UPDATE

Interpersonal Therapy: a brief and focal model

Marcelo Feijó de Mello[a]

[a]Departamento de Psiquiatria da UNIFESP e Departamento de Psiquiatria e Comportamento Humano da Brown University (Pesquisador associado visitante)

Abstract

Psychotherapy is a particular form of treatment in Psychiatry. Its use is widespread and has many different approaches.
Objective: *In this article, the author makes some considerations about Interpersonal Therapy (IPT), a brief and focal psychotherapy. Initially created to treat depression, other researchers had successfully increase its spectrum. It could be divided in three phases. Initial, when the therapist makes the diagnosis of the disorder and also the interpersonal problematic is pointed out; the patient received a sick role. Intermediary when the focus is treated, and the final phase when the therapist encourages the patient to recognize and consolidate gains and prepare the patient to use it in the future.*
Methods: *It is stressed that IPT is a testable form of psychotherapy and the scientific evidences of its efficacy are showed.*
Conclusions: *The results assure that IPT is an efficient form of psychotherapy for depression with a great acceptability from the patients.*

Keywords*: Psychotherapy. Efficacy. Depression.*

Introduction

Psychotherapy is a form of treatment, which uses as its instruments the communication and the systematized relationship between the therapist and one or more patients (group, family and couple therapies). In this form of treatment, the therapist aims to enable patients to identify, understand and give a meaning to their conflicts, still aiming to correct the distortions in the perceptions that patients have about themselves and their environment, as well to improve their interpersonal relationships.[1]

The therapist, enabled by his/her theoretical formation, will show the patients the pathways to achieve the treatment goals. As a rule, therapists receive their formation after college. Besides this theoretical formation, it is desirable that therapists undergo a psycotherapic process to not harm their patients, by confusing their anguishes and conflicts with the patients'.[1]

Psychotherapies have diverse theoretical foundations, the so-called psychotherapic lines. Therapists use one or more lines to achieve their objectives. Some authors count even more than hundred different lines, what is pertinent due to the variation in the human being's world visions. Actually, each therapist follows a basic theoretical line, which is deeply influenced by his/her particular way of interpreting the reality, the world, the relationships and the development of mankind.[1]

Most widespread psychotherapic lines are the psychoanalytical ones, which appeared with the works of Sigmund Freud between the end of the 19th and the beginning of the 20th centuries, with several followers and creators of particular aspects of practicing and understanding psychoanalysis such as: Adler, Melanie Klein, Bion, Lacan. Other lines known in Brazil are psychodrama, created by Moreno, Jung's Analytical Psychology and the Existential Analysis of several psychiatrists such as Binswanger, Minkowiski and philosophers such as Sartre and Merleau Ponty.

Some psychotherapies have already been tested within an empirical scientific model. Among them, Psychodynamic Brief Psychotherapy, Klerman's Interpersonal Therapy,[2] Beck's Cognitive Therapy,[3] and the Behavioral Therapy**.** All of them are efficient in treating several psychiatric disorders.

These brief psychotherapic forms are not so well-known in our society. Beck's cognitive therapy[3] and behavioral therapy are already practiced in some centers and there are some formation courses in Brazil. However, they are generally restricted to academic centers.

Interpersonal Therapy (IPT) has been used in several clinical trials, mainly in English-speaking countries. Many colleagues who read articles, in which IPT is referenced, are curious about

this form of treatment due to its good results. In Brazil there is a group in Porto Alegre, linked to a university center, which has been applying IPT for several years. Recently it was applied for the accomplishment of a clinical trial in São Paulo.[4] This experience is extremely modest for such a big country as Brazil, which has a strong psychotherapic tradition.

Interpersonal Therapy

IPT was created in 1970 as a brief treatment for major depression. IPT was defined in a manual developed by Gerald Klerman et al.[2] and tested in a series of controlled clinical trials for depression. IPT is also used in the treatment of other psychiatric disorders:[5] dysthymia,[6] anxiety,[7] bipolar,[8] dependence on psychoactive substances,[9] post-traumatic stress,[10] eating disorders[11] and in some special groups of patients: adolescents[12] and elderly.[13-16]

Studies about the efficacy of psychotherapies as a way of treating depression have been reviewed in some publications.[17,18] IPT has been initially conceived to have a fixed duration (12 weekly sessions), and to be applied in non-hospitalized depressed subjects.[2] This proposal is based on the ideas of the interpersonal school,[19] although it does not perform etiological presuppositions (regarding the cause of depression). IPT makes connections between the beginning of the depressive symptoms and the current interpersonal problems, as a pragmatic treatment focus. IPT deals more with the current interpersonal relationships than with past ones, focusing on the immediate social context of the patients. The interpersonal therapist tries to intervene in the symptoms' formation and in the social dysfunction associated with depression than in personality aspects of the patients.[20]

The original IPT has three phases (Appendix 1). The first one, normally has from 1 to 3 sessions and includes the collection of psychiatric history and diagnostic assessments. At this phase, the treatment focus is determined. The therapist reviews the symptoms, diagnoses the patients as depressed according to a standard criterion (such as the ICD-10 or the DSM-IV), and, therefore, attributes patients the 'sick role'[21] while naming their complaints. The English sociologist Parson has demonstrated that when subjects are ill they have a differentiated role in Western society. They can be exempted from certain responsibilities, being cared in their state. Giving patients the 'sick role' provides a relief from the common guilt of not being capable of performing their basic activities. When receiving the diagnosis which corresponds to their symptoms, patients understand the reasons of their illness. The 'sick role' can relief the excess of guilt for not being able to have a good social functioning, but this cannot lead to an accommodation, and the therapist makes a deal with the patients (as part of the psychotherapic contract), in order that they persevere in the treatment to achieve a complete recovery. The 'sick role' is transient and linked to the psychotherapic work. A review of the current social functioning and the close relationships, their patterns and mutual expectations are part of the assessment. This review allows the understanding of the social and interpersonal context at the beginning of the depressive symptomatology and defines a treatment focus.[20]

Education about depression is performed by means of the explicit debate about the diagnosis, including the set of symptoms which defines depression, and about what patients expect from the treatment and its actual goals. The therapist, then, performs a link between the depressive symptoms and the interpersonal situation in a formulation[22] which uses one of the problematic interpersonal areas: 1) grief, 2) interpersonal role dispute, 3) role transition, or 4) interpersonal deficits.[20]

Therefore, we may observe that IPT is a psychotherapy which uses the concept of disease or disorder. Diseases are concepts to study certain pathological conditions of human beings.[23] Depression is a multicausal disorder and among its causes, the environmental factors, such as the interpersonal relationships, have great relevance. IPT assumes that the treatment of problematic interpersonal relationships (associated with psychopharmacotherapy, when indicated) will lead to an improvement in the depressive symptomatology. The causal connections are exposed to the patients as scientific evidence, with a therapeutic use of this information.

This issue becomes relevant as IPT is not intended to be a form of broader psychotherapy but to be focal and linked to the improvement in the symptoms of the treated disease. It does not intend to treat the patients' personality.

When the problematic situation is diagnosed and both the patient and the therapist reach an agreement regarding the focus, starts the intermediate phase, which can last from 4 to 8 sessions. Specific strategies (described below) for each problematic interpersonal area are worked during the intermediate phase.[2]

Grief is the result of a real loss of a beloved one. The therapist will work the relationships between the patient and the deceased. The therapeutic work seeks to find the actual relationship between them, working the related conflicts. In these protracted bereavements we usually find a denial of the loss, feelings of anger against the beloved person, which are conflictive, leading to a stagnation of the affective and functional life of the patients. In the intermediate phase, we work, therefore, the loss, trying to remove patients from this paralysis, opening the path for current relationships, which help them to get rid of the imaginary relationship with the beloved person.

The dispute of interpersonal roles is characterized by a conflict in a relationship, be it affective or professional. Among them, conjugal relationships are the most frequent. Regarding this focus, the therapist should try to classify at which point the conflict is situated: at a phase of confrontation, dissolution or else at a temporary truce, when there is no explicit aggression, but indifference between peers. Depending on the stage the strategy will differ, trying to establish communication and to achieve a new agreement between the participants in the conflict. The goal here is to help patients to recognize their conflicting feelings of anger, fear and sadness, and to find strategies to cope with them and to avoid situations in which those feelings may arise, by expressing directly their desires, reducing impulsive behaviors based on irrational distrusts. Depressed patients frequently have difficulty to be assertive in their needs and desires and to express adequately their anger in interpersonal situations.

When patients develop an sufficiently clear understanding about the role disputes, including their particular role, they can assess together with the therapist the possible consequences of a number of alternatives before starting their actions.[5]

The focus of interpersonal problems related to the role transition is diagnosed when the person has difficulties to deal with life changes. All of us have several roles in the social system and these roles become indistinguishable parts of our sense of identity. The roles per se and the statuses attached to them exert an important influence in the social behavior and in the patterns of interpersonal relationship of the subjects. A deficit in the social functioning occurs frequently as a response to a quick demand of adaptation to new and strange roles, especially those experienced by subjects as a loss. For example, we could think of retirement, of the acquisition of a superior hierarchical position which demands much responsibility or of the loss of power or of an economic condition or, else, of consequences of a disease, divorce and even subtler situations such as the loss of leisure due to the birth of a child. These are situations which modify the possibilities or projects of the subjects. In this situation, they cannot adapt to this new role, do not create new references, starting and/or maintaining the depressive picture. Together with the therapist they will then assess their old and new roles, in a real way, with their pros and cons, seeking forms to face up the new role, to deal with the difficulties, pointing them out and reformulating their way of acting.

The most common issues related to the difficulties to deal with the role transition are: family/social loss of support and links; management of emotions that accompany them (e.g., anger or fear); a demand of a new repertoire of social skills for the new roles; and a decrease of the self-esteem due to not valuing these new roles as much as the old ones.

The problems which are usually associated with the role transition are: giving up the old role; expression of guilt, anger or loss; acquisition of new skills; development of new links and support, besides the difficulty in the positive identification with aspects of the new role.

For its being generally chronic, the last problematic area and the most difficult to be dealt with in IPT are the interpersonal deficits. These are characterized by the difficulty of the patients in their relationships due to their way of being. Patients with such a deficiency may have never established an intimate and lasting relationship as adults, or have persistent feelings of social loneliness and isolation, not specifically related to recent transitions or interpersonal disputes. In IPT patients many times are able to detect this problem and to relate it to their psychiatric disorder, leading to an improvement in the depressive symptomatology. In general, these patients should be referred to a form of traditional, non-focused psychotherapy after the symptomatic improvement.

The therapist will have three tasks in the management of the interpersonal deficit as the treatment focus: reviewing the past significant relationships, including the negative aspects; exploring parallel and repetitive problems in these relationships; and discussing with the patients the negative and positive feelings regarding the therapist and other parallel relationships.

In IPT, the current relationships are worked out, as the focus is the here-and-now. Many techniques used in IPT are common to psychodynamic psychotherapy. On the other hand, IPT differs from psychodynamic psychotherapy in important areas.[24]

Among the techniques there are the exploratory ones: 1) **non-directive exploration** means using open, general questions or verbalizations. It is better for the development of a free discussion of the material, especially in the first phase. Part of it is the *supportive recognition*, a non-directive technique which includes meta-communications such as saying 'hum hum' , 'I understand', 'go on', or other encouraging comments of the speech. Extension of the *discussed topic,* when the therapist encourages patients to continue or to start a subject. *Receptive silence*, when the therapist keeps an interested and attentive attitude which encourages patients to keep on talking. Other exploratory technique is the 2) **directive assessment of material** when the therapist questions about a certain topic. Formal questionnaires with items about depressive symptoms can be part of this technique.[5]

Besides the exploratory techniques in IPT patients are encouraged to express their feelings. Depending on the nature of the affections and of each patient, the therapist should pursue three general strategies: facilitating recognition and acceptance of painful affections about events or questions that cannot be modified; helping patients to use their affective experiences for the desired alterations in the current interpersonal relationships; encouraging the development of new and desirable affects which may lead to growth and change.[5]

Clarification can be used to restructure and provide a recognition of the material produced by patients. This technique aims to make patients aware of what was actually communicated. Clarification techniques in IPT are: asking patients to repeat or rephrase what they said, which is particularly useful in cases of 'Freudian slips', when patients spoke in a surprising or unusual way or contradicted their previous statement.

Other resource of IPT is the analysis of the communication, which is used to examine and identify communication failures, in order to help patients to learn to better express themselves. Some common difficulties of communication are: 1) indirect, ambiguous communication, as a replacement of an open confrontation. 2) Incorrect recognition of the communication of others. 3) Incorrect statement that the other understood what was said. 4) unnecessary indirect communication. 5) Silence – closing the possibility of communication.

IPT uses the relationship with the therapist as a technique, when the feelings and perceptions of the patient about the therapist are discussed, being that the focus of the discussion.

Furthermore, IPT uses the technique of behavioral alteration through directive techniques which include education, modeling; or helping directly the patient to solve simple and practical problems. Other technique of behavioral modification is the analysis of decisions, when the therapist helps patients to consider a wide variety of alternative actions (and their consequences) which can be adopted to solve the problems. This is an important technique of IPT oriented towards action and should be explicitly taught to the patient for the use beyond the treatment. This technique generally uses the analysis of the communication. Role-playing is also used when the therapist (in

individual IPT) adopts the role of any relationship in the patient's life. This is useful to explore the feelings and stile of the patients in the communication with others and to create new ways of relationship with other people.

The final phase of IPT occurs in the last sessions, supporting patients in their new sense of independence and competence, by means of the recognition and consolidation of the therapeutic gains. The therapist also helps patients to anticipate and develop ways of identifying and dealing with depressive symptoms in case they arise in the future.[20]

Efficiency of IPT in depression

Despite the great number of controlled clinical trials on the use of IPT in depression which had positive results and the fact that IPT is included in the guidelines of the APA as effective therapeutics[25] as well as in the guidelines for primary care attention (general clinic),[26] IPT is still unknown by many psychiatrists and other mental health professionals.

In the department of psychiatry of the Federal University of São Paulo (UNIFESP), it was recently performed a systematic review and meta-analysis of the literature and a meta-analysis about the efficacy of IPT in depressive spectrum disorders.[27] After a search in several bibliographic databases ('MEDLINE, EMBASE, LILACS, PsycINFO, The Cochrane Depression, Anxiety and Neurosis Group Database of Trials, The Cochrane Controlled Trials Register and SCISEARCH'), using the following categories of key-words ('medical subject heading – MeSH'): 'Interpersonal therapy; Outcome/Adverse Effects/Efficacy; Depression/Depressive Disorder', 29 references of published articles were found and were afterwards selected. Selection criteria of articles were defined as: 1) being a comparative random controlled clinical trial; 2) having standardized diagnostic criteria about depressive disorder; and 3) a defined end of participation in the study (e.g., 12 weeks). The results of the search were expanded through the bibliographic references of the selected articles, recently published IPT compendia,[5,6] besides contacts with IPT centers ('Cornell University, Pittsburg University, Iowa University, McMaster University and Columbia University'). Abstracts of published articles obtained in this search were separately and independently assessed by two researchers and were selected from the proposed inclusion criteria. The results of each of them were confronted and the discrepancies were discussed up to the achievement of a consensus.

Out of eleven studies[4,15,16,24,28-34] which met inclusion criteria to be analyzed, 5 meta-analyses were performed. Their results were: IPT was superior to placebo in efficacy and was not different from antidepressive medication. The combination of IPT with antidepressive medication was not significantly better than medication alone in the acute treatment (considering the studies which lasted less than 16 weeks) and also had no augmentation in the maintenance treatment. IPT was superior to Cognitive-Behavioral Therapy in the acute treatment of depression. This study concluded that IPT is an efficient form of psychotherapy to depressive spectrum disorders. Two studies[16,34] assessed the prophylaxis of recurrence of new episodes, and the findings confirmed that IPT alone was superior to placebo, although it has not differed statistically from the antidepressive medication or from the combination of IPT and medication.

Discussion

Adding one more form of psychotherapy to the existent ones can be deemed a gain, as IPT can be assessed in an empirical context. Using this model we can confirm or not the efficacy of IPT in specific cases, adapting the psychotherapic practice to the model of evidence-based medicine.

Out of the scientific evidence we can discuss, using concrete data, with patients, health professionals, with those who plan the public health, and also with those who are responsible for the financing of the medical activity, about the needs and advantages of using specific treatments for the clinical conditions. In the case of depression and, moreover, of psychological therapies, objective evidence is more easily accepted by people outside the mental health area.

IPT was initially created for the treatment of depression. Scientific evidence points to depression as a prevalent and chronic disorder with a considerable socioeconomic burden. One study of WHO, jointly with the department of Public Health of the Harvard University and the World Bank,[35] calculated the socioeconomic impact of the diseases in the world. Depression was the second pathology which caused more losses, losing only to cardiovascular diseases. The projections for the year 2030 are that depression will keep having this significant role. Therefore, WHO considers prioritary the reallocation of funds for the treatment of this condition among other psychiatric pathologies (bipolar, schizophrenia, panic and obsessive-compulsive disorders). For depression, medications are known as efficient although some patients have drug intolerance and other do not respond. The assessment of other therapeutical forms for depression, such as psychotherapy, should be performed.

Some authors have performed socioeconomic studies within this spirit. Browne et al.[33] in one study with 707 dysthymic patients found that, although the combination of IPT and sertraline was not more efficient than the latter alone, the combination had a better cost-benefit ratio. Despite being more expensive in the short-time due to the need of a trained professional, time and institutional space for the performing of psychotherapy, the overall cost of treatment after a 2-year follow-up was lower. Patients who had IPT combined with medication used less health resources, that is, sought less for these services and were less ill. Efficacy is a fundamental item, but it is not the only one in the assessment of a treatment.

Conclusion

Interpersonal therapy is an easily-applied form of treatment which has proven results in the treatment of depression and in other pathologies. Its use in our society should be stimulated, as we have a psychotherapic tradition and several professionals able to learn how to use it. The use of brief therapies, with proven efficacy, is a requisition for health management organizations accepting reimbursements.

The application in our society was well-succeeded, with a good acceptance by our patients.[4] This form of psychotherapy, which

can be scientifically assessed, should be more divulged in our environment.

Sponsor: Inexistente
Received 30.07.2002
Accepted 04.11.2003

References

1. Ramadam Z. O que é Psicoterapia. São Paulo: Ática; 1987.
2. Klerman GW, Weissman MM, Rounsavile BJ. Interpersonal Psychotherapy of Depression. New York: Basic Books; 1984.
3. Beck AR, AJ, Shaw BF, et al. Cognitive therapy for depression. New York: Guilford; 1979.
4. Mello MF, Myczcowisk LM, Menezes PR. A randomized controlled trial comparing moclobemide and moclobemide plus interpersonal psychotherapy in the treatment of dysthymic disorder. J Psychother Pract Res 2001;10(2):117-23.
5. Weissman MM, Markowitz JC, Klerman GL. Comprehensive Guide to Interpersonal Psychotherapy. New York: Basic Books; 2000.
6. Markowitz JC. Interpersonal psychotherapy for dysthymic disorder. Washington, DC: American Psychiatric Press; 1998.
7. Lipsitz JD, Markowitz JC, Cherry S, Fyer AJ. Open trial of interpersonal psychotherapy for the treatment of social phobia. Am J Psychiatry 1999;156(11):1814-6.
8. Frank E, Hlastala S, Ritenour A, Houck P, Tu XM, Monk TH, et al. Inducing lifestyle regularity in recovering bipolar disorder patients: results from the maintenance therapies in bipolar disorder protocol. Biol Psychiatry 1997;41(12):1165-73.
9. Rounsaville BJ, Bryant K, Babor T, Kranzler H, Kadden R. Cross system agreement for substance use disorders: DSM-III-R, DSM-IV and ICD-10. Addiction 1993;88(3):337-48.
10. Krupnick JL. Brief psychodynamic treatment of PTSD. J Clin Psychol 2002;58(8):919-32.
11. Wilfley DE, Agras WS, Telch CF, Rossiter EM, Schneider JA, Cole AG, et al. Group cognitive-behavioral therapy and group interpersonal psychotherapy for the nonpurging bulimic individual: a controlled comparison. J Consult Clin Psychol 1993;61(2):296-305.
12. Mufson L, Moreau D, Weissman MM, Klerman GL. Interperssonal therapy for depressed adolescents. New York: Guilford Press; 1993.
13. Reynolds 3rd CF, Frank E, Perel JM, Imber SD, Cornes C, Morycz RK, et al. Combined pharmacotherapy and psychotherapy in the acute and continuation treatment of elderly patients with recurrent major depression: a preliminary report. Am J Psychiatry 1992;149(12):1687-92.
14. Reynolds 3rd CF, Frank E, Kupfer DJ, Thase ME, Perel JM, Mazumdar S, et al. Treatment outcome in recurrent major depression: a post hoc comparison of elderly ("young old") and midlife patients. Am J Psychiatry 1996;153(10):1288-92.
15. Reynolds 3rd CF, Miller MD, Pasternak RE, Frank E, Perel JM, Cornes C, et al. Treatment of bereavement-related major depressive episodes in later life: a controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. Am J Psychiatry 1999;156(2):202-8.
16. Reynolds 3rd CF, Frank E, Perel JM, Imber SD, Cornes C, Miller MD, et al. Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomized controlled trial in patients older than 59 years. Jama 1999;281(1):39-45.
17. Jarrett RB, Rush AJ. Short-term psychotherapy of depressive disorders: current status and future directions. Psychiatry 1994;57(2):115-32.
18. Klerman GW, Weissman MM, Markowitz JC. Medication and psychotherapy. In: Bergin AE GS, editor. Handbook of Psychotherapy and Behavior Change, 4th ed. New York: Wiley; 1994. p. 734-82.
19. Sullivan H. The Interpersonal Theory of Psychiatry. New York: WW Norton; 1953.
20. Weissman MM, Markowitz JC. An Overview of Interpersonal Psychotherapy. In: Markowitz JC, editor. Interpersonal Psychotherapy. Washington, DC: American Psychiatric Press; 1998. p. 1-33.
21. Parson T. Illness and role of the physician: a sociological perspective. Am J Orthopsychiatry 1951;21:452-60.
22. Markowitz JC, Swartz HA. Case formulation in interpersonal psychotherapy of depression. In: TD E, editor. Handbook of Psychotherapy Case Formulation. New York. New York: Guilford; 1997. p. 192-222.
23. Sonenreich C, Estevão G, Silva Filho, LMA. Psiquiatria: Propostas, Notas e Comentários. São Paulo: Lemos Editorial; 1999.
24. Markowitz JC, Kocsis JH, Fishman B, Spielman LA, Jacobsberg LB, Frances AJ, et al. Treatment of depressive symptoms in human immunodeficiency virus-positive patients. Arch Gen Psychiatry 1998;55(5):452-7.
25. Karasu TD, JP, Gelenberg, A. Practice Guidelines for major depressive disorders in adults. Am J Psychiatry 1993;150:1-26.
26. Department of Health and Human Services AfHCPaR. Depression Guideline Panel: Clinical Practice Guideline: Depression in Primary Care Vol 1-4. Rockville MD: Department of Health and Human Services, Agency for Health Care Policy and Research; 1993. Report Nº: AHCPR Publ No 93-0550-0553.
27. Mello MF, Mari JJ, Bacaltchuk J, Verdeli H, Neugebauer R. A Systematic Review of Research Findings on the Efficacy of Interpersonal Therapy for Depressive Disorder. European Archives of Psychiatry and Clinical Neuroscience 2003; submitted.
28. Weissman MM, Prusoff BA, Dimascio A, Neu C, Goklaney M, Klerman GL. The efficacy of drugs and psychotherapy in the treatment of acute depressive episodes. Am J Psychiatry 1979;136(4B):555-8.
29. Elkin I, Shea MT, Watkins JT, Imber SD, Sotsky SM, Collins JF, et al. National Institute of Mental Health Treatment of Depression Collaborative Research Program. General effectiveness of treatments. Arch Gen Psychiatry 1989;46(11):971-82; discussion 983.
30. Brown C, Schulberg HC, Madonia MJ, Shear MK, Houck PR. Treatment outcomes for primary care patients with major depression and lifetime anxiety disorders. Am J Psychiatry 1996;153(10):1293-300.
31. Rossello J, Bernal G. The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. J Consult Clin Psychol 1999;67(5):734-45.
32. Mufson L, Weissman MM, Moreau D, Garfinkel R. Efficacy of interpersonal psychotherapy for depressed adolescents. Arch Gen Psychiatry 1999;56(6):573-9.
33. Browne G, Steiner M, Roberts J, Gafni A, Byrne C, Dunn E, et al. Sertraline and/or interpersonal psychotherapy for patients with dysthymic disorder in primary care: 6-month comparison with longitudinal 2-year follow-up of effectiveness and costs. J Affect Disord 2002;68(2-3):317-30.
34. Frank E, Kupfer DJ, Perel JM, Cornes C, Jarrett DB, Mallinger AG, et al. Three-year outcomes for maintenance therapies in recurrent depression. Arch Gen Psychiatry 1990;47(12):1093-9.
35. Murray CJ, Lopez AD. Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study. Lancet 1997;349(9063):1436-42.

Correspondence
Marcelo Feijó de Mello
Rua Pedroso Alvarenga, 1046 conj. 45
04531-004 São Paulo-SP
e-mail: mf-mello@uol.com.br
Phone/Fax: (011) 30786829

Appendix 1

Outline for Interpersonal Psychotherapy in Major Depression

I. Initial Sessions.

A. Dealing with depression.

1) Review the depressive symptoms.

2) Give the syndrome a name.

3) Explain depression as a medical disorder and explain the treatment.

4) Give the patient the 'sick role'.

5) Assess the need of medication.

B. Relate depression to the interpersonal context

1) Review the current and past relationships as well as their relation with the depressive episode. Determine with the patient:

a) Nature of the interaction with significant people;

b) Mutual expectations between the patient and other significant people, and which of them were achieved;

c) Satisfactory and dissatisfactory aspects of relationships;

d) Changes that patients would like to occur in the relationships.

C. Identification of the main problematic areas;

1) Determine the problematic area related to the current depressive episode and emphasize the treatment goals.

2) Determine which relationship or aspects of it are related to depression and what can be changed.

D. Explain the concepts and contract of IPT

1) Explain your understanding of the problem

2) Reach an agreement regarding the treatment goals, determining which is the problem to be focused.

3) Describe the procedures of IPT: focus in the 'here-and-now', the patient should discuss important concerns, review of current relationships, discussion about the practical aspects of the treatment -duration, frequency, timetables, fees, absence policy.

II. Intermediate Sessions – problematic areas.

A. Grief.

1) Goals

a) Facilitation of the mourning process

b) Helping the patient to reestablish interests and relationships as a replacement of what has been already lost.

2) Strategies

a) Review the depressive symptoms

b) Relate the beginning of depressive symptoms to the death of the significant person.

c) Rebuild the relationship of the patient with the deceased.

d) Describe the sequence and consequence of the events which had happened just before, during and after the death.

e) Explore the associated feelings (negative as well as positive)

f) Consider possible ways of being involved with other people.

B. Interpersonal disputes.

1) Goals

a) Identify.

b) Choose an action plan.

c) Modify the flawed expectations or communications in order to achieve a satisfactory solution.

2) Strategies.

a) Review the depressive symptoms.

b) Relate their beginning to the dispute with the significant person with whom the patient has a relationship.

c) Determine at which stage is the dispute:

i. Renegotiation (sooth the participants in order to facilitate the solution).

ii. Standstill (increase the disharmony to facilitate the negotiation).

iii. Dissolution (help in the process of grief).

d) Understand how non-reciprocal expectations are related to disputes:

i. Which are the disputed issues?

ii. Which are the differences between expectations and values?

iii. Which are the options?

iv. Which are the possibilities of finding alternatives?

v. Which resources are available to lead to a change in the relationship?

e) Are there parallels with other relationships?

i. What are the patient's gains?

ii. Which non-said attitude is hiding behind the patient's behavior?

f) How occurs the dispute?

C. Role transition.

1) Goals

a) Grief and acceptance of the loss of the old role.

b) Helping patients to face up more positively to their new role.

c) Recover the patient's self-esteem by developing a domain of the new demands.

2) Strategies.

a) Review the depressive symptoms.

b) Relate the depressive symptoms with the difficulty of dealing with the recent changes in life.

c) Review the positive and negative aspects of the old and new roles.

d) Explore the feelings about what was lost.

e) Explore the opportunities of the new role.

f) Assess realistically what was lost.

g) Encourage the appropriate release of affections.

h) Encourage the development of a system of social support and of new skills demanded by the new role.

D. Interpersonal deficits.

1) Goals.

a) Reduce the social isolation of the patient.

b) Encourage the development of new relationships.

2) Strategies.

a) Review the depressive symptoms.

b) Relate the depressive symptoms to the problems connected to social isolation.

c) Review the significant relationships of the past, including their positive and negative aspects.

d) Explore repetitive patterns in the relationships.

e) Discuss positive and negative feelings of the patient regarding the therapist and seek parallels with other relationships.

III. End.

A. Make explicit the discussion about the end.

B. Recognize that the end is a mourning process.

C. Show the patients the recognition of their competence and independence.
D. Deal with the lack of response to the treatment.
E. Continuation and maintenance treatment.

IV. Specific techniques.
A. Exploratory.
B. Encouragement of the affection.
C. Clarification.
D. Analysis of the communication.
E. Therapeutic use of the relationship.
F. Techniques to modify the behavior.
G. Accessory techniques.

V. Role of the therapist
A. Patient but not neutral listening.
B. Active, not passive.
C. The therapeutic relationship is not interpreted as a transference
D. Therapeutic relationship is not friendship.