipolar disorder,

eating disorders, and anxiety disorders [8].

This topic will review specific IPT interventions and techniques for treating depressed adults. The indications, theoretical foundation, general concepts, and efficacy of IPT are discussed separately, as are other treatments of depression. See (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy" and "Unipolar major depression in adults: Choosing initial treatment" and "Unipolar depression in adults: Choosing treatment for resistant depression".)

THERAPEUTIC STRATEGIES

Several therapeutic strategies and procedures are used throughout treatment with IPT. These include procedures and themes specific to IPT, as well as techniques that apply to all psychotherapies. In addition, self-report, standardized rating scales are regularly completed by the patient, as is done for any treatment of depression. Some severely ill patients may require both IPT and pharmacotherapy.

Principles of IPT — Certain themes and procedures specific to IPT are repeatedly emphasized throughout therapy [14,15].

Current, upsetting life events are associated with depressive episodes in vulnerable patients. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy", section on 'Link between life events and depression'.)

The symptoms of major depression include feelings of worthlessness and excessive guilt, and patients often blame themselves for their illness and problems. As part of IPT, clinicians strive to help patients view major depression as a treatable medical illness that is not the patient's fault [14]. Consistent with this view, clinicians "blame the patient's depression" when patients falter in social situations or in treatment. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy", section on 'Medical model'.)

IPT focuses upon the interpersonal problem area that is most closely linked to the depressive episode. In IPT there are four types of interpersonal problem areas: grief, role disputes, role transitions, and interpersonal deficits. (See 'Select interpersonal problem area and formulate the case' below.)

The clinician explores alternative ways of handling problematic interpersonal situations, and encourages the patient to experiment and make constructive changes in the interpersonal

problem area.

Common therapeutic factors — Clinicians delivering IPT use therapeutic factors that are common to all psychotherapies. These include [16]:

- Maintaining a warm, supportive, and understanding attitude
- Fostering hope
- Encouraging patients to express emotions
- Developing a strong therapeutic alliance

The therapeutic alliance is discussed separately. (See "Unipolar depression in adults: Psychodynamic psychotherapy", section on 'Therapeutic alliance' and "Overview of the therapeutic relationship in psychiatric practice".)

Monitoring — The severity of depression is monitored by asking patients to complete a self-report, standardized, depression rating scale prior to the beginning of each session. We suggest the widely-used Patient Health Questionnaire – Nine Item (PHQ-9), which is a well-validated depression self-report scale (table 1) [17,18]. Alternatives include the Clinically Useful Depression Outcome Scale (CUDOS) (form 1) [19,20] and the Quick Inventory of Depressive Symptoms – Self Report 16 Item (QIDS-SR16) (www.ids-qids.org) [21,22]. The rating scale quantifies the severity of the patient's depression and enables the clinician to track improvement over time. Changes in symptoms are explicitly linked to changes that patients make in their interpersonal problem area, underscoring the link between depression and interpersonal functioning. Measuring the intensity of symptoms also helps the patient understand that major depression is a real medical illness. In addition, the scale educates patients about the clinical features of depression so that patients can learn to recognize them on their own.

Using scales to monitor treatment of depressed patients is discussed separately. (See "Using scales to monitor symptoms and treat depression (measurement based care)", section on 'Self-report scales in the public domain'.)

Combining IPT with pharmacotherapy — For severely depressed patients, combining antidepressant pharmacotherapy and IPT is readily feasible and has been used to good effect in several studies [23-25]. Combining IPT with pharmacotherapy is discussed separately. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy", section on 'Indications'.)

DELIVERING INTERPERSONAL PSYCHOTHERAPY

Format — Although IPT is usually administered face-to-face with an individual patient, other formats include group therapy, online therapy, telehealth, and telephone therapy.

- **Individual versus group format** – IPT is usually conducted with an individual patient, and most studies have evaluated IPT in this context. However, IPT has been adapted for use in groups [26]. The choice is based upon patient preference and availability of resources. The World Health Organization (WHO) has published an eight-session version of group IPT for use in low-resourced health settings. The manual is available free of charge on the WHO website.

- **Face-to-face versus telepsychiatry format** – IPT is generally administered face to face but has been adapted for delivery in a telepsychiatry format for mildly ill patients who can be treated with a self-guided self-help therapy. A four-week randomized trial compared internet IPT with a standard internet therapy (cognitive-behavioral therapy [CBT]) in 1233 depressed patients, and found that improvement was comparable for the two groups, with medium to large clinical effects for each group [27]. However, attrition was high in both groups; among the patients who were assigned to internet IPT, fewer than 30 percent completed the program. A free online IPT program is available at e-couch.

- **Telehealth IPT** – It appears that IPT can be delivered via telehealth without loss of fidelity or efficacy. One trial randomly assigned patients with unipolar major depression (n = 77) to eight sessions of IPT or CBT; the therapies were initially administered in-person and subsequently by telehealth due to the coronavirus disease 2019 (COVID-19) pandemic [28]. Improvement was comparable in the IPT and CBT groups, and was comparable with the in-person and telehealth formats. In addition, the number of completed sessions was greater with the telehealth format. However, a limitation of the study is that patients were not randomly assigned to treatment format.

- **Telephone-based IPT** – Randomized trials indicate that IPT can also be delivered via telephone:

  - A nine-week trial compared telephone IPT with usual care in HIV positive patients with depression (n = 132) who resided in rural settings [29]. IPT consisted of nine weekly, one-hour sessions administered one-to-one for one hour via telephone. Response (reduction of baseline depressive symptoms ≥50 percent) was greater with telephone-based IPT than standard care (22 versus 4 percent of patients).

  - A 12-week trial compared telephone IPT to usual care for women with postpartum unipolar major depression (n = 241) [30]. IPT was administered by nurses and consisted of 12 weekly, one-hour sessions via telephone. Women who received telephone IPT

were 4.5 times less likely to meet criteria for major depression posttreatment than those receiving usual care.

Duration of therapy — IPT was initially delivered in 12 to 16 weekly sessions, each lasting 45 to 50 minutes [2]. Shorter courses of treatment have subsequently been used, including an eight-session format [31,32]. In practice, the clinician adjusts the number of sessions to meet the needs of the patient and health care setting, but it is important to define from the outset a discrete time frame for treatment. For patients who successfully complete a course of IPT, maintenance treatment may be indicated. (See 'Termination' below.)

IPT follows a preset structure and limited timeline. The finite duration of treatment is connected to the goal of relieving symptoms quickly. Limiting the amount of time mobilizes and motivates both the clinician and patient to rapidly identify the core problem and change the patient's interpersonal behavior and environment. Unlike open-ended psychotherapies, the clinician does not have the luxury of allowing the therapy to unfold slowly. Thus, IPT focuses upon a relatively narrow interpersonal problem.

If there is no significant improvement of depressive symptoms after four to eight weeks of treatment, the clinician should change the treatment plan [13].

Stages of treatment — IPT is divided into three phases: initial, middle, and termination. Each phase has specific goals and tasks, and a predetermined duration. The initial phase of IPT lasts up to 3 sessions, the middle phase 10 sessions, and termination 2 to 4 sessions.

Initial phase — The initial phase of IPT lasts up to three sessions. The different tasks completed in this phase are centered on selecting an interpersonal problem area as the focus of treatment. (See 'Select interpersonal problem area and formulate the case' below.)

The components of the initial phase include (table 2) [14,15]:

- Diagnosing major depression
- Giving the patient the sick role
- Taking an interpersonal inventory
- Establishing a depression timeline
- Selecting an interpersonal problem area and formulating the case
- Providing hope
- Discussing the treatment contract

These tasks are integrated across the first three treatment sessions. The clinician must collect the relevant information and cover the necessary components, but has considerable latitude in

how the process unfolds during the course of the three sessions.

Diagnose major depression — The first step is to give the illness a name and diagnose an episode of unipolar major depression according to criteria from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (table 3) [33] or the International Classification of Diseases-11th revision (ICD-11) [34]. The diagnosis is based upon the history of current and past psychiatric symptoms, nonpsychiatric medical history, family psychiatric history, current and prior treatment history, and the mental status examination. Laboratory tests should be ordered when indicated to rule out other possible explanations for psychiatric symptoms, such as thyroid function tests to rule out hypothyroidism or a toxicology screen to rule out a substance use disorder. Suicidality is assessed to determine whether hospitalization is necessary.

The clinical features and diagnosis of depression is discussed separately. (See "Unipolar depression in adults: Assessment and diagnosis".)

Give the patient the sick role — The clinician gives the patient the sick role, which is a temporarily occupied social role that absolves the patient from responsibilities precluded by the depressive episode [14]. The sick role also requires the patient to assume new responsibilities necessary to treat the depressive illness, such as attending therapy sessions and addressing the identified interpersonal problem area [35]. The sick role follows from the medical model, which states that the patient is not at fault for becoming depressed.

Take an interpersonal inventory — The interpersonal inventory consists of a comprehensive and detailed assessment of the important relationships in the patient's life and of recent significant changes that have occurred in these relationships and in psychosocial functioning. The clinician asks about:

- Confiding relationships
- Romantic and sexual relationships
- Daily contacts
- Family of origin
- Friends and social supports
- Conflicted relationships
- Recent deaths
- Emotional losses
- Changes in vocational status
- Changes in health
- Changes in housing

In discussing the patient's relationships, the clinician asks about mutual goals, probing specifically for nonreciprocal role expectations in close relationships, ie, disagreements about the expectations of one another. As an example, a wife may wish to equally divide childrearing and financial responsibilities with her husband, whereas the husband may expect the wife to stay at home and assume the majority of childcare responsibilities while he is the primary breadwinner. There are always expectations within a relationship; problems arise when there is a disagreement that cannot be negotiated.

Establish the depression timeline — In taking the history, the clinician establishes a timeline for the current depressive episode by determining when the initial depressive symptoms began and when the depressive syndrome began. For patients who suffer from either chronic depression (major depressive episode lasting more than two years) or "double depression" (a major depressive episode that occurs during dysthymia), the clinician determines when the depressive syndrome progressed and became worse [36]. The diagnosis of major depression and dysthymia (persistent depressive disorder) are discussed separately. (See "Unipolar depression in adults: Assessment and diagnosis", section on 'Diagnostic criteria and classification'.)

The changes in interpersonal circumstances (collected in the interpersonal inventory) are superimposed onto the depression timeline. The clinician then determines which interpersonal events are temporally associated with the onset and/or maintenance of the current depressive episode. The interpersonal problem area represented by the life events temporally associated with the depressive episode is selected as the focus of treatment.

Select interpersonal problem area and formulate the case — One (occasionally two) of four possible interpersonal problem areas is selected as the focus of treatment. In addition, the clinician formulates the case to focus treatment sessions upon the selected problem area to familiarize the patient with the IPT model.

According to IPT, depression is caused by a current, unresolved interpersonal problem in at least one of four possible areas:

- Grief – unresolved mourning for the death of an important person
- Role dispute – conflicts with a significant other over different expectations about the relationship
- Role transition – difficulty with a major change in the patient's life circumstances

- Interpersonal deficits – chronically unfulfilling relationships, pervasive problems starting and maintaining relationships, and social isolation

(See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy", section on 'Interpersonal problem areas'.)

The clinician selects the interpersonal problem area that is:

- Temporally associated with the onset or maintenance of the depressive episode as established in the depression timeline
- Emotionally charged and meaningful to the patient
- Explicitly acceptable to the patient as a focus for treatment

The interpersonal deficits problem area is selected only if the patient lacks life events and none of the other three categories is appropriate.

The case formulation synthesizes the elements covered in the initial phase [37]. The clinician reviews the patient's diagnosis, explicitly links the interpersonal problem area to the onset of the depressive episode, and obtains explicit agreement from the patient to focus on this problem area for the remainder of treatment. The clinician uses the IPT label to explain the interpersonal problem area ("We call this a role dispute"), except for the area of interpersonal deficits. Due to the disparaging connotation of the word "deficits," clinicians explain this problem area using the term "interpersonal sensitivity" or "social isolation."

Provide hope — The IPT clinician conveys the hopeful message that depression is usually a treatable illness and that the patient can expect to improve over the course of IPT [14]. This optimism is intended to counteract the inherent pessimism of the depressed patient and facilitate the treatment alliance [38]. For patients who remain skeptical about improving, the clinician reminds them that hopelessness is a symptom of depression and that other treatment options are available in the event that IPT is not successful. Other treatments for depression are discussed separately. (See "Unipolar major depression in adults: Choosing initial treatment" and "Unipolar depression in adults: Choosing treatment for resistant depression".)

Discuss treatment contract — A formal, verbal treatment contract is explicitly discussed. The number of sessions is determined by the clinician and patient, and the clinician explains the principles of IPT, what will occur during the sessions, and what the patient is expected to do. In addition, the clinician should address the logistical aspects of treatment and explicitly state what the policy is for tardiness, missed appointments, emergencies, and payment.

If patients are late for a session, the clinician blames the depression rather than the patient ("when you are depressed, it is hard to get motivated to leave the house"). However, the clinician also points out the time-limited nature of IPT ("Unfortunately, we will only be able to meet for the remaining 20 minutes of your session, and there only seven sessions left. Let's think together about some strategies that will make it easier for you to get out of the house, even though your mood and energy are low, so we can make the most of our last seven sessions").

Middle phase — The middle phase consists of sessions 4 to 13. During this phase, the clinician and patient work to resolve the selected interpersonal problem area chosen as the treatment focus in the initial phase. Some of the interventions used by the clinician are specific to the selected interpersonal problem area, whereas other procedures are used for all patients, regardless of the problem area (table 4).

Each session seeks to deepen the patient's understanding of the link between current life events and depression, which is accomplished by consistently exploring the link between the patient's symptoms and the selected interpersonal problem area. Focusing upon the problem area is at the core of IPT's structured approach, and clinicians should avoid pursuing interesting clinical material that is extraneous and ultimately a distraction. Post-hoc analysis of a randomized trial found that a more intense focus on the interpersonal problem area was associated with better outcomes for patients receiving IPT [39].

Interventions for each interpersonal problem area — There are specific IPT techniques used with each interpersonal problem area. The definition of each problem area is discussed separately. (See 'Select interpersonal problem area and formulate the case' above.)

Grief (bereavement) — The clinician connects the depressive syndrome to feelings about the deceased. Initially, the clinician facilitates the mourning process by systematically asking about the circumstances leading up to the death, events immediately following the death, the patient's role in these circumstances and events, and rituals observed at the time of the death. The relationship with the deceased is reviewed in detail, including both positive and negative aspects.

The patient may fear the intense emotions associated with grief, and the clinician reassures the patient these feelings are normal and will subside over time. Each session should be paced so that the patient is not overly distraught at the end of the session.

It may be helpful for patients to visit places associated with the deceased, including the grave; look at photographs or mementos of the individual; write a letter to the deceased; or make a

scrapbook. Toward the end of the middle phase, the patient is encouraged to reestablish interest in other people and activities, and to find a substitute for what has been lost.

Role dispute — The clinician connects the depressive syndrome to difficulties in a major relationship that stem from different expectations about roles. Initially, the clinician identifies the specifics of the dispute, focuses on the impact of nonreciprocal expectations in the relationship, and examines expectations in other relationships to help the patient understand patterns of behaviors and how the dispute is perpetuated.

The clinician determines the stage of the dispute and whether the two parties are:

- Actively negotiating the dispute unsuccessfully
- Locked in a stalemate (have ceased negotiating)
- Ready to end the relationship

Depressed patients tend to see hopeless impasses even when it is possible to work things out [14].

If the two parties are still actively negotiating, better communication is emphasized. If there is an impasse, the clinician attempts to move the patient and other party back to negotiating the dispute, with the warning that "things may get worse before they get better." Role playing is helpful for learning better communication skills. (See 'Interventions for any interpersonal problem area' below.)

Whether the two parties are negotiating or at an impasse, it is necessary that they modify their expectations. If this is not possible and they are ready to end the relationship, the clinician frames this as a role transition, with the patient mourning the loss of the old relationship and focusing on new relationships and activities.

IPT for a role dispute has been described as "unilateral couple's therapy" [40]. It may be helpful to have the other party attend a single session to educate the individual about depression and to gain a better understanding of the relationship. However, aside from one pilot study [41], IPT has not been conceptualized as couple's therapy.

Role transition — The clinician relates the depressive syndrome to difficulties in managing the change from an old role to a new role. Treatment involves helping the patient to accept the new role while developing a more balanced view of the old role.

Therapy for role transitions has two parts. Initially, the patient mourns the loss of the old role, which has typically been idealized, and discusses feelings about the change. The old role is likely to have been simplified in the process of idealization, and the patient develops a more complex

and "three dimensional" view of this role. In the latter part of therapy, the clinician points out opportunities afforded by the new role, which has typically been devalued. In addition, the patient is encouraged to master the skills needed for the new role.

Interpersonal deficits — The clinician relates the depressive syndrome to difficulties establishing and maintaining interpersonal relationships. Treatment involves decreasing social isolation by using past relationships and the relationship with the therapist as models for new relationships. The clinician asks about the positive and negative aspects of prior relationships and determines whether any maladaptive patterns occurred. The clinician may also discuss the patient's feelings about the clinician (this represents a departure from what is usually done in IPT), looking for parallels in other relationships. The patient is encouraged to experiment and form new relationships, utilizing every opportunity in the environment, including web-based communication, encounters in stores and coffee shops, and participation in classes and other organized group activities.

Interventions for any interpersonal problem area — Interventions that can be used for any of the four interpersonal problem areas include psychoeducation, communication analysis, role play, exploration of options and decision analysis, and socialization and pleasurable activities.

- Psychoeducation – Education about major depression, including its symptoms, epidemiology, etiology, course of illness, and prognosis. Knowledge about the illness can relieve distress. As an example, knowing the widespread prevalence normalizes the condition, and information about prognosis instills hope.

  In addition, the clinician uses every opportunity to remind the patient that depression is a medical illness with biologic underpinnings [42]. When a patient has difficulty accomplishing a task or managing an interpersonal interaction, the clinician generally blames it on the depression, pointing out how the symptoms of depression (anergia, poor concentration, irritability, anhedonia) interfere with functioning.

- Communication analysis – Examination and improvement of communication skills. Depressed patients may be irritable and short with others, or withdrawn and slowed down. Impaired communication may be a long-standing problem or may be directly related to the depressive episode.

  Patients describe in detail a conversation with a significant person in their life. The clinician obtains the equivalent of a movie script, complete with details about setting (location, time of day, and who else was present), exact words ("he said" then "she said"),

tone of voice, and gestures. In addition, the patient describes the feelings that occurred, which the clinician tries to validate.

After the exchange is reconstructed, the clinician points out the successful and maladaptive aspects, and explores their impact upon the patient's partner. Suggested changes include making direct and positive requests ("How about if we see a movie next weekend," rather than "I wish you wouldn't play golf every Sunday"). In addition, patients are encouraged to articulate their feelings more precisely, listen actively to others, and minimize distractions in their environment when discussing important issues (eg, television or radio).

- Role play – The clinician and patient rehearse anticipated interactions or replay old, problematic ones. The clinician will typically alternate playing the role of the significant other and the role of the patient so that the patient can practice new communication strategies and acquire new skills. Periods of role play alternate with periods of coaching in which the clinician teaches the patient about problematic interactions.

- Exploration of options and decision analysis – For any given interpersonal problem, the clinician encourages the patient to consider what solutions are available and to pick one. When the initial response of a depressed patient is despondency or hopelessness to resolving a problem, the clinician persists and explains that the depression is causing hopelessness and that there are usually options. The clinician may initially need to be active and suggest options, to help the patient generate a list. After evaluating the feasibility of each option, the patient selects a solution for the interpersonal problem. The patient then considers what resources are needed to resolve the problem, creates a plan, and implements it.

  Depressed patients often neglect their own needs and desires because they lack energy, motivation, or interest. Patients are encouraged to think about the outcome they want in an interpersonal problem area. As a result of treatment, the patient may pursue a previously deferred goal (eg, applying for a different job), in which case the clinician will help the patient develop a strategy to achieve the desired goal. Conversely, the patient may decide that it is time to abandon an unattainable goal (eg, an inappropriate romantic interest), in which case the clinician helps the patient mourn the loss of the relinquished object and move on to new goals.

- Socialization and pleasurable activities – Socialization and recreation are inherently antidepressant. These activities represent behavioral activation, which is a key active ingredient in CBT and has become a free-standing therapy [43]. Clinicians encourage

depressed patients to gradually increase their activity level and social contacts, commensurate with what the depression allows. If a patient is isolated and withdrawn, the therapist may initially suggest limited activities like a walk around the block or an online chat group. More socially connected patients are encouraged to increase the frequency of contact with others and broaden their support network.

Anhedonia may leave patients unable to enjoy any activity. The clinician should explain the symptom and encourage the patient to participate in a potentially pleasurable activity, regardless of the outcome. Even if patients “don’t feel like it,” they should be reassured most people enjoy the particular activity, and instructed to persist with the activity several times. It is less important that patients find the “right” activity to do and more important that they experiment with some activity. Unlike behavior therapy, IPT clinicians do not assign socialization and pleasurable activities as homework.

Termination — Termination comprises the final two to four sessions. IPT likens termination to a graduation. The clinician praises the patient's accomplishments and new skills, and highlights the symptomatic improvement that has occurred over the course of treatment. Credit for these changes is bestowed upon the patient.

The clinician actively elicits responses to the end of treatment if the patient does not spontaneously offer them, and encourages the patient to express feelings about ending the relationship with the clinician and moving on. Feelings of sadness about the separation are normalized and distinguished from the pathological symptoms of major depression. Clinicians may acknowledge they will miss working with the patient if this is true, while expressing confidence in the patient’s ability to independently remain well.

During sessions, the clinician and patient (table 5):

- Assess treatment progress so that patients can identify interpersonal gains and connect them to reduction of depressive symptoms over the course of therapy. The clinician may wish to re-examine weekly PHQ-9 scores with the patient.

- Discuss remaining treatment needs and options so that patients can be referred for appropriate follow-up care as needed. The therapy is blamed if the patient has not improved, and the patients are given credit for the efforts they have made.

- Consider ongoing, monthly, maintenance IPT, which delays or prevents recurrences of major depression [23,44]. Among the factors to consider in prescribing maintenance IPT are the number of years the patient has had major depression and the number of depressive episodes and hospitalizations that have occurred during that time. The goals

for maintenance therapy are to reduce subsyndromal symptoms, maintain recovery from the presenting acute depressive episode, prevent recurrence of new episodes, reduce the risk of suicide, and promote psychosocial functioning.

- Revisit the link between current life events and depression, in order to anticipate future vulnerability to depression in the face of stressful life events and to develop strategies to minimize the impact of potential stressors.

- Plan future treatment of depression if the need arises. Clinicians should provide psychoeducation about the risk of recurrence; discuss the concept of early, prodromal symptoms; encourage patients to seek help prior to the onset of future depressive syndromes; review symptoms of depression so the patient can identify future episodes of depression; and review treatment options. The clinician should leave the door open to future work with the patient, if this is possible.

EVIDENCE OF EFFICACY

Multiple randomized trials have demonstrated that IPT is efficacious for treating unipolar major depression. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy", section on 'Evidence of efficacy'.)

OTHER RESOURCES

Additional resources that are available to learn more about using IPT include treatment manuals and a professional organization. Both a comprehensive and an abbreviated manual are available to help deliver treatment in a standardized (consistent) manner [2,45]. The comprehensive manual has been translated into multiple languages, including French, German, Italian, Japanese, and Spanish.

The International Society of Interpersonal Psychotherapy is a global organization that enables researchers and clinicians to share information about IPT. The society organizes conferences and provides current information about international training opportunities in IPT, which is available on their website.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders".)

SUMMARY

- **Overview** – Interpersonal Psychotherapy (IPT) is a time-limited psychotherapy for treating depression. The treatment focuses upon improving problematic interpersonal relationships or circumstances that are directly related to the current depressive episode. (See 'Introduction' above.)

- **Therapeutic strategies** – Several therapeutic procedures are used throughout IPT, including psychoeducation that major depression is a treatable medical illness that is not the patient's fault, and that current, upsetting life events trigger depressive episodes in vulnerable patients. The clinician also develops a strong therapeutic alliance, encourages patients to express emotions, and focuses upon specifics. In addition, self-report, standardized rating scales are regularly completed by the patient. Some severely ill patients may require both IPT and pharmacotherapy. (See 'Therapeutic strategies' above.)

- **Stages of treatment** – IPT is divided into three phases: initial, middle, and termination. Each phase has specific goals and tasks, and a predetermined duration. (See 'Stages of treatment' above.)

  - **Initial** – The initial phase of IPT lasts up to three sessions. The different tasks completed in this phase are centered on selecting an interpersonal problem area as the focus of treatment. Problem areas include grief (complicated grief), role disputes (different expectations about roles), role transitions (major change in the patient's life circumstances), and interpersonal deficits (social isolation).

    The components of the initial phase include diagnosing major depression, giving the patient the sick role, taking an interpersonal inventory, establishing a depression timeline, selecting an interpersonal problem area and formulating the case, providing hope, and discussing the treatment contract. (See 'Initial phase' above.)

  - **Middle** – The middle phase consists of sessions 4 to 13, during which the clinician and patient work to resolve the selected interpersonal problem area chosen as the treatment focus. Some interventions are specific for a given problem area, whereas other procedures may be used for any problem area. (See 'Middle phase' above.)

For grief, the clinician facilitates the mourning process by asking about the circumstances around the death and the patient's relationship with the deceased. The patient is also encouraged to reestablish interest in other people and activities. For a role dispute, the clinician identifies the specifics of the dispute and the different expectations in the relationships. Better communication is emphasized if the two parties are negotiating with each other; if the two parties are ready to end the relationship, the patient mourns the loss and focuses on new relationships and activities. For a role transition, the patient mourns losing the old role and masters the skills needed for the new role. For interpersonal deficits, IPT uses past relationships as models for new relationships. (See 'Grief (bereavement)' above and 'Role dispute' above and 'Role transition' above and 'Interpersonal deficits' above.)

Interventions that can be used for any of the four interpersonal problem areas include psychoeducation, communication analysis, role play, exploration of options and decision analysis, and socialization and pleasurable activities. (See 'Interventions for any interpersonal problem area' above.)

- **Termination** – Termination comprises the final two to four sessions. The patient's interpersonal gains and symptomatic improvement are reviewed, the link between current life events and depression is revisited, and options for any remaining treatment needs are discussed, including maintenance IPT. In addition, the clinician provides psychoeducation about the risk of recurrence and the patient plans future treatment if the need arises. (See 'Termination' above.)

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