Interpersonal psychotherapy: recent indications beyond major depression

La psicoterapia interpersonale: recenti indicazioni oltre la depressione maggiore

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Summary

Objectives

Interpersonal psychotherapy was proposed in 1984 by Klerman and colleagues. It is a time-limited psychotherapy (12-16 sessions/a week), diagnosis-focused, based on a medical model, according to which the patient has a treatable illness that is not his/her fault. Psychiatric symptoms develop in an interpersonal context, acting on which it is possible to induce remission and prevent subsequent relapses. IPT seeks the resolution of the interpersonal crisis improving social functioning and psychiatric symptoms, too.

At first it was aimed to treat major depression, not psychotic or bipolar. Later IPT has been applied to a growing number of psychiatric disorders, because of their frequent and predominant interpersonal dimension. However, specific adaptations of IPT have been required to consider the different clinical characteristics of the disorders and to satisfy patient's needs. This review will present and comment the results of the available studies of IPT adapted to mental disorders different from major depressive disorder.

Methods

Open-label and controlled studies concerning the use of IPT in Axis I and II disorders different from major depression were systematically searched for and commented.

Results

Chronic depressions, as dysthymic disorder, have usually been considered more difficult to treat with IPT, because their symptoms are more commonly egosyntonic and it is not possible to identify a life event at the onset of the current episode. The IPT-D, a model of IPT structured in at least 24 sessions, was so developed to treat dysthymia. It proposes a iatrogenic role transition as a recent interpersonal problem to work on with.

The close correlation among life events, regularity of circadian rhythms and mood regulation, particularly in bipolar patients, has contributed to the development of the interpersonal and social rhythms psychotherapy (IPSRT). IPSRT is an interpersonal and psycho-educational intervention that considers these three factors and prevents pathological mood shifts first of all by the stabilization of patients' social rhythms.

The frequent comorbidity between substance abuse and mood disorders has also encouraged the use of IPT in the treatment of addictions. In particular, IPT has been used in subjects with alcohol, cocaine, and opiates dependence.

The IPT has also found a promising field of application in eating disorders, particularly bulimia and binge-eating-disorder. It doesn't directly address the pathological eating behavior, but it focuses on the interpersonal problematic areas. These problems are related to a difficult managing of emotions, that triggers binges. The IPT aims to stop the use of food as a coping strategy that is called "emotional eating".

Because of the interpersonal nature of their symptoms, also anxiety disorders are potential indications for IPT. In the treatment of social phobia, modified IPT (IPT-SP) focuses on the most problematic interpersonal area in these patients: the role transition. Preliminary data on the application of this therapy in panic disorder are now available. Finally, the IPT has been tested in post-traumatic stress disorder (IPT-PTSD). The IPT-PTSD first addresses, in a flexible way, relational and social consequences of the trauma and aims to reinforce the patient's social network. Secondary, a well developed social support helps to understand and deal with the trauma.

To date, among Axis II disorders, only borderline personality disorder (BPD) has been a focus of IPT. The frequent comorbidity with mood disorders and the relational problems due to BPD core symptoms are the main reasons for the proposal of an adapted model of IPT: the IPT-BPD. This is an intervention of longer duration than traditional IPT (34 sessions in 8 months), adding to the problematic areas "the image of the self". It's designed to take into account the chronicity of BPD and the poor therapeutic alliance and high risk of suicide of these patients.

Conclusions

Both classical model of IPT and several specific adaptations have been recently used to treat an increasing number of Axis I and II disorders. Initial results are overally promising, but only limited data are available for each indication. At the moment, a slightly larger number of studies has been performed for bipolar disorders and eating disorders, but replication of results in well-designed investigations is generally required.

Key words

Interpersonal Psychotherapy • Dysthymic Disorder • Bipolar Disorders • Substance Abuse • Bulimia • Binge Eating Disorder • Social Phobia • Panic Disorder • Post Traumatic Stress Disorder • Borderline Personality Disorder

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Interpersonal psychotherapy (IPT)

Interpersonal psychotherapy developed from an idea by Harry Stack Sullivan [1], an American psychiatrist who focused on psychoanalytical theories that see man as a 'product of his interpersonal relations, and cultural and environmental interactions' [2]. This conception was influenced by the psychobiological theories of Adolf Meyer and is based on the clinical observation of a primary social group and the immediate involvement of the subject with one or more significant persons. Interpersonal intervention is centred on the intimate relations of the patient, starting with the conception of self as a result of the continuous of the ego with reference individuals. The individual is therefore supported and continuously defineed by the relations that are established and by the social role that the individual plays. Interpersonal psychotherapy (IPT) starts with the biunivocal relation between the psychopathology and a social role, and between symptoms and the interpersonal dimension.

Klerman et al. [3] defined the methods and techniques of this psychotherapeutic approach, which consist of brief psychotherapy sessions (12-16 weekly sessions lasting 1 hour each), generally for treatment of patients with major depression who are not psychotic and without bipolar disorder. The intervention has a distinct medical setting based on the formulation and communication of a diagnosis [4], and on the transitory attribution of the phenomena of illness to the patient [5]. Such an approach removes responsibility from the patient regarding guilt and frustration for their emotional experience, and at the same time defines the symptoms in a syndromic context that is known and therefore curable. This pragmatic model of IPT [6] highlights how depression develops in an interpersonal context, and by acting on this it is possible to induce remission of symptoms. Thus, IPT has the aim of resolving on-going relational crises, improve social functionality and relieve depressive symptoms. It also has the objective of preventing recurrence of major depression. It is structured in three successive phases. The first phase (1-3 sessions) is concentrated on analysis of interpersonal relations of the patient, present and past, in order to formulate a correct diagnosis and identify the relations that are associated with a problematic interpersonal core: inability to mourn a death, interpersonal contrasts, role transitions or interpersonal deficits. This approach is particularly effective in major depression, which allows the possibility to relate interpersonal problems with the onset of the on-going depressive episode. In the next phase, focus is placed on analysis of previously-identified issues. Beginning with emotionally relevant events that emerge during each session, the emotional experience of the patient is analyzed: the objective is to substitute relational styles based on emotional and cognitive dysfunctions of oneself and others with more adaptive models, without making the psychodynamic assumptions of IPT explicit. The final phase starts with a comparison of predetermined objectives with the observed improvements in order to plan the end of treatment: on one hand, the therapy recognizes the physiological sadness induced by the end of therapy, a moment of separation and transition, and on the other emphasizes a sense of dependence associated with the end of the psychotherapy.

The efficacy of IPT in treatment of major depression is well-established, and a recent meta-analysis has confirmed its utility in both monotherapy and in association with pharmacotherapy. It was also suggested that IPT should be included among treatments recommended in guidelines as its efficacy is based on clinical evidence [7].

Studies comparing various psychotherapies have demonstrated that IPT is superior to supportive psychotherapy (SP) and has an efficacy similar to cognitive-behavioural therapy (CBT) in improving global depressive symptoms. It is interesting to highlight that IPT is one of the most effective psychotherapies for improving relational dynamics and social integration [4 8]. The superiority of combined treatment over pharmacotherapy or psychotherapy alone has not been demonstrated, even if there is such evidence in severe depression.

Over the years, IPT has been applied to other psychiatric disturbances, beginning with the changes in interpersonal functioning. Among Axis I disorders, IPT has been studied in dysthymia, bipolar disorder, substance abuse, post-traumatic stress disorder, social phobia, panic disorder and eating disorder. Among Axis II disorders, IPT has been used in treatment of borderline personality disorder.

Mood disorders

Originally proposed for treatment of unipolar depression, IPT was later used with promising results in treatment of bipolar I and II disorder (BP-I and BP-II) and dysthymia. The chronic nature of affective symptoms (characteristic of dysthymia and even BP, the frequency of episodes and presence of residual symptoms in the so-called symptom-free intervals) leads to difficulty in identifying a recent life event that is associated with the onset of symptoms. Thus, IPT must be modified to render it appropriate for the treatment of these disorders.

Bipolar I and II disorders

IPT, in the IPSRT version (interpersonal social rhythm therapy) [9 11], has been used together with pharmacotherapy in the treatment of BPD-I, and as monotherapy in BP-II. IPRST correlates life events, variations in circadian rhythms and alteration in mood. At present, it is well known that stressful socio-environmental factors (sleep

deprivation, work shifts, insomnia) can cause alterations in circadian rhythms [12 13] and favour the development of transitory somatic and cognitive symptoms. In individuals subject to affective disturbances, such variations can lead to significant mood alterations [14-16]. This is especially true for sleep deprivation and the consequent appearance of an expansive episode on BP [17 18]. To prevent and treat thymic variations in these patients, it is this necessary to prioritize regulation of circadian rhythms, maintaining a constant equilibrium between the loss of "Zeitgebers" or "time givers" [19] (socio-environmental factors that synchronize vital rhythms), and the presence of "Zeitstorers" or factors that alter regularity [12]. IPSRT, an intervention with is also psychoeducational, behavioural and interpersonal, has the objective of resolving interpersonal crises, thymic stabilization and especially normalization of circadian rhythms. It is used in the acute phase with curative intent and in the maintenance phase with prophylactic intent. It is modular and can be modulated [10 11], and is divided into four phases.

In the first phase, through anamnesis of the patient, life events are correlated with alterations in circadian rhythm and mood. Psychoeducational intervention is also carried out to increase awareness of the disease and compliance. It is important to combine evaluation of circadian rhythms, using the Social Rhythm Metric (SRM, 20), with interpersonal relations, through administration of the Interpersonal Inventory. A problematic interpersonal area is then chosen on which to focus. The next phase is characterized by interpersonal intervention, aimed at resolving on-going socio-relational crises, and by behavioural intervention to normalize circadian rhythms. The maintenance phase reinforces the newly-acquired social abilities and sustains a constant daily cycle. The last phase concerns autonomization of the patient by reducing the frequency of sessions, initially bi-weekly then monthly, to prepare the individual for interruption of treatment. One can also opt for continued sessions with reduced frequency.

In an initial study [21], the efficacy of IPRST was evaluated in combination with pharmacotherapy in the acute treatment of patients with BP; 42 patients were enrolled and treated with either combined IPSRT therapy (n = 21) or a clinical approach called Clinical Status and Symptom Review Treatment (CSSRT) (n = 21). Once stabilized, patients then entered a continuation and maintenance phase that lasted at least 2 years. The results showed a moderate efficacy of IPSRT, but not in the acute phase, with a limited ability to reduce the time of remission of an episode. The investigators thus stressed a prophylactic role for IPSRT. However, these discouraging results have been questioned in later studies [9 22-24].

A second RCT [22] studied a cohort of patients with BP that was treated in the acute and maintenance phases with combined therapy consisting in pharmacotherapy and IPSRT or a psychoeducational intervention, namely Intensive Clinical Management (ICM). After stabilization, patients were randomly reassigned to one of the two psychosocial treatments before entering the maintenance phase lasting 2 years. IPSRT demonstrated a higher capacity for stabilization of circadian rhythms and more rapid remission of a depressive episode. Both treatments, however, showed a similar rate of recurrences, which was influenced more by discontinuation of treatment than the type of treatment: a greater risk of recurrence (> 40% *vs*. < 20%) was, in fact, associated with a change in psychotherapy in the maintenance phase.

In 2002, Rucci and colleagues [25] compared the efficacy of IPSRT and ICM, associated with lithium, in reducing the risk of suicide in patients with BP. It was found that the risk was from 25-50%, and was not sufficiently reduced by the administration of lithium alone [26 27]. A total of 175 patients were enrolled and followed for 2 years; all individuals were treated in the acute phase with pharmacotherapy and maintenance therapy with either IPSRT or ICM. In both groups, significant reduction in suicide risk was seen, especially during the maintenance phase. Of the 5 attempts, 4 were in the ICM group, which demonstrates that specific therapy such as IPSRT is more effective in reducing the risk of suicide, especially when carried out in a structured clinical setting. Frank and coworkers [28] carried out a study of 175 patients with type I BPD in a trial lasting 2 years, comparing the efficacy of therapy combined with either IPSRT or ICM. Patients were inserted in one of four treatment groups: IPSRT in the acute and maintenance phases, ICM in the acute and maintenance phases, IPSRT in the acute phase followed by ICM in the maintenance phase, or ICM in the acute phase followed by IPSRT in the maintenance phase. Patients treated with IPSRT in the acute period, independently of the type of maintenance therapy, showed faster time to remission, even if the rate of remission was similar between the two groups. In contrast to the previous results of Hlastata [21], these authors highlighted that the acute phase is a more favourable period for change from a motivational standpoint. Moreover, regularization of circadian rhythms, which is associated with a lower risk of remission, was found to be related to the specificity of IPSRT. This latter therapy was not, however, the treatment of choice for all patients: in fact, patients who were more compromised from a personal standpoint and with higher levels of anxiety showed a greater response to ICM.

Miklowitz and investigators published two studies on the efficacy of different psychotherapeutic interventions (IPSRT, CBT, family psychoeducation [FP]), in addition to pharmacotherapy, compared to brief psychoeducational intervention. In the first study [23], 152 patients with BP type I or II were enrolled, and randomized to psychotherapeutic intervention (n = 84), characterized by 30 sessions in 9

months, or to structured psychoeducational intervention in 6 sessions. Depressive symptoms were evaluated at baseline and every 3 months for the 9-month follow-up period using the Montgomery-Åsberg Depression Rating Scale (MADRS [29]) and Longitudinal Interval Follow-Up Evaluation Range of Impaired Functioning Tool (LIFE-RIFT [30 31]). Specific psychotherapy showed greater efficacy on total and interpersonal functioning, with a progressive decrease in depressive symptoms. There were no significant differences in functioning related to work or social skills. In the second investigation [24], which was similar to the previous in terms of methodology but in 293 patients with a follow-up of 12 months, the efficacy of psychotherapeutic and psychoeducational intervention was assessed in remission of depressive episodes and maintenance of the euthymic state. Specific psychotherapeutic intervention led to more rapid and duration of remission, and was also associated with a higher number of subjects in the euthymic state during follow-up. However, among the various psychotherapies, no difference was noted in terms of specificity.

The same authors [32] have also attempted to distinguish between the common, specific elements of the different interventions used in order to target therapeutic strategies to the clinical needs of the individual patient. Despite the large number of common elements (the promotion of greater awareness and understanding of the disease, early recognition of prodromic symptoms of recurrence and assessing pharmacological compliance), 'active' interventions (CBT, IPSRT and FP) are differentiated from treatment-as-usual (pharmacological therapy associated with non-structured psychoeducational intervention) in techniques of problem solving and development of the ability to cope with social stigma related to mental illness. All therapies have been shown to have a specificity of action that is related to the initial state: IPSRT, for example, can be distinguished by the regularization of sleep/wake patterns and daily routine.

A pilot study in 2009 evaluated the use of IPSRT as monotherapy in treatment of patients with type I or II BP [33]. This requires several adaptations that take into account the clinical problems related to subacute symptoms of the disturbance, and in particular the need to reinforce the importance of regularity of circadian rhythms, controlling environmental stimulations to prevent recurrence, the difficulty in recognizing affective states, interpersonal problems related to hypomanic grandiosity and affective modulation, and lastly the important comorbidity with substance abuse [34].

A total of 17 patients with type II BP in the depressive phase were treated with 12 weekly sessions of IPSRT. At the end of treatment, responders were enrolled in the maintenance phase (8 weekly sessions), while non-responders were treated with lamotrigine or an alternative psychotherapy. At the end of the first 12 weeks, 7 patients (41%) responded to therapy (n = 7), which was similar to the drop-out rate. At the end of follow-up, 53% of patients showed improvement, while 29% achieved complete remission of symptoms. IPSRT was particularly efficacious in treatment of manic symptoms, with no differences observed for demographic or clinical characteristics between responders and non-responders, except for a greater number of women who responded to therapy (50% *vs*. 29%). Compared to pharmacological treatment, these data are encouraging considering the difficulty in treating bipolar depression [35 36]. IPT and IPSRT have been used, with appropriate adaptations, to adolescents with both unipolar (IPT-A) [37-39] and bipolar (IPSRT-A) [40 41] depression. The unbalanced sleep-wake rhythms of adolescents, often in sleep deficit [42 43], their difficult interpersonal relations and poor pharmacological compliance, which are risk factors for recurrence [44], justify alternative interventions in these patients. Considering the severity of bipolar disorder and the need for regularization of circadian rhythms, IPSRT-A is structured in a greater number of sessions (e.g. 16-18). Moreover, a brief, "teen friendly" version of the Social Rhythm Metric, the SRM-A, is used [40]. This intervention involves the patient, teachers and family when necessary, focusing firstly on regularization and respect for scholastic patterns.

The efficacy of IPSRT-A was investigated in a pilot study [41] in a cohort of 12 bipolar adolescents (12-18 years old), in the acute phase, treated with 12-16 weekly sessions, and followed with 2-4 biweekly sessions. Patients were evaluated at baseline and monthly for the duration of the trial. At the end of treatment, significant improvement was seen in psychiatric, depressive and manic symptoms, as well as in global functioning. These results were attributed to the flexibility of treatment and confirmed the efficacy of IPSRT-A in the acute treatment and maintenance of bipolar adolescents, highlighting that stabilization of patients is the first priority [9 23 24].

Dysthymic disorder

For treatment of dysthymic disorder (DD), pharmacological antidepressant therapy is generally used. However, the chronic nature of the disorder often implies the reappearance of symptoms after pharmacological therapy is stopped, giving rise to substantial issues regarding the duration of therapy [45]. Moreover, 50% of patients with DD do not respond to pharmacotherapy or discontinue pharmacotherapy due to adverse effects [46]. For these reasons, some patients might benefit from concomitant psychotherapy and pharmacotherapy [47], and in particular from psychodynamic psychotherapy, CBT [48 49] or IPT.

The success of IPT in treatment of major depression and interpersonal dysfunction in chronic depression has

led many authors to study the applicability of DD [50-55]. Markowitz [55] elaborated the IPT-D, which can be used together with pharmacotherapy [56] and adapted to the clinical characteristics of the disturbance. The chronicity of dysthymia, and consequently the frequent ego-syntonic character of some symptoms, requires that intervention lasts at least 6 months, while the lack of a life event, correlated with the appearance of an index episode, is compensated with the transition of an iatrogenic role that identifies the missing life event with psychotherapy. During the course of treatment, the patient learns to differentiate a chronic disease, understandably confused with personality, from oneself; the resolution of the role transition coincides with the dissolution of the diagnosis.

A pilot study [57] evaluated the efficacy of IPT-D on 17 patients with recent onset DD. In the patient cohort, 50% of patients had double depression [58], and 40% had been previously treated for 10 weeks with desipramine without benefit. After 16 sessions of IPT-D, promising results were reported: the rate of remission was about 65% (n = 11), with a significant mean decrease in depressive symptoms, and no cases showing worsening of symptoms.

Feijò de Mello et al. [59] published a study on 35 dysthymic patients evaluating the efficacy of moclobemide in association with either IPT-D (n = 16) or clinical management (n = 19). Patients in both groups received the same pharmacological treatment for 8 months (moclobemide 150-300 mg/day). Patients treated with IPT-D also received a cycle of 16 weekly sessions, followed by 6 monthly maintenance sessions. Clinical management consisted in non-structured psychoeducation. All patients were evaluated at baseline, and at 12, 24 and 48 weeks. Even considering the small number of patients, greater therapeutic benefit, fewer drop-outs (37.5 % *vs*. 57.9%) and progressive improvement in depressive symptoms were seen in patients treated with IPT-D. The study also confirmed that pharmacotherapy has a more rapid onset of action compared to psychotherapy, which requires more time to consolidate a new "euthymic trace" that allows good social functioning [47 4]. These data further affirmed the initial observations of Klerman [60] regarding pharmacological therapy and psychotherapy in the depressive forms.

A study in 2002 [61] carried out in 707 patients with DD evaluated the efficacy of IPT-D and sertraline on depressive symptoms either alone or in combination. Patients were randomly assigned to one of three groups (IPT, IPT + sertraline, sertraline) and treated for 16 months with a follow-up period of 18 months. All patients were evaluated with the MADRS during follow-up and at the end of therapy. Greater efficacy was seen in the groups of patients treated with sertraline both during treatment and follow-up (IPT + sertraline, sertraline): of these, combined therapy was associated with a greater reduction in healthcare costs and greater compliance with pharmacological treatment.

The results of an earlier study were confirmed in the investigation by Markowitz and colleagues in 2005 [62]. In a 16-week study on 94 'pure dysthymic' patients, i.e. those without comorbid major depression or double depression, the efficacy of IPT-D and sertaline, alone or in combination, was compared to brief supportive psychotherapy (BSP). All four treatment groups (sertraline, sertraline + IPT-D, IPT-D, BSP) showed improvement in anxiety symptoms, while treatment with sertraline (sertraline or sertraline + IPT-D) was more effective that either psychotherapy alone in improvement of social functioning and depressive symptoms, with a greater rate of response and remission. The main limitation of this study is the difficulty in differentiating the action of the drug from psychotherapy, and in characterizing the specific role of IPT-D. However, an antidepressant seems to play an important therapeutic role in patients with chronic depression.

Lastly, a pilot study conducted in 2008 [63] compared the efficacy of IPT-D and BSP in the treatment of dysthymic patients with comorbid alcohol abuse. In 1981, Akiskal highlighted the frequent comorbidity between chronic mood disorders and substance abuse. Treatment of such patients with a dual diagnosis has involved numerous pharmaco- and psychotherapies, with results that are generally good on depressive symptoms but poor on substance abuse [64-67]. In the pilot study, 26 patients were enrolled and randomized to 16-18 weekly sessions of IPT-D (n = 14) or BSP (n = 12). The Time-Line Follow Back Method (TLFBM) [68] was used to evaluate the type and frequency of substance abuse, while the HDRS [69], BDI [70] and Cornell Dysthymia Rating Scale (CDRS) [71] were utilized to assess depressive symptoms. Improvement in abstinence and depressive symptoms was reported in both groups, although the IPT-D was superior to BSP. For this reason, IPT may represent a valid alternative in the treatment of patients with alcohol abuse who refuse pharmacological therapy. Nonetheless, the modest action of IPT-D on the percentage of abstinent days showed that, in agreement with previous studies [72], therapy in these patients, including drugs, has a greater and more specific action on affective symptoms that does not significantly impact abuse.

Substance abuse

The study of Markowitz [63] allowed for the introduction of another application of IPT, namely dependence on psychoactive substances, and in particular cocaine, alcohol and heroin. Regarding cocaine abuse, several types of psychotherapies have been attempted with psychodynamic and cognitive orientations [73-75]. Rounsaville and colleagues [76] developed a model of IPT that can be associated with pharmacotherapy whose primary objective is decrease or interruption of cocaine use, and the development of adaptive strategies to manage social and

interpersonal problems that trigger substance abuse. In contrast to opioid dependence, for which psychotherapy alone is insufficient in leading to abstinence [77], for cocaine abuse psychotherapy alone can be adequate in some subgroups of patients [78].

A study by Carroll et al. [79] investigated the efficacy of detoxification from cocaine with two 'active' psychotherapies that were adapted to this category of patients, namely modified IPT [76] and Relapse Prevention Therapy (RPT), a cognitive-behavioural matrix. A total of 42 patients dependent on cocaine were randomly assigned to one of the two psychotherapies and treated for 12 weeks. Outcome, including compliance to therapy and reduction in cocaine use, were evaluated weekly with the Cocaine Craving and Use Scale (CCUS) [80], which assesses the quantity and frequency of abuse, and also considers craving. It was seen that patients treated with RPT more easily reached 3 weeks of abstinence (57% *vs*. 33%), with a greater frequency of remission (43% *vs*. 19%) compared to IPT. Moreover, the difference between the two psychotherapies was also evident considering the severity of abuse: patients with greater severity of abuse, in fact, responded better to RPT, while those with less severe abuse responded similarly to the two psychotherapies.

In 2004, Carroll et al. [81] compared the efficacy of disulfiram to placebo, in association with CBT or IPT in management of cocaine abuse. First used for treatment of alcoholism, disulfiram has also been sued for cocaine detoxification: it is believed that a reduction in alcohol abuse is associated with a consequent reduction in cocaine abuse, often used as an antidote to the sedative effects of alcohol. A total of 121 patients were randomized on one of four study groups (disulfiram 250 mg/day + CBT, disulfiram + IPT, placebo + IPT, placebo + CBT) and treated for 12 weeks. A greater reduction in cocaine abuse was observed in patients treated with disulfiram, especially in association with CBT. Absence of concomitant alcohol abuse was a positive prognostic factor and improved compliance. Psychotherapeutic intervention, even if added to pharmacotherapy, was seen to be essential in treatment of cocaine abuse, although the best results were seen with cognitive-behavioural techniques rather than interpersonal therapies.

At present, there is little empirical evidence regarding the efficacy of psychotherapy in the treatment of opioid dependence: in general, patients in maintenance with methadone, if treated with CBT [82], psychodynamic therapy [83] or Implosive Group Therapy [84] have better outcomes compared to a control group. Even IPT can be used in these patients considering the high frequency of interpersonal and social problems [85], and the elevated rate of comorbid major depression [85 86].

Several years ago, Rounsaville and colleagues [87] evaluated the efficacy of IPT in association with methadone on psychiatric comorbidities during maintenance treatment of heroin-dependent patients. Patients (n=72) were treated for 6 months with IPT (n = 37) or low-contact therapy (LCT) structured in monthly sessions (n = 35). IPT was seen to be more efficacious in terms of self-control, development and reinforcement of the locus of internal control [88]. LCT had greater effects on resolution of areas identified as problematic. The difficulty of compliance to treatment was confirmed by the high rate of drop-outs: 62% of patients treated with IPT *vs*. 46% of those treated with LCT. This demonstrates that more structured and challenging therapies can lead to substantial problems with compliance in this population of patients. It should be pointed out that none of the patients abandoned therapy with methadone, which confirms its utility as a primary tool for detoxification.

Eating disorders

Bulimia

Once believed resistant to treatment [89], today bulimia is treated with various antidepressant pharmacotherapies and/or psychotherapeutic interventions. Among these, CBT, when appropriately adapted [90], is an acceptable treatment option [91 92]. However, a model of IPT, adapted to the needs and characteristics of patients with bulimia, can also be considered a valid alternative therapy to CBT [93 94]. Such a psychotherapeutic model does not directly address the pathological eating disorder, but through analysis of the clinical history of the patient aims to identify problematic interpersonal areas, often correlated with difficulty in managing affectivity, that modulate the emotive states that underlie and trigger eating binges and aberrant behaviour. The fundamental supposition of this type of intervention is that eating disorders depend on interpersonal problems [94].

An early study evaluating IPT adapted to bulimia [95], carried out for 19 weeks in a group of 75 patients, compared the efficacy of IPT (n = 25), CBT (n = 25) and behavioural therapy (BT) (n = 25) on eating and affective symptoms. IPT and CBT showed similar efficacy on binge eating and associated psychiatric symptoms, and especially with depressive symptoms [96 97]. CBT, in contrast, showed greater efficacy in treatment of some ego-syntonic aspects of eating disorders, such as dysmorphophobic symptoms and resorting to overly drastic diets.

In a later study in the same cohort of patients (n = 93), the authors examined the efficacy of IPT, CBT and BT during a follow-up of 12 months defined as 'closed', i.e. without the administration of any therapy except for particular clinical needs. Patients were evaluated at 4, 8 and 12 months after psychotherapy with the Eating Disorders Examination (EDE), an interview that assesses the major psychopathological phenomena of eating disorders [98 99].

Also in this study, both IPT and CBT had similar efficacy on bulimic behaviour, in which improvements obtained in the previous phase of therapy were maintained during follow-up. Both psychotherapies were associated, in about 50% of cases, with the progressive regularization of the menstrual cycle, if previously altered. Likewise, dysmorphophobia and social functioning showed further improvement during follow-up. BT was less effective than CBT on dysmorphophobic and restrictive eating symptoms, with a greater rate of drop-outs. Lastly, regularization of eating was not associated with substantial weight gain in either the short or long term. This aspect is undoubtedly essential in maintaining successful therapy in these patients.
In a trial in 220 patients with bulimia treated as in the previous studies with IPT, CBT or BT, Agras and investigators [100] confirmed the data published by Fairburn. Jones et al. [101], in a similar study, noted a greater specificity of CBT compared to IPT, and that the results were not maintained after 7 weeks following the end of treatment. According to these authors, CBT can be considered as first-line therapy in the treatment of bulimia.
In 1995 [102], the results of a long-term follow-up of 99 patients with bulimia were published; patients were enrolled between 1982 and 1988 to compare outcomes after treatment with IPT, CBT or BT. It was reported that after a mean of 10 years after treatment, 20% of patients treated with all three psychotherapies still had diagnostic criteria for bulimia, 75% had received additional therapy and 25% had developed an eating disorder not otherwise specified (EDNOS), especially in patients treated with BT. The development of nervous anorexia was infrequent. These data are in agreement with previously published studies by other authors [103-105]. Prognosis would thus appear to be influenced by the type of psychotherapy received: better and similar results were seen for IPT and CBT, while poorer outcomes were observed for BT.
A case report in 2005 [106] described integrated consecutively administered IPT and CBT in the treatment of bulimia. These authors affirmed that the integration of two models is a valid treatment option allowing for control of binge eating, purging and dysmorphophobic symptoms. The validity of integrating these two therapies, even in a group context, was later confirmed by Nevonen et al. [107].

Binge eating disorder and obesity

The first choice of therapy in treatment of binge eating disorder (BED) is group CBT [108 109]. However, some studies have reported, following treatment with CBT, a remission rate of only about 50% [110-112]. It is therefore necessary to investigate alternative psychotherapies [113 114]. IPT is a valid tool in reducing episodes of binge eating since eating disorders can be related to pathological management of negative emotions bound to the interpersonal sphere, defined as 'emotional eating' [115-117]. Through improvement of emotive and interpersonal management of relations, IPT attempts to interrupt resorting to food as a coping strategy.
The efficacy of IPT and group CBT in the treatment of BED have been compared in a study of 56 patients, assigned to a cycle of 16 weekly sessions of IPT, CBT or a wait-list control group [113]. Patients were evaluated by the EDE and the frequency of binge eating (FBE) at baseline, at the end of therapy, and at the follow-up visits at 6 and 12 months. Patients in the control group were evaluated after 16 weeks of waiting. As observed in previous studies [110 118 119], the two active therapies, compared to the wait-list control, showed comparable and greater reduction in FBE, and significantly less than baseline during the entire follow-up period. This investigation thus demonstrated the efficacy of treating BED with a therapy focusing on eating behaviour and interpersonal background.
Agras et al. [118] studied a population of non-responders to a cycle of 12 sessions of CBT, in order to determine if IPT was associated with significant improvements in psychopathology and eating behaviour, after failure of CBT. The 50 patients examined, after 12 sessions of CBT, were enrolled in a weight loss programme if they obtained improvement in eating behaviour. If however the psychopathological and eating symptoms were unchanged, they were treated with IPT for the same number of sessions. According to the data reported by these authors, IPT did not lead to significant improvements in non-responders to CBT, indicating that the two therapies were ineffective in different populations.
A study carried out in 2002 [120] compared the efficacy of IPT CBT in a group of 162 patients treated with a cycle of 20 weekly sessions. Patients were evaluated with the BMI and EDE at baseline, at the end of treatment and every 4 months for the entire year of follow-up. The two groups showed similar outcomes in the rates of remission (64% *vs*. 59%), both at the end of treatment and at the one-year follow-up, with a reduction in psychiatric comorbidity. The frequency of binge eating, however, slightly increased during follow-up, but was nonetheless less than baseline values. The two therapies did however differ in terms of the timing of improvement of dietary restriction, which was more rapid in patients treated with CBT.
It has been observed that BED in an adolescent age is a significant risk factor for obesity, with all of its associated complications. Therefore, BED has been included among the target of intervention in the primary prevention of obesity [121-126]. In 2010, a pilot study [126] evaluated the efficacy of IPT in the prevention of overweight in a population of adolescents (12-17 years old) with a BMI above normal limits, while a control group received health education. A specific type of IPT was used, namely IPT Weight Gain (IPT-WG), modified according to the needs of this patient subgroup, which compromised 12 weekly group sessions, and evaluated with the EDE and BMI at 6 and 12 months

after the end of therapy. The results indicated that the IPT-WG was associated with a significant decrease in binge eating, and was also more effective in preventing weight gain.

Anxiety disorders

Social Anxiety Disorder

The therapeutic approach to social anxiety disorder (SAD) is generally based on psychotherapy together with pharmacological treatment. CBT is considered the treatment of choice [127-130], even if one third of patients do not respond [131-133], and many responders, even while showing improvement, retain residual symptoms [134]. The importance of the interpersonal component in social phobia is easily seen by the relation between the onset of symptoms and interpersonal problems, and especially those related to changes in social roles [135]. Lipsitz and Markowitz [136] assessed the efficacy of IPT-SP, which is a type of IPT specific for social phobia: it consists of brief psychotherapy sessions (e.g. 12-16), concentrating on problems related to role transition.

An open study [136] examined the efficacy of IPT-SP in the treatment of 9 patients with a diagnosis of SAD. Patients were evaluated at baseline, and at 7 and 14 weeks using the CGI and Liebowitz Social Anxiety Scale (LSAS) for phobia, and the HARS and HDRS for avoidance of social and interactive situations. IPT-SP was well tolerated, with no drop-outs and with outcomes generally similar to treatments commonly used in SAD [137]. Its efficacy was confirmed with a response rate of 78% (n=7) and improvement in the quality of life, especially during the second half of treatment. Thus, IPT-SP can be considered to have an efficacy that is comparable to group CBT [130], but with slower improvement compared to pharmacotherapy [137].

Later, an RCT [138] was published on 70 patients with SAD, randomized to receive either 14 sessions of IPT-SP (n = 36) or supportive psychodynamic psychotherapy (ST) (n = 34). Patients were evaluated at baseline, at 7 and 14 weeks after the initiation of therapy, and at 6 and 12 month follow-up visits. It was observed that IPT-SP was an efficacious therapeutic option in the treatment of SAD, although it was not statistically superior to ST: both treatments were associated with substantial reduction in both symptoms and disabilities, and analogous clinical response rates. IPT was superior to ST only in improvement of phobic fear of negative judgment and social situations. The study also demonstrated improvement in the second phase of treatment, leading one to believe that a longer therapeutic strategy (e.g. 16-20 sessions) may have been even more effective. In fact, in IPT the lack of exposure techniques, characteristic of CBT, renders the acquisition of new social skills and adaptive behaviours slower. In the authors' opinion, CBT is still the most effective treatment for SAD, which has a specific action in this disorder. The percentage of responders to IPT was similar to ST (42% *vs*. 47%), but much lower than that generally seen in other trials on CBT (response rates from 58-76%) [134 128]. Even the scores seen in the LSAS were lower in patients treated with CBT. IPT was, however, more effective in the long-term: at one year after the end of therapy patients treated with IPT maintained the results obtained, which were analogous to those seen with CBT [93].

A recent study [139] examined a cohort of 118 patients with SAD, randomized to either 16 weeks of IPT-SP (n = 38), cognitive therapy (CT, n = 38) or waiting-list (WL, n = 42). This latter group of patients, after 20 weeks of waiting, received either CT or IPT-SP. Patients were evaluated at baseline, at the end of therapy and after one year. IPT-SP and CT were observed to have a greater efficacy compared to WL. However, compared to IPT, CT was associated with a larger proportion of responders (65.8% *vs*. 42.1%), greater reduction in symptoms and more improvement in functioning, which were maintained at post-treatment follow-up. IPT had a better efficacy in the treatment of anxiety symptoms.

Hoffart et al. [140] compared 80 patients randomized to either IPT or residential CT for 10 weeks: the two groups showed similar outcomes. It also demonstrated the importance of identifying factors that are predictive of response to treatment as they could allow for more personalized and targeted therapeutic strategies. In 1991, Sotsky [141] highlighted that CT was associated with better results in patients with less cognitive distortions at baseline, while IPT was more effective in patients with less social deficits. These characteristics may offer an initial indication that could orient the choice of psychotherapy. Nonetheless, there is still no agreement on the possibility of identifying factors that are predictive of response to psychotherapy [142]: some authors [143] have held that they cannot be evaluated, while others believe that some predictive factors have already been identified. In psychotherapy of social phobia, positive expectations of the patient, a good therapeutic alliance and the presence of agoraphobia [144] are positive predictors of response, while the following factors are associated with negative outcome: early age of onset, severity and duration of disease, low level of functioning [145], comorbid Axis I or II disorder, especially in those with an avoidant personality [146], depressive episode in patients who avoid attachment and the presence of symptoms of body dysmorphic disorder [147].

Panic disorder

Panic attacks generally require pharmacotherapy, while psychotherapy has a complementary role. CBT, based on

the systematic desensitization of the patient to the feared situation is the type of psychotherapy most commonly employed. In panic disorder (PD), there is an important interpersonal component related to the social dimension of the crisis and subsequent sequelae of isolation. Several studies have assessed the efficacy of IPT in treatment of PD. Lipsitz et al. [148] elaborated an model that was adapted to this disorder (IPT-PD). In an initial study [148] on 12 patients treated with 12 sessions of IPT-PD, they evaluated its efficacy on anxious and depressive symptoms. Patients were assessed at baseline, during treatment and at the end of the therapy: a response rate of 75% was observed, with significant improvement in symptoms of panic, associated anxiety and related depressive symptoms. Likewise, indices of emotional and physical well-being were also improved. The results obtained were analogous to those obtained in trials in which conventional therapies such as CBT were utilized. Even if the study involved a small number of patients, these initial results on IPT in the treatment of PD appear to be promising.

Post-traumatic stress disorder

The most effective therapy for post-traumatic stress disorder (PTSD) appears to be prolonged exposure therapy (PET), which, through imagination or live exposure, desensitizes the patient to the memory of the trauma, and to disperse anguish [149-153]. At present, little is known about the possibility to utilize other types of psychotherapy. Some authors have reported that traumatized patients with substantial dissociative symptoms show poor response to PET, and thus require other therapies [154]. Moreover, not all patients accept exposure therapy due to the intense emotional commitment needed. These considerations and the important interpersonal symptoms that develop post-trauma have led to the development of a form of IPT modified for PTSD, namely IPT-PTSD [155 156]. This therapy addresses the social and relational consequences of trauma, focusing in a flexible manner on social functioning and relationship skills. Through reinforcement of interpersonal relationships and the social environment, the patient is provided with the tools to deal with and process the trauma by 'leaning on' a safe social network [153 156 157]. This confirms the theory that a safe attachment and well developed social support can protect against the development of PTSD following trauma [158 159].

An early study [155] evaluated 14 patients with PTSD treated for 14 weeks with IPT-PTSD. Patients were evaluated with the Clinician Administered PTSD Scale (CAPS) [160] for symptoms and severity related to the trauma. It was reported that 93% of patients concluded treatment, with a response rate of 69% and a remission rate of 38%. The severity of depressive symptoms was also decreased. Patients that showed improvement of symptoms and interpersonal functioning spontaneously chose to confront the memory and re-elaborate the trauma. In 2009, Markowitz [153] performed a similar study in terms of both sample size and methodology, with results that were analogous to those reported by Bleiberg.

Other authors [161-163] have examined the application of group IPT-PTSD (IPT-G-PTSD) [164], with the idea that an individual approach is not sufficient to address the entire spectrum of interpersonal sequelae of the trauma. A group setting might favour the recovery of lost social skills, as it would allow sharing of trauma experiences and suffering, leading to the development of an empathetic social support network [163]. The first study that applied IPT-G-PTSD was in 2007 [161]. In all, 13 patients were treated for 8 weeks, with a follow-up visit at 3 months. All patients completed the therapy, reporting a slight improvement in avoidance behaviour and depressive symptoms. Subjective perception of improvement in social functioning and general well-being were significant, and all positive improvements were maintained at follow-up.

In 2008, Krupnick et al. [162] carried out a study in 48 women PTSD, with low incomes, belonging to an ethnic minority, most of whom were victims of physical violence. Patients were assigned to either IPT-G-PTSD (16 sessions) or a waiting list (WL), and were evaluated at baseline, at the end of treatment and at 4 months. Monetary compensation was also offered at each phase of the study if successively concluded. The authors reported that active therapy was superior to WL in both remission rates (30% *vs*. 71%, respectively) and maintaining improvement (50% *vs*. 23%, respectively), confirming that the target of action of IPT-PTSD is reduction of symptoms associated with PTSD and improvement of social functioning. A group setting was also preferable to individual therapy in individuals with poor socio-economic status and a low level of education.

Schaal et al. [165] published an RCT on 26 Rwandese orphans who were victims of genocide, treated with either 4 weekly sessions of IPT-G-PTSD (n = 14) or individual narrative exposure therapy (NET) (n = 12). All patients were re-evaluated at follow-up visits at 3 and 6 months for diagnostic criteria and severity of post-traumatic and depressive symptoms. At the end of treatment, there was no difference between the two groups, but during follow-up a significant benefit was seen in the control treatment compared to group interpersonal therapy. In fact, at the 6-month follow-up visit, only 25% of patients treated with NET met diagnostic criteria for PTSD, compared to 71% of those treated with IPT-G-PTSD. At follow-up, both depressive symptoms and severity of PTSD also showed greater improvement with NET.

Campanini et al. [163] investigated the use of IPT-G-PTSD as supplementary treatment after failure of pharmacological therapy. In particular, 40 with PTSD were enrolled,

all with severe symptoms and who did not respond to at least 12 weeks of pharmacological treatment. All patients were treated with 16 weekly group sessions, in addition to 4 individual sessions at the beginning (n = 2), halfway through (n = 1), and at the end of treatment (n = 1). It was observed that IPT-G-PTSD was an effective supplement to pharmacological therapy. In fact, good adherence to therapy was seen, with a drop-out rate of only 17.5%, and a statistically significant decrease in severity of post-traumatic symptoms measured with CAPS (72.3 ± 3.36 *vs*. 36.54 ± 5.44). Improvements were also seen in anxiety and depressive symptoms as well as quality of life.

Lastly, a recent study in 2010 [166] investigated the application of IPT-G-PTSD in 9 veterans of the Vietnam War. Interpersonal intervention confirmed its efficacy in reducing anger, stress and depressive symptoms. However, improvements in interpersonal functioning and reduction of psychological stress were not maintained in the long term.

Among the various types of traumas that can lead to the development of PTSD, sexual abuse must be noted, especially if suffered in childhood. In adults, a history of abuse has been reported to correlate with major depression in 25% of cases and with PTSD in 66% of cases *vs*. [167]. IPT has been shown to be effective in women with depressive symptoms and a history of abuse [168-70]. IPT has also been evaluated in terms of post-traumatic symptoms following violence.

In 2011, the results of a study were published *vs*. [167] on 70 women with depression and a history of sexual abuse in childhood, which compared the efficacy of IPT to usual care psychotherapy (supportive, cognitive-behavioural or dialectical-behavioural, integrated and eclectic and client centred) on post-traumatic depressive symptoms, shame and social and mental functioning. 37 patients were treated with IPT and 33 with usual care psychotherapy. All patients were evaluated at baseline and at 10, 24 and 36 weeks after therapy was initiated using the Childhood Trauma Questionnaire Short Form (CTQSF) [171] and Traumatic Life Events Questionnaire (TLEQ) [172]. IPT was more effective than usual care psychotherapy in improving the severity of PTSD, shame, depressive symptoms and functioning within the family. However, social and mental functioning were comparable in the two groups. Comorbidity with PTSD was also demonstrated to be a negative predictive factor to response to therapy as was comorbidity with an Axis II disorder, and in particular with borderline personality disorder.

Borderline personality disorder

Borderline personality disorder (BPD) is the only personality disorder for which the American Psychiatric Association (APA) has issued treatment guidelines [173], which anticipate psychotherapeutic intervention, usually associated with pharmacotherapy. If one considers the central nature of the borderline psychopathology in problematic relationships and the frequent comorbidity with mood, eating and substance abuse disorders, it is easy to understand the rationale for using IPT in the treatment of these patients.

Our group carried out a study [174] comparing the efficacy of pharmacotherapy alone (fluoxetine 20-40 mg/day) to combined therapy (IPT + fluoxetine) in treatment of BPD patients with major depression. The two treatments were comparable in terms of responder rates and improvement of global and anxiety symptoms. However, combined therapy was associated with greater efficacy in improving depressive symptoms, subjective perception of quality of life and interpersonal relations. Additional studies have been published that confirm the superiority of combined therapy in the management of patients with BPD [175]. A second study from our group [176] compared the efficacy of two combined therapies: IPT + fluoxetine (20-40 mg/day) and CT + fluoxetine (20-40 mg/day). The two treatments were similar for the number of responders, improvement in global symptoms and socio-occupational functioning. CT was superior in improving anxiety symptoms and decisional psychological functioning, in agreement with the hypothesis of Gunderson according to whom a direct approach helps to control anxiety symptoms in these patients. IPT was more efficacious in improvement of subjective perception of social and relational functioning, which is an elective target of this psychotherapy.

The first attempt at adapting the IPT to BPD was in 1994, when Angus and Gillies, while maintaining the intensive format and brief duration, added the image of self to the problematic areas. These authors believed that the nucleus of relational deficit in patients with BPD should be examined not only in affective instability, but also in a labile sense of self and change. Considering this, they performed an explorative randomized trial in 24 patients assigned to IPT or relational management therapy. However, the trial was prematurely terminated due to the high drop-out rate (75%).

Considering the clinical characteristics of these patients and the consequent practical needs, Markowitz et al. [177] elaborated a model of IPT adapted to borderline patients (IPT-BPD). The crucial nodes that rendered manual revision of traditional therapy necessary are the particular conceptualization of BDP, chronic nature of the disorder, early stability of a therapeutic alliance, duration of treatment, elevated risk of suicide, conclusion of treatment and patient selection.

Markowitz et al. [177] published the results of a pilot study in 8 patients with BPD, with comorbidity for mood disorder or other Axis II disorders, and treated for 8 months with IPT-BPD. Of the patients that completed the study

(n = 5), none had diagnostic criteria for BPD, demonstrating significant improvement in the CGI, HDRS, SAS and SC-90. A study from our group [178] showed results that were only partially in agreement with previous literature reports. We compared the efficacy of combined therapy (IPT-BPD + fluoxetine 20-40 mg/day) to pharmacotherapy alone (fluoxetine 20-40 mg/day) in a cohort of patients with BPD and comorbid Axis I or II disorders. Our results showed that both treatments were effective in the management of these patients, and showed similar percentages of response rates and improvement of global psychopathology. Combined therapy was, however, more efficacious in improving anxiety symptoms measured with the HARS, improving subjective perception of the quality of life measured with the SAT-P, and in control of interpersonal relations, affective impulsiveness and instability according to the items of the BPDSI.
From the available data, it is clear that the use of IPT in severe personality disorders is very limited, and that confident conclusions regarding efficacy require additional studies in larger patient cohorts.

Conclusions

The interpersonal dimension of many psychiatric disturbances has allowed progressive enlargement of the spectrum of applications for IPT. The clinical heterogeneity of various disorders requires multiple adaptations to conform to the needs of both patients and the clinical disorder being treated. Apart from its primary indication, namely unipolar major depression, IPT has yielded promising results in the treatment of several Axis I and II disorders: bipolar disorder, dysthymia, substance abuse, bulimia, binge eating disorder, social phobia, panic disorder, PTSD and borderline personality disorder.
An interpersonal, psycho-educational approach, and in some aspects behavioural, proposed by the IPSRT has found utility in the treatment of bipolar disorder, in association with pharmacotherapy for BD-I, and also in monotherapy for BD-II. From analysis of the literature, the efficacy of this psychotherapy can be confirmed, with a specificity of action and efficacy that lies mainly in the stabilization of circadian rhythms. Recovery of regularity of circadian rhythms has been demonstrated, in fact, to be a fundamental element for resolution of episodes of mood alteration, and especially for their prevention. Moreover, IPSRT in association with lithium has been demonstrated to be effective in reducing the risk of suicide in patients with bipolar disorder.
In the treatment of dysthymia, the central role of antidepressant therapy can be confirmed. Together with psychotherapy, and in particular IPT-D, the data demonstrate that combined therapy is superior to monotherapy in improvement of depressive symptoms, interpersonal functioning and reducing healthcare costs, especially in the long-term. Pharmacotherapy and IPT-D have different mechanisms of action, and should thus be considered complementary and synergic. Therefore, combined therapy has been proposed as the therapy of choice in DD.
Substance abuse can also be treated with IPT, considering its frequent comorbidity with mood disorder, although the results obtained are somewhat modest. For cocaine abuse, IPT in monotherapy has not been shown to be effective in relapse prevention therapy (RPT) even though it is associated with a higher rate of clinical response and abstinence, especially in more severe cases. Even in association with disulfiram, IPT was not observed to be more effective than CBT. The efficacy of IPT was modest even in treatment of heroin addicts in maintenance therapy with methadone. The high rate of dropouts demonstrates that less intense psychotherapies are more efficacious.
In the treatment of bulimia nervosa, IPT has been shown to be a valid alternative to CBT, which is commonly used in this disorder. IPT and CBT, in fact, although with different timings and methods, have both been shown to be efficacious in the long-term, while in the acute phase the former is even more efficacious than CBT. By addressing and correcting the pathological eating behaviour, CBT produces rapid changes that are maintained in the long-term. IPT, on the other hand, works on the interpersonal dimension, leading to improvements in eating behaviour that are secondary to relational improvements, and thus occur at a later stage. IPT shows similar improvements in the long-term to those observed in the short-term with CBT.
In binge eating disorder, the utility of intervention focused on eating behaviour has been demonstrated, in addition to interpersonal background. IPT-WG, in particular, by decreasing emotional eating, has been shown to be an effective tool for both control and maintenance of body weight in BED, and can be inserted in obesity prevention programmes, which is a frequent and important complication in this pathology.
In spite of the limitations of the studies reviewed, often based on small, uncontrolled cohorts of patients, the efficacy of IPT can be confirmed in the treatment of PTSD (IPT-PTSD). This type of intervention can be attributed to the attachment theory of Bowlby, according to which a safe attachment and solid social network are the cardinal elements for overcoming and re-elaborating the trauma encountered. In contrast to commonly-used therapies, namely exposure, IPT-PTSD attempts to reconstruct a social and relational network that the patient can 'lean' on to overcome a traumatic event. Interpersonal therapy is associated with improvement in symptoms without direct exposure to the traumatic memory. Re-elaboration of the trauma occurs spontaneously after improvement of general and interpersonal symptoms. Even IPT-G-PTSD, or group

therapy, has been shown to be effective in reducing post-traumatic symptoms, including anxiety and depressive symptoms, with improvement in the quality of life.
According to the available data, IPT has shown promising results in the treatment of Axis II disorders. In the treatment of BPD, IPT-BPD, especially if used in association with pharmacotherapy, considering the preliminary data, is a useful therapeutic tool to improve anxiety symptoms, subjective quality of life and regulation of interpersonal relationships, in addition to impulsiveness and affective instability. The limited information available from studies with small numbers of patients, however, makes it difficult to compare the available results. Further studies are therefore needed in order to confirm these data.
Some of the most controversial aspects concern the efficacy of IPT *vs.* other psychotherapies, and in particular CBT, in the treatment of several mental disorders. In the present review, it has been highlighted that such a comparison is often controversial, and that some aspects of IPT may be more favourable than CBT. It can likely be concluded that behavioural techniques are more direct and act quicker on symptoms, and are thus associated with an earlier change in the clinical picture which is therefore more significant in the short-term. However, interpersonal therapy, which in some ways is analogous to brief psychodynamic therapies, exerts its primary effects on organization and functioning of the relational network and social skills of these patients. These effects result in improvement of symptoms that occurs only at a later phase of treatment. This leads to changes in the overall clinical picture that is slower, but which tends to increase with time, and maintain improvements in the long-term. Such considerations are still in large part theoretical, and only partially supported by empirical evidence. Thus, additional investigations are warranted in order to confirm the results observed to date in controlled studies, with longer duration and adequate follow-up periods after treatment has been completed.

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