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Telephone-delivered Interpersonal Psychotherapy: a systematic review

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Review

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Abstract

Background. The aim of this paper is to review evidence on Interpersonal Psychotherapy (IPT) administered via telephone (IPT-T).
Methods. We conducted a systematic review of studies published between January 1, 1990 and June 30, 2020, assessing the efficacy of IPT administered by phone, using PubMed.
Results. Originally, we found 60 papers; the final selection led to 13 papers. Six studies were performed using a randomized clinical trial methodology (6/13, 46.2%), three were prospective open-label not randomized studies (3/13, 15.7%), three were pilot studies (3/13, 23.1%), and one was a feasibility/acceptance study (1/13, 7.7%). The number of subjects included in the studies ranged between 14 and 442 (mean: 140.0 ± 124.9), for a total of 1850 patients. The mean age of the enrolled subjects was 47.8 ± 9.3 years (range: 27.4-70.4). Thirty-four different instruments were utilized. Qualitative synthesis was conducted only on randomized controlled trials (RCTs), namely on six studies. RCTs were almost all of good quality (mean score/standard deviation of the RCT-Psychotherapy Quality Rating Scale omnibus rating: 5.6 ± 1.2 points; range: 3-7).
Conclusions. IPT-T showed response rates similar to IPT administered in the usual way. Results are limited by small samples sizes, selection bias of the less severe depressed patients, and the heterogeneity of rating scales.

Introduction

Interpersonal Psychotherapy (IPT) is a time-limited, dynamically informed and present-focused psychotherapy that emphasizes the interpersonal context of several psychopathological areas, mainly based on Sullivan's Interpersonal Theory[1] and on Bowlby's[2] Attachment Theory. IPT was originally conceptualized for *pure* unipolar depression, and then modified for a number of depressed special populations, such as postpartum depressed women or adolescents, and for other *disorders*, including Eating and Feeding Disorders.[3-4] Evidence from randomized controlled trials (RCTs) indicates that IPT, either alone or in combination with antidepressants, is effective in decreasing the number and the severity of depressive symptoms by improving interpersonal functioning.[5] It is usually administered over 8 to 20 sessions.[6] After the assessment of interpersonal functioning with the *interpersonal inventory*, there is the case formulation and the choice of the main focus of treatment. Current issues are classified into four problem areas, namely role transition, interpersonal disputes, grief and social isolation. During the initial sessions, the therapist makes the clinical diagnosis, and then examines social functioning, close relationships, communication patterns, interpersonal expectations and the social context of depression.[7] The therapist educates the patient about the causes of his/her disorder and helps him/her to assume the *sick role.* The middle sessions involve communication analysis, decision analysis and behavioral changes to resolve interpersonal dysfunctions. Patients learn how to communicate their needs effectively and how to improve their social networks. In the final sessions, the therapist reviews acquired lifelong interpersonal skills, reinforces competence and discusses the end of the therapeutic relationship.

IPT is usually a face-to-face treatment. However, a number of individuals interested in psychological treatments describe obstacles to care, including low availability of therapists, and difficulties related to the stigma of going to a psychiatric/psychological service.[8] As a consequence, during the last two decades, several psychotherapies have been adapted to their remotely delivered form, with the aim to overcome such difficulties, including telephone-administered cognitive-behavioral therapy, and mindfulness.[9] Telephone-delivered forms of IPT (IPT-T) have been also considered a tool that may facilitate treatments' access.[10-12] To date, IPT-T in its structured forms (individual or group) has been studied in a limited number of clinical reports in adult. Aim of this paper is to provide a systematic review of studies conducted with IPT-T. Thus, during the present COVID-19 pandemic, the demand of remote delivery for

psychological interventions has increased worldwide, and accelerated the transition from the most typical delivery of psychotherapies to remote options.

Objectives

We set out to systematically review the published literature on IPT-T, in agreement with the Population, Intervention, Comparison, Outcomes and Study (PICOS)[13] process as follows: P—population: female and male patients of any age and with any diagnosis who were treated with IPT-T, individual or group sessions; I—intervention: studies addressing the IPT-T, in individual or group form, from 6 to 20 sessions, administered only by telephone by trained therapists (clinical psychologists and/or trained nurses), in clinical settings or general population; C—comparison: patients before and after treatment with IPT-T, and/or matched groups treated with other forms of psychotherapy, or with IPT delivered face-to-face or control groups (when available); O—outcome: changes in depressive symptomatology or in psychological distress; S—study design: RCTs, cohort studies, case–control studies, follow-up studies, pilot studies, quasi-experimental studies, case series, or case reports.

Materials and Methods

We conducted a systematic search of the literature including studies published between January 1, 1990 and June 30, 2020, using PubMed. The time frame was defined in order to include all the available published studies on the selected topic.

We adhered to the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guidelines in completion of this systematic review.[14]

Protocol and registration

There is no published review protocol for this review.

Information source and search strategy

The literature search was designed and independently performed in duplicate by two authors (M.M. and F.M.). The MEDLINE search was conducted using the following syntax: ("interpersonal psychotherapy" [MeSH Terms] OR ("interpersonal" [All Fields] AND "psychotherapy" [All Fields]) OR "interpersonal psychotherapy" [All Fields]) AND ("telephone" [MeSH Terms] OR "telephone" [All Fields] OR "telephones" [All Fields] OR "telephoned" [All Fields] OR "telephonic" [All Fields] OR "telephonically" [All Fields] OR "telephoning" [All Fields]). We found 60 papers. Nineteen papers out of 60 were excluded because not focused on IPT (n = 19/60; 31.6%). Nineteen papers were excluded because they were reviews focused on other topics, methodological papers or editorials (n = 19/60; 31.6%). Of the remaining 22 papers, 6 were excluded because the interventions were time-limited modifications of IPT not delivered by telephone (n = 6/60; 10.0%); three papers were excluded because not written in English (n = 3/60; 5.0%), leading to a final selection of 13 papers (13/60, 21.7%); (see PRISMA flow diagram, for a detailed description) (Figure 1).

Eligibility criteria

The field of search was determined using the PICOS strategy,[13] as detailed in Table 1.

Papers were selected for full-text analysis based on the title, abstract and keywords, provided that they met the following criteria: (1) studies addressing the IPT-T, in individual or group form, from 6 to 20 sessions, administered only by telephone by trained therapists (clinical psychologists and/or trained nurses); (2) original papers on studies with a longitudinal design; (3) prospective or retrospective, observational (analytical or descriptive), experimental, or quasi-experimental, controlled or noncontrolled studies; (4) papers accepted for publication in a peer-reviewed journal; and (5) written in English. Reviews and nonoriginal articles (ie, case reports, editorials, Letters to the Editor, and book chapters) or methodological papers were not included.

Studies selection

Two authors independently screened the resulting papers for their methodology and appropriateness for inclusion, and assessed the language suitability and subject matter of each paper. The studies thereby selected were assessed for their appropriateness for inclusion and quality of method. The first author, year of publication, design, sample size, intervention, number of sessions, kind of therapists who administered the sessions and main findings are summarized in Table 2.

Risk of bias

To assess the risk of bias of individual studies we utilized the RCT of Psychotherapy Quality Rating Scale (RCT-PQRS),[15] a 25-item measure designed and tested in the context of an assessment of the empirical psychodynamic literature, but applicable to all RCTs of psychotherapy. The final version of the scale contained 25 items, which were grouped into six domains: (1) Subjects description (4 items); (2) Treatment definition and delivery (5 items); (3) Outcome measures (5 items); (4) Data analysis (5 items); (5) Treatment assignment (3 items); and (6) Study overall quality (3 items).

For each item, the scale provides a short description, along with a clear specification of the requirements for receiving each individual score on that item. Items 1 through 24, which refer to individual study elements, are scored 0, 1, or 2. Item 25, an omnibus rating of the quality of the entire study, is scored from 1 to 7. Consensus discussion has been used to resolve disagreements between the two reviewers who performed the evaluation.

Quality score of each RCT that passed the two rounds of screening is summarized in Table 3.

Results

Study characteristics

Six studies were performed using a randomized clinical trial methodology[16-21] (6/13, 46.2%), three were prospective open label not randomized studies[22-24] (3/13, 15.7%), three were pilot studies[12,25-26] (3/13, 23.1%), and one was a feasibility/acceptance study[27] (1/13, 7.7%).

The number of subjects included in the studies ranged widely, between 14 and 442 (mean: 140.0 ± 124.9), for a total of 1850 patients. One study did not report on the gender composition of the sample.[17] While reviewing the 12 papers reporting this information, there was a preponderance of female gender, with 1105/1718 females (64.3%), considering also the number of studies on

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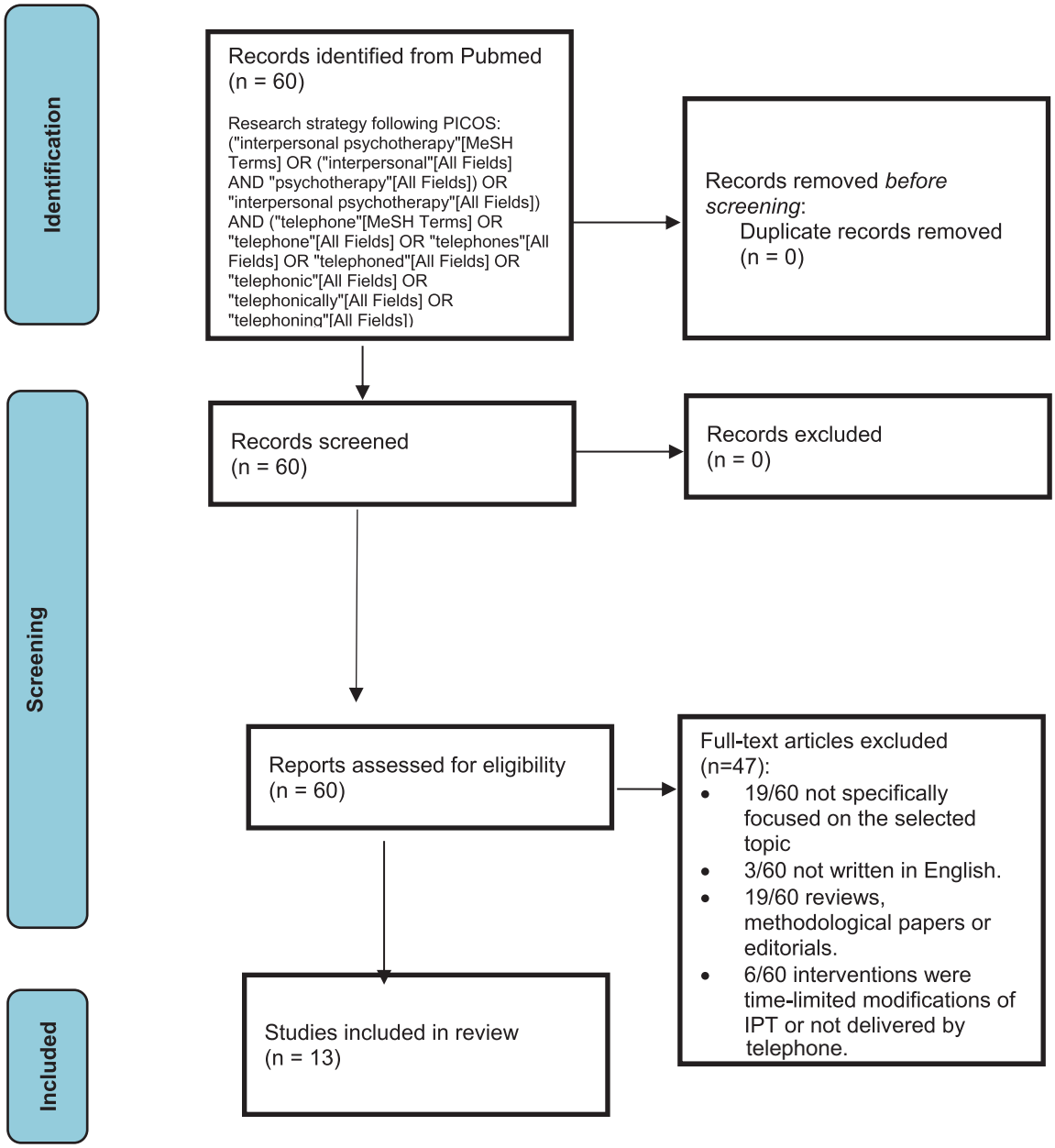

Figure 1. Overview of selection procedures.

Table 1. Eligibility Criteria

Systematic Review Components	Inclusion Criteria	Exclusion Criteria
Population	Patients	Not applicable
Intervention	IPT-T in its structured forms (individual or group) from 6 to 20 sessions, administered only by telephone by trained therapists (clinical psychologists and/or trained nurses)	IPT face-to-face or mixed (sessions administered face-to-face and by telephone)
Comparison	Other interventions delivered by telephone or face-to-face, online interventions, IPT-administered face-to-face, standard care, TAU	Not applicable
Outcomes	Primary outcome: efficacy of IPT-T Secondary outcomes: effects of the delivery by telephone on subjects' outcomes (eg, patients' satisfaction)	Not applicable
Study design	Original articles on studies with a longitudinal design; prospective or retrospective, observational (analytical or descriptive), experimental or quasi-experimental, controlled or noncontrolled studies; articles accepted for publication in a peer-reviewed journal, written in English	Reviews and nonoriginal articles (ie, case reports, editorials, letters to the Editor and book chapters). Paper published not in English

Abbreviations: IPT, Interpersonal Psychotherapy; IPT-T, Interpersonal Psychotherapy administered via telephone; TAU, treatment as usual.

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Table 2. Studies on Telephone IPT-Based Interventions in Depressive Spectrum Disorders

Author	Pub. Year	Study Population	Study Design	Number of Patients	DSM Classification	Number of Rating Scales	IPT-T Sessions		Results
Dennis et al	2020	PPD	Prospective Open Label • IPT-T vs standard post-partum care • Randomization	241	DSM-5	4	12 weekly sessions	Trained nurse	• IPT-T group 4.5 times less likely to be clinically depressed than control group at 12 wk. • Attachment avoidance decreased more in the IPT-T group than in the control group ($P = .02$). • No relapses in IPT-T responders by 36 wk. • Between-group SCID differences were not sustained at 36 wk.
Guille and Douglas	2017	PPD	Prospective Open Label • IPT-T vs standard care • No randomization	41	DSM-IV	1	8 weekly sessions	CNMs	Women receiving IPT-T had lower mean HAM-D at 8 wk (7.9 ± 1.2 vs 12.3 ± 1.2) and 12 wk (7.4 ± 1.2 vs 12.4 ± 1.7), than mental health providers' patients.
Posmontier et al	2016	PPD	Prospective Open Label • CNM-IPT vs TAU • No randomization	61	DSM-IV	6	8 weekly sessions	CNMs	Forty-one women in the treatment group received up to eight 50-min CNM-IPT sessions, and 20 in the control group referred to mental health professionals. • HAM-D scores at 8 and 12 wk were significantly lower in treatment than in control group. • Patients' satisfaction was high in both groups.
Grote et al	2015	PPD	Randomized Clinical Trial • Brief IPT and/or antidepressants vs Maternity Support Services (MSS-Plus) • Randomization	168	DSM-IV	4	8 weekly sessions	Depression care specialists	MOMCare (n = 83) compared to MSS-Plus participants (n = 85) showed: • significantly higher rates of depression remission, • lower levels of depression severity and PTSD severity, • greater likelihood of receiving ≥4 mental health visits and of adhering to antidepressants in the prior month.
Heckman et al	2018	HIV Depression	Randomized Clinical Trial • IPT-T + standard care vs standard care • Randomization	167	DSM-IV	4	9 weekly sessions	PhD-level clinical psychologists	IPT-T long-term depression treatment efficacy assessed through BDI self-administrations at 4 and 8 months. • Intention-to-treat analyses found fewer depressive symptoms in IPT-T than in controls at 4- ($d = 0.41$; $P < .06$) and 8-month follow-up ($d = 0.47$; $P < .05$). • Completer-only analyses were similar.
Anderson et al	2018	HIV Depression	Randomized Clinical Trial • IPT-T + standard care vs standard care • Randomization	147	DSM-IV	4	9 weekly sessions	Therapists	147 depressed HIV patients from rural communities enrolled, 75 with nine sessions of IPT-T + standard care and 72 with standard care only. • IPT-T reduced depression both indirectly via decreased social avoidance and directly with an effect on depression. • Working alliance relieved depression via reductions in social avoidance.

(Continued)

Table 2. *Continued*

Author	Pub. Year	Study Population	Study Design	Number of Patients	DSM Classification	Number of Rating Scales	IPT-T Sessions		Results
Heckman et al	2017	HIV Depression	Randomized Clinical Trial • IPT-T vs standard care • Randomization	132	DSM-IV	4	9 weekly sessions	Therapists	Depressed HIV patients from rural communities randomized to either nine sessions of IPT-T (n = 70) or standard care (n = 62). • IPT-T patients reported significantly lower depressive symptoms and interpersonal problems than controls • Twenty-two of IPT-T group responded (≥50% reductions in depressive symptoms) compared to 4% of controls in intent-to-treat analyses.
Ransom et al	2008	HIV Depression	Pilot Study • IPT-T vs standard care • Randomization	79	DSM-IV	3	6 weekly sessions	11 master's-level clinical psychology trainees and one PhD-level clinical psychologist	Participants randomly assigned to a usual care control condition or to a six-session IPT-T. • IPT-T group showed greater reductions in depressive symptoms and in overall levels of psychiatric distress. • Nearly one-third of IPT-T patients reported clinically meaningful reductions in psychiatric distress from pre- to postintervention.
Corruble et al	2016	MDE	Randomized Clinical Trial • T-IPSRT and T-ICM in add-on to agomelatine vs TAU • Randomization	442	DSM-IV	2	8 weekly sessions	Psychologist	Two telephone-administered psychotherapies (T-P), namely T-IPSRT and T-ICM in add-on to agomelatine in MDD pts vs "Treatment as usual" (TAU). • No significant differences found between T-IPSRT and T-ICM. T-P associated with higher response rates (65.4% vs 54.8%, $P < .02$) and a nonsignificant trend toward higher remission rates (33.2% vs 25.1%) compared to TAU.
Miller and Weissman	2002	MDE	Pilot Study • IPT-T vs no treatment • Randomization	30	DSM-III-R	3	12 weekly sessions	Psychotherapists	12-wk pilot controlled clinical trial with random assignment on feasibility and efficacy of IPT-T vs no treatment, for women with a lifetime history of recurrent depression. • IPT-T vs no treatment was more efficacious at reducing symptoms between baseline assessment and 12-wk follow-up.
Miller et al	2018	CG/ Bereavement	Feasibility/ Acceptance Pilot • IPT-T vs peer support • No randomization	14	DSM-5	2			Subjects with DSM-5 criteria for MDD or ICG score > 19, 6 months or more post loss, assigned to 12–16 wk of IPT-T (n = 8) or to peer support (n = 6). • Pre/post-PHQ-9 scores were 5.3 ± 2.4 vs 3.2 ± 4.1 ($P = .2$) and 16.6 ± 7.1 vs 8.4 ± 5.7 ($P = .06$), respectively. • Pre/post-ICG scores were 12.5 ± 4.7 vs 5.0 ± 2.5 ($P = .01$) and 35.1 ± 5.1 vs 8.4 ± 5.7 ($P = .06$), respectively.

(Continued)

Table 2. *Continued*

Author	Pub. Year	Study Population	Study Design	Number of Patients	DSM Classification	Number of Rating Scales	IPT-T Sessions		Results
Lesperance et al	2007	MDE in Heart Diseases	Randomized Clinical Trial • IPT-T + clinical management vs clinical management • Randomization	284	DSM-IV	2	12 weekly sessions	IPT-certified therapists	Short-term efficacy of citalopram and IPT in reducing depressive symptoms in patients with CAD and MDE, with two randomizations: (1) to receive 12 weekly sessions of IPT + clinical management or clinical management only, and (2) to receive 12 wk of citalopram, or matching placebo. • No evidence of added value of IPT over clinical management.
Donnelly et al	2000	Cancer Patients	Pilot Study • IPT-T for patients and family members • Single-arm study	14	No DSM assessment	8	16 weekly sessions for patients and 11 for family members	Clinical psychologists	A single-arm pilot study explored the feasibility of adapting IPT-T to reduce psychological distress and to enhance coping during cancer treatment, both in patients and their partners. • Satisfaction with the program was rated between "good" and "excellent". • No efficacy tests were performed.

Abbreviations: BDI, Beck Depression Inventory; CAD, coronary artery disease; CG, Complicated Grief; CNM, certified nurse-midwife; HAM-D, Hamilton Depression Rating Scale; ICG, Inventory of Complicated Grief; IPT, Interpersonal Psychotherapy; IPT-T, Interpersonal Psychotherapy administered via telephone; MDD, major depressive disorder; MDE, Major Depressive Episode; PPD, postpartum depression; PHQ-9, Patient Health Questionnaire-9; TAU, treatment as usual; T-IPSRT, Telephone Interpersonal and Social Rhythm Therapy; T-ICM, Telephone Intensive Clinical Management; SCID, Structured Clinical Interview for DSM Disorders.

pregnancy/postpartum/perinatal depression. Sample size and composition varied widely. The mean age, according to studies that reported this variable (n = 11), was 47.8 ± 9.3 years (range: 27.4-70.4).

With regard to psychiatric diagnoses, two studies adopted the DSM-5[28] (2/13, 15.4%) criteria,[22,27] nine studies adopted the DSM-IV[29] criteria (9/13, 69.3%),[16-21,23-25] one the DSM-III-R[30] (1/13, 7.7%)[12]; one study had no categorical assessment[26] (1/13, 7.7%; clinical definition of "*psychological distress*").

Outcome measures adoption was largely inhomogeneous: we found 34 different instruments. There was one study that utilized one instrument.[23] The remaining studies utilized >1 instrument, with one study that utilized nine different instruments.[26] Consequently, the range was 1to 9 with a mean of 3.8 ± 2.3 instruments adopted for each study.

Qualitative synthesis was conducted only on RCTs, when available, namely on six studies.[16-21] The RCTs were almost all of good quality (mean score/SD of the RCT-PQRS[15] omnibus rating: 5.6 ± 1.2 points; range: 3-7).

Data synthesis

Studies varied in terms of how outcomes were measured and of sample selection criteria. Hence, this systematic review is presented as a narrative synthesis, according to the diagnosis of the enrolled samples, namely: studies on Depressive Spectrum Disorders[12,19] (2/13, 15.4%); Pregnancy/Postpartum/Perinatal Depression[20,22-24] (4/13, 30.7%); Complicated Grief and Bereavement[27] (1/13; 7.6%); Depressive Spectrum Symptoms in HIV patients[16-18,25] (4/13, 30.7%); Depressive Spectrum Symptoms in patients with severe chronic diseases[21,26] (2/13, 15.4%).

Summary of evidence

Studies on major depression

We found two studies on this topic. Miller and Weissman[12] carried out a pilot controlled clinical trial of IPT-T to a sample of women with a lifetime history of recurrent or chronic depression. Inclusion criteria were: a lifetime history of recurrent major depression (MDD), dysthymia, recurrent depression not otherwise specified, mild/moderate depressive symptoms according to the Hamilton Rating Scale for Depression (HRSD score < 18),[31] and no current involvement in maintenance treatments. Patients with bipolar disorder, schizophrenia spectrum disorders, a history of suicidal ideation/intent, and low IQ were excluded. Patients were randomly assigned to the treatment condition (12 1-hour weekly sessions of IPT-T) (n = 15) or to a no-treatment condition (n = 15). They were evaluated not only with the HRSD,[31] but also with the Global Assessment Score,[32] the Social Adjustment Scale Self-Report (SAS-SR),[33] at baseline and after a 12-week follow-up. Subjects in treatment condition were also asked to rate their individual satisfaction levels regarding treatment (including the telephone administration) with a five-point scale. IPT-T was more effective than no treatment in reducing depressive symptoms comparing baseline scores and 12-week follow-up of all scales in the areas of work and nonfamilial social interaction. However, six patients out of 15 from the IPT-T group dropped out before the completion of treatment.

Corruble et al[19] utilized a telephone adaptation of the *Interpersonal and Social Rhythm Therapy*[34] for Bipolar Depression (T-SRT) in a sample of 221 adult outpatients. Patients were randomly assigned to eight sessions of weekly T-SRT (n = 110) or to Telephone Intensive Clinical Management[35-37] (T-ICM)

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Table 3. Research Clinical Trials on Telephone IPT for Depressive Spectrum Disorders: RCT of Psychotherapy Quality Rating Scale Scoring

	Anderson et al[16]	Heckman et al[17]	Heckman et al[18]	Corruble et al[19]	Grote et al[20]	Lesperance et al[21]
Description of subjects						
1. Diagnostic method and criteria for inclusion and exclusion	1	2	2	2	2	2
2. Documentation or demonstration of reliability of diagnostic methodology	2	2	2	2	2	2
3. Description of relevant comorbidities	2	2	2	0	2	2
4. Description of numbers of subjects screened, included, and excluded	2	2	2	1	2	2
Definition and delivery of treatments						
5. Treatment(s) (including control/comparison groups) are sufficiently described or referenced to allow for replication	1	2	2	2	2	2
6. Method to demonstrate that treatment being studied is treatment being delivered	2	2	2	2	2	2
7. Therapist training and level of experience in the treatment(s) under investigation	1	1	1	1	0	2
8. Therapist supervision while treatment is being provided	1	0	0	1	0	2
9. Description of concurrent treatments allowed and administered	0	1	1	2	2	2
Outcomes measures						
10. Validate outcomes measures	2	1	2	2	2	2
11. Primary outcomes measures specified in advance	2	2	2	2	2	2
12. Outcomes assessment by raters blinded to treatment group with established reliability	2	2	2	1	1	2
13. Discussion of safety and adverse events during study treatments	0	1	0	1	2	2
14. Assessment of long-term post-termination outcome	0	1	1	0	2	1
Data analysis						
15. Intent-to-treat method for data analysis involving primary outcome measure	2	1	2	2	2	2
16. Description of dropouts and withdrawals	2	2	1	0	1	2
17. Appropriate statistical tests	2	2	2	2	2	2
18. Adequate sample size	2	2	2	2	2	2
19. Appropriate consideration of therapist and site effects	-	1	1	1	1	1
Treatments assignment						
20. *A priori* relevant hypotheses that justify comparison groups	2	2	2	2	2	2
21. Comparison group(s) from same population and time frame as experimental group	2	1	1	1	2	2
22. Randomized assignment to treatment groups	2	1	1	1	2	2
Overall quality of study						
23. Balance of allegiance to types of treatment by practitioners	2	1	1	2	2	2
24. Conclusion justified by sample, measures, and data analysis as presented	2	1	1	1	1	2
25. Omnibus rating	7	6	6	5	7	7

Items 1 through 24, which refer to individual study elements, are scored 0, 1, or 2. Item 25, an omnibus rating of the quality of the entire study, is scored from 1 to 7 Items from 1 to 11: 0 = "poor"; 1 = "brief"; 2 = "full".
Item 12: 0 = poor or no blinding of raters to treatment group; 1 = blinding of independent raters to treatment group or established reliability; 2 = blinding of independent raters to treatment group and established reliability. Item 13: 0 = poor or no discussion of safety and adverse events; 1 = brief discussion of safety and adverse events; 2 = full discussion of safety and adverse events.
Item 14: 0 = poor or no post-termination assessment of outcome; 1 = medium-term assessment of post-termination outcome (2-12 months post-termination); 2 = long-term assessment of post-termination outcome (≥12 months post-termination).
Item 15: 0 = no description or no intent-to-treat analysis with primary outcome measure; 1 = partial intent-to-treat analysis with primary outcome measure; 2 = full intent-to-treat analysis with primary outcome measure.
Item 16: 0 = poor or no description of dropouts and withdrawals; 1 = brief description of dropouts and withdrawals; 2 = full description of dropouts and withdrawals (must be explicitly stated and include reasons for dropouts and withdrawals).
Item 17: 0 = inappropriate statistics; 1 = moderately appropriate; 2 = fully appropriate statistics.
Item 18: 0 = inadequate justification and inadequate sample size; 1 = adequate justification or adequate sample size; 2 = adequate justification and adequate sample size.
Item 19: 0 = therapist and site effects not discussed or considered; 1 = therapist and site effects discussed or considered statistically; 2 = therapist and site effects discussed and considered statistically. Item 20: 0 = poor or no justification of comparison group(s); 1 = brief or incomplete justification of comparison group(s); 2 = full justification of comparison group(s).
Item 21: 0 = comparison group(s) from significantly different population and/or time frame; 1 = comparison group(s) from moderately different population and/or time frame; 2 = comparison group(s) from same population and time frame.
Item 22: 0 = poor (eg, pseudo-randomization, sequential assignment) or no randomization; 1 = adequate but poorly defined randomization procedure; 2 = full and appropriate method of randomization performed after screening and baseline assessment.
Item 23: 0 = no information or poor balance of allegiance to treatments by study therapists; 1 = some balance of allegiance to treatments by study therapists; 2 = full balance of allegiance to treatments. Item 24: 0 = poor or no justification of conclusions; 1 = some conclusions of study justified or partial information presented; 2 = all conclusions of study justified and complete information presented. Item 25: omnibus rating: 1 = exceptionally poor; 2 = very poor; 3 = moderately poor; 4 = average; 5 = moderately good; 6 = very good; 7 = exceptionally good.
Abbreviations: IPT, Interpersonal Psychotherapy; RCT, randomized controlled trial.

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(n = 111), in add-on to antidepressant agomelatine. Trained psychologists blind to other treatment aspects delivered entirely by telephone both psychotherapies. Enrolled patients of both arms were *a posteriori* matched with a similar sample of depressed bipolar outpatients receiving treatment as usual (TAU) as control group (n = 221). The primary outcome was the percentage of responders on the 16-Item Quick Inventory of Depressive Symptomatology, Clinician Rating (QIDS-C),[38] consisting in 16 items to assess depression severity after 8 weeks of treatment.

Responders were defined by a decrease in the QIDS-C[38] score of at least 50% from baseline to follow-up. QIDS-C[38] score ≤ 5 defined remitters. The two active treatments shared some similarities. The T-ICM consisted in a manual-driven psycho-education approach (each session lasting 30-45 minutes) to the medical management of depression.[35-37] Patients were helped to become familiar with signs and symptoms of their bipolar depressive disorder and to address issues relevant to medication adherence, such as education about depression, the medications used to treat this disorder, the basic sleep hygiene, the careful review of symptoms, and the behavioral management of adverse effects. The T-SRT was an eight-session intervention (each session lasting 30-45 minutes) based on IPSRT,[34] and on the social *zeitgeber* hypothesis by Ehlers et al.[39] T-SRT helped patients to regulate their social rhythms (daily routines) and levels of daily activity/stimulation in order to achieve regularity of underlying biological rhythms. Moreover, as T-ICM,[35-37] the psycho-educational approach was part of the intervention. The TAU group received face-to-face sessions with a psychiatrist and antidepressant agomelatine, but no psychotherapy. Both treatments were superior to TAU in terms of response rates and trend toward remission rates. No significant differences were found between T-SRT and T-ICM.[35-37] Both groups showed improvement of social rhythmicity, as well as improvement of depressive symptomatology as rated by the QIDS-C[38], 16-Item Quick Inventory of Depressive Symptomatology, self-report (QIDS-SR),[38] and CGI-S.[40] The null finding on differences between the two treatments was explained by the fact that all study participants received agomelatine, an antidepressant with resynchronizing properties, that created a *ceiling effect* on the rhythm aspects.

In summary, the two studies[12,19] demonstrated that IPT-T was superior to standard clinical approaches but not to other structured approaches (such as T-ICM). Main limitations were the small sample size of the first study and the short-term period of observation of both studies. Moreover, in the Miller and Weissman's study,[12] 6 out of 15 enrolled patients (40%) discontinued treatment prematurely, raising question on IPT-T acceptability.

Studies on pregnancy depression/postpartum depression

We found four studies in this area of interest.[20,22-24] The first one was a prospective, nonrandomized, open label study comparing IPT delivered by trained nurse-midwives over the phone to the usual care (UC), during the referral to mental health providers for postpartum depression (PPD).[23] Women receiving routine postpartum care by their obstetrics were referred for study participation if they reported a score of ≥9 on the Edinburgh Postnatal Depression Scale (EPDS).[41] A total of 41 patients were enrolled in the IPT group and 20 in the UC group. After accounting for baseline group different scores on the HRSD,[31] they were compared at week 8 and 12. Women receiving IPT-T had lower mean HRSD[31] compared to those referred to mental health providers at 8 weeks (7.92 ± 1.20 vs 12.30 ± 1.27), and 12 weeks (7.49 ± 1.27 vs 12.43 ± 1.74), but no statistical differences were found, mainly because of the small sample's sizes.

In a prospective cohort study, women with symptoms of PPD were nonrandomly assigned to a control group or to IPT-T administered by certified nurse-midwives (CNM-IPT).[24]

The initial planning of the study was based on a randomized clinical trial design, but potential eligible patients expressed their willing to participate only if they had the choice to receive IPT from their CNMs. Patients were enrolled even when treated with antidepressants. Conversely, they were excluded if their infants had major medical complications lasting more than 6 weeks postpartum, birth defects, or were given up for adoption, or if mothers had severe cognitive deficits, current alcohol or substance abuse, active suicidality, homicidal intents, psychoses, or serious medical illnesses (such as, severe hypertension and cardiac diseases). The intervention group received IPT-T for 8 sessions lasting 50 minutes for a maximum period of 12 weeks, unless women dropped out. The control group received TAU, namely the referral to mental health professionals providing psychotherapeutic modalities other than IPT (supportive and psychodynamic psychotherapy). A group of research assistants, blinded to treatment, administered an encrypted online survey of instruments via telephone to women in the control and intervention groups, at baseline and 4, 8, and 12 weeks postenrollment. Patients were evaluated with the MINI-International Neuropsychiatric Interview (M.I.N.I.),[42] the HRSD,[31] the Global Assessment of Functioning,[43] the EPDS,[41] the Dyadic Adjustment Scale (DAS),[44] the Mother-to-Infant Bonding Scale,[45] and the Social Support Questionnaire.[46] Treatment acceptability was assessed with the Client Satisfaction Questionnaire, and two qualitative questions (*What worked for you during this study?* and *What did not work for you during this study?*).[47] Sixty-one patients out of 166 screened were enrolled, 41 in the CNM-IPT group, and 20 in the TAU group. Patients in the CNM-IPT group scored significantly lower compared to the control group on the HRSD,[31] at 8 and 12 weeks (Week 8, $P = .047$; Week 12, $P = .029$). However, the TAU group was characterized by more severe depression at baseline, as demonstrated by HRSD[31] ($P = .001$), and EPDS[41] scores ($P = .027$) than the CNM-IPT group. Moreover, women in TAU group had more frequently a history of bipolar disorder ($P = .039$). The two groups did not differ in terms of chronic medical illness, antidepressant use, negative life stress, or current psychiatric comorbidities.

Grote et al[20] conducted a study on a sample of pregnant socioeconomically disadvantaged women, comparing a culturally relevant collaborative care intervention (the MOMCare) vs the public health Maternity Support Services (MSS-Plus) in Seattle (United States). The MSS social workers and nurses routinely screened pregnant patients for depression on the Patient Health Questionnaire-9 (PHQ-9),[48] and referred to the study those patients who scored 10. The initial screening inclusion criteria were: age ≥ 18 years, diagnosis of probable major depressive disorder (MDD; at least five symptoms scored as ≥2 with one cardinal symptom on the PHQ-9,[48] plus a functional impairment item), or diagnosis of probable dysthymia based on the M.I.N.I. 5.0,[42] 12 to 32 weeks gestation, telephone access, and being English-speaking. Patients who were eligible on the initial screen, were evaluated with additional exclusion criteria, such as acute suicidal behavior or multiple (≥2) prior suicide attempts, schizophrenia, bipolar disorder, recent substance abuse/dependence, severe intimate partner violence, or currently seeing a psychiatrist or a psychotherapist. The MOMCare included a pre-therapy engagement session to help resolve practical, psychological, and cultural barriers to care. Afterward, patients had the choice of brief IPT (at least eight acute treatment sessions) and/or pharmacotherapy

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Selective serotonin reuptake inhibitor (SSRIs) for acute treatment, and the additional choice for telephone sessions instead of in-person visits. After the acute phase of treatment (about 3-6 months postbaseline) patients were followed up to 18 months. Baseline and 3-, 6-, 12-, and 18-month assessments were carried out via telephone by interviewers blinded to interventions. After completing the overall eligibility screen sessions, 83 patients were randomized to MOMCare and 85 to MMS-Plus. The attrition rate was low, considering that only eight patients (5%) did not initiate treatments or missing the assessments. The MOMCare (n = 83) compared to MSS-Plus participants (n = 85) showed significantly higher rates of remission of depressive symptoms, lower levels of depression severity, and a greater likelihood of receiving ≥4 mental health visits. Across the study period, MOMCare patients had a mean of 4.7 (±4.1) acute in-person sessions and a mean of 4.8 (±4.3) acute telephone sessions.

The most recent study was carried out on a sample of women experiencing depressive symptoms between 2 and 24 weeks postpartum, recruited through advertisement for self-referral and treated by trained nurses in this field.[22] Patients who were willing to participate were contacted by telephone and administered with the SCID-I depression module.[49] Depression was of mild/moderate severity, with an inclusion cut-off of EPDS score > 12.[41]

Exclusion criteria were: current treatments with antidepressants or antipsychotics, being already in psychotherapy, active suicidal/self-harm or infanticide thoughts, psychotic symptoms, and chronic depression. Patients were randomly allocated to the control group (having access to standard locally available postpartum care, including PPD services from public health nurses, physicians, and community resources at maternal discretion) or to the intervention group (that had access to the same postpartum care services plus IPT-T). Patients allocated to the intervention group received 12 weekly 60-minute IPT-T sessions, with the first contact to initiate treatment occurring within 72 hours from trial enrolment. Intervention adherence was considered good when participants completed at least ten 30- to 60-minute sessions of IPT-T, within a 16-weeks program. Patients were evaluated not only with the EPDS,[41] but also with the State-Trait Anxiety Inventory,[50] the DAS,[44] and the Experiences in Close Relationships Scale.[51] A total of 241 patients were enrolled (120 in IPT-T and 121 in the control group). Telephone follow-up to assess outcomes was masked to group allocation, and conducted by the trial coordinator at 12-, 24- and 36-weeks postrandomization. At 12 weeks, 10.6% of women in the IPT-T group (11/104) and 35% in the control group (35/100) were still suffering for depressive symptoms (odds ratio [OR] = 0.22, 95% confidence intervals [CI]: 0.10-0.46). The IPT-T group was 4.5 times less likely to be clinically depressed than the control group. Attachment avoidance decreased more in the IPT-T group than in the control group (P = 0.02). None of the IPT-T responders relapsed by 36 weeks. The differences between the two groups were sustained at 24 weeks, but not at 36 weeks. The most relevant limitations of this study were the enrollment method that could enhance the participation of the most motivated patients and the absence of a comparison group in active treatment.

In summary, the findings in the field of pregnancy/postpartum depression are meager and difficult to generalize. The Guille and Douglas' study[23] reported no significant differences in terms of clinical response between IPT-T and UC. The remaining three studies[20,22,24] demonstrated a superior effect of IPT-T on depression when compared to TAU. However, in the Postmontier et al's study[24] the TAU group was characterized by more severe depression at baseline and by a more frequent diagnosis of bipolar depression. Conversely, depression was only of mild/moderate severity at baseline in the Dennis et al[22] and in the Grote et al's studies.[20]

Studies on complicated grief and bereavement

A sample of 20 adult subjects with complicated grief within 9 months of becoming bereft was enrolled in a pilot study on feasibility and acceptance of IPT-T delivered on a weekly or bi-weekly basis.[27] Trained volunteers from a grief center in Pittsburgh (the Good Grief Center, GGC) provided support to their peers. Two main limitations affected the generalizability of results: patients were assigned to treatments according to their preferences, and complicated grief symptoms severity was mild or moderate. Indeed, subjects who met DSM-5[28] criteria for major depressive disorder (MDD) at baseline, or who scored 20 or higher on the Inventory of Complicated Grief (ICG)[52] 6 months or more post loss, were not assigned to peer supporters at any time, and, rather, they were enrolled directly in IPT with a trained therapist. Both samples were small: eight patients completed the peer support and six completed the IPT trained therapist protocol. Both groups reported a good response, with pre/post PHQ-9 scores[48] of 5.38 (2.45) vs 3.25 (4.13) (P = .266) in peer support group, and 16.67 (7.17) vs 8.40 (5.73) (P = .063) in IPT group.

Pre/post ICG[52] scores were 12.50 (4.72) vs 5.00 (2.51) (P = .016) and 35.17 (5.12) vs 8.4 (5.73) (P = .063). The major strength of this study was that an independent rater evaluated over the telephone the enrolled subjects completing a brief psychiatric history and administering the rating scales for measuring grief severity. Another strength was that patients who already were on psychotropic medications were not asked to make any changes, in order to keep this variable constant in results' interpretation.

In summary, limited evidence on efficacy of IPT delivered by phone is available for patients with complicated brief and/or bereavement. However, we should consider that grief is a challenging problematic area of IPT, independently from IPT administration type.

Studies on HIV patients with depressive disorders

Ransom et al[25] conducted a pilot study on a sample of 79 subjects with HIV and depressive symptoms. They explored the effect of a brief, telephone-delivered, interpersonal therapy (IPT-T), comparing pre- to postintervention on 41 subjects randomized to IPT-T vs 38 subjects randomized to UC condition. Participants assigned to IPT-T (N = 41) received six 50-minute sessions of telephone-delivered therapy, and had access to HIV services, similarly to subjects randomized to UC group. Subjects were evaluated with the 21-Item Beck Depression Inventory (BDI-II),[53] the 45-Item Outcomes Questionnaire (OQ),[54] the Provision of Social Relations Scale (PSRS),[55] and the UCLA Loneliness Scale.[56] Results were unclear: IPT-T subjects evidenced greater reductions in depressive symptoms and in overall levels of psychiatric distress, compared with those in the UC group. However, 31 participants completed the IPT-T sessions, and only 7/31 (22.5%) showed a clinically meaningful reduction on BDI-II[53] (improvement of at least 9 points with postintervention scores <13). Moreover, 13 subjects (16%) did not complete the study, 10 subjects in the IPT-T group, and three subjects in the UC group. Finally, among subjects who completed the IPT-T sessions, only nine (29%) evidenced a reduction on the OQ[54] scores of ≥14 points and had final OQ[54] scores of ≤63; three (10%) showed a decrease of ≥9 points in OQ[54] scores and post-intervention scores ≥63; the remaining 19 (61%) showed no relevant changes.

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Another randomized clinical trial tested IPT-T on a sample of 132 HIV-infected rural patients with a Mood Module of the Primary Care Evaluation of Mental Disorders (PRIME-MD)[57] diagnoses of major depression (MDD), partially remitted MDD or dysthymic disorder.[18] Patients were randomly allocated to IPT + Standard Care (SC) or to SC alone. They were evaluated for depressive symptoms (primary outcome), interpersonal problems (secondary outcome), and social support (secondary outcome), at baseline (pre-intervention), postintervention, and in a 4- and 8- month follow-up. The only exclusion criterion was a serious cognitive or neuropsychiatric impairment based on the telephone-administered version of the Modified Mini-Mental State Examination (scores <70).[58] Patients were not excluded if they reported alcohol or substance use disorders, active bipolar disorders, psychotic symptoms, or current receipt of psychotherapy or pharmacotherapy. The main outcome measure was BDI-II.[53] The Inventory of Interpersonal Problems (IIP)[59] and the PSRS[55] were administered as secondary outcome measures. Patients randomized to SC received no active treatments but had access to community-based support services, namely AIDS-related support groups, 12-step programs, individual therapy, or antidepressant medications. No limitations were imposed on patients' use of psychosocial services outside study procedures, but such use was eventually documented. Tele-IPT + SC patients received 9 weekly, 1-hour telephone IPT treatments, adapted for depressed HIV-seropositive patients. One hundred and thirty-two patients were initially enrolled but 19 patients dropped out, with 113 completers. Results were encouraging but limited from a clinical point-of-view. IPT-T was perceived as a highly acceptable form of treatment. Moreover, IPT-T patients reported significantly fewer depressive symptoms and interpersonal problems at postintervention than SC. However, the percentage of responders was modest: the 23% of IPT-T patients described a reduction in depressive symptoms of 50% or greater, and intervention effect sizes were *medium* in magnitude, in completers analyses, thus confirming the Ramson's study results.[25] The authors stated that the low percentage of responders could be due to the brevity of IPT delivered (nine sessions), the formal training provided to IPT tele-therapists (defined as *minimal*) and to the enrollment of patients with previous mental illnesses, such as substance use disorders, usually excluded from AIDS psychotherapy outcomes research.

The same research group published a second paper analyzing the role of working alliance in this sample.[16] They found that working alliance influenced the reductions in depressive symptoms indirectly, through the reductions of interpersonal problems (especially social avoidance).

A third paper from the same group was focused on the enduring effects of IPT-T when the sample was followed up at 4 and 8 months.[17] Completers were the 77% of both the original IPT-T sample (n = 60) and the SC sample (n = 53). Again, results were partially encouraging. Both with a completer-only approach and an intention-to-treat approach, between-group differences were not statistically significant according to the 64-item self-administered IIP scores,[59] at 4-month or 8-month follow-up. The between-group differences in depressive symptoms at 4- and 8-month follow-up were significant with the completers' only approach in terms of BDI-II[53] means (at 4-months follow-up, tele-IPT = 21.28, controls = 25.08, Cohen's $d = 0.46$; $P = .035$; at 8-months follow-up: Tele-IPT = 20.12, controls = 24.43, Cohen's $d = 0.52$; $P = .017$), but partially with the intent-to-treat analyses. In this case, the between-group difference was marginally significant at 4-month follow-up (Tele-IPT = 21.71, controls = 25.08, Cohen's $d = 0.41$, $P = .058$) and statistically significant at 8-month follow-up (Tele-IPT = 20.55, controls = 24.43, Cohen's $d = 0.47$, $P = .029$).

Studies on patients with severe physical diseases

The Canadian Cardiac Randomized Evaluation of Antidepressant and Psychotherapy Efficacy Study (CREATE),[21] in which citalopram and IPT were compared on a sample of patients with coronary artery disease and depression, allowed a maximum number of four IPT sessions delivered by telephone when necessary, out of a total of 12 sessions (30%). The study enrolled a total of 284 randomized patients with major depression and a HRSD score of ≥20.[31] Participants underwent two separate randomizations, namely: to receive 12 weekly sessions of IPT plus clinical management (n = 142) or clinical management alone (n = 142), and to receive 12 weeks of citalopram, 20 to 40 mg/d (n = 142) or matching placebo (n = 142). The authors utilized, as primary outcome measures, the change between baseline and 12 weeks of the 24-item HRSD[31] and of the self-reported BDI-II,[53] both administered blindly. Citalopram was superior to placebo in reducing 12-week HAM-D scores, whereas there was no evidence of a benefit of IPT over clinical management, with the HRSD[31] scores favoring clinical management.

A pilot single-arm study with a pre-/post-test design investigated the feasibility of a telephone intervention based upon IPT on a sample of patients from an intensive oncology unit.[26] The main hypothesis was that a treatment focused on present condition, on role changes, and on the modification of closest relationships due to cancer could be ideal to face the numerous sources of distress in this population. The therapeutic tasks proposed by Donnelly et al[26] with IPT were nine: to explore the physical, psychological, and social impact of cancer and its treatment; to prepare patient and partner psychologically for upcoming treatment events; to encourage communication in all relationships; to enhance affect expression; to support psychological defenses; to foster independence; to facilitate coping through education, suggestion and advice, modeling, and decision analysis; to optimize social support; and finally, to address practical problems. Eligible patients were affected by breast cancer and treated on either of two high-dose chemotherapy protocols with stem cell transplantation. Their partners or companion were involved in IPT. Weekly telephone sessions began close to the time of the first chemotherapy and ended 4 weeks after the discharge. Patients were then interviewed before chemotherapy began (baseline), after the completion of 3 months chemotherapy, and 2 weeks after the final IPT session (5-months follow-up). Fourteen patients and 10 partners were involved; completers were 12 patients and seven partners. Patients received a mean of 16 telephone sessions, whereas partners had a mean of 11. Satisfaction with the program was rated between "good" and "excellent." No efficacy tests were performed, considering the small sample size and the absence of a randomized design.

Discussion

The soundly based evidence of IPT efficacy in mood disorders, when administered face-to-face, has allowed IPT telephone-administration (IPT-T) in different psychological/psychopathological areas, including depressive disorders, PPD and peri-partum depression, HIV, complicated grief, bereavement, cancer, or cardiac diseases. Evidence from available studies suggests that IPT-T-based interventions could be a reasonable alternative to

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conventional IPT at least in the short-term period. Conversely, results on the long term have not been sufficiently tested.

However, there is a clear need for more research on the use of IPT-T. In PPD and peri-partum depression, the body of evidence supporting IPT-T is far more modest than it is for its conventional form. More important is the paucity of research on the effectiveness of IPT-T in patients with other disorders, except maybe for HIV patients, even if the available observations for this population of patients derive from the same group. The Ransom's study[23] was promising: it was based on a short form of IPT-T, but the number of completers was low, with an even more limited number of subjects who showed clinically meaningful improvement of their depressive symptomatology. Research is also required to define how IPT-T might actually work for these patients.

Finding of this review revealed that psychologists, nurses, nurse-midwives, and other health professionals that administered IPT-T received training and supervision specific for the conducted intervention: *simplicity in training* has been considered one of the IPT strengths, since the beginning. However, details about training were scattered in available studies, and the degree of training necessary to replicate studies' results can be questionable.

Even if this can be said for a number of short-term psychotherapies, we have to notice that there is no information available in current studies on how different health professionals applied for IPT-T, for example, by the administration of adherence rating scales.

In summary, the overall literature on IPT-T demonstrated that this treatment has been used for a good range of psychological/psychopathological syndromes, but led to limited evidence of clinical response, even with an easy-to-administer way, similar to that of conventional IPT. Even with many limitations, there is some strength in the retrieved findings on IPT-T. Thus, 46.1% of the selected studies (6/13) were RCT.[16-21] When analyzed in detail with the RCT-PQRS,[15] they showed *exceptionally good* or *very good* omnibus ratings, except for one study[19] that scored *moderately good*. However, we should consider that the included RCTs utilized different types of control groups.

Summary of limitations

The results of this review must be interpreted with caution due to several limitations. We found studies that varied in terms of design, interventions, and populations sampled. Thirty-four different instruments were used in the reviewed studies, raising questions on how to compare findings from such a number of scales, exploring in different ways several psychological and psychopathological areas. Only four studies utilized the BDI-II,[53] and five the HRSD [31] as main outcome measures. However, we have to consider that the above-mentioned heterogeneity reflected the effort of exploring a number of different dimensions, including depressive spectrum, anxiety spectrum, the overall functioning, the interpersonal functioning, and the overall quality of life.

Only one trial formally accounted for the attrition by using an intent-to-treat analysis[17]; a previous one[25] considered the attrition rate but participants with missing postintervention data (n = 13) were retained for final outcome analyses by using a last-observation-carried-forward approach.

Nearly all studies, except for the ones on patients with HIV, listed among the exclusion criteria severe depression, suicidal thoughts, bipolar disorders, and comorbid substances abuse, thus limiting the generalizability of results in clinical settings characterized by the treatments of patients with more severe forms of depression or with psychological/physical comorbidities.

Follow-up data were also absent for many studies. Miller and Weissman[12] Heckman et al,[18] and Dennis et al[22] were the only three studies with pre-, post-, and follow-up data. However, Miller and Weissman[12] reported nearly a 40% attrition rate between pre- and postscores with six patients out of 15 from the IPT-T group who dropped out. Finally, each study population ranged between 64% and 100% of women, except for four studies,[16,18,21,25] and considering the 13 studies as a whole, it is difficult to generalize the effect of IPT-T on treating depressed men. Moreover, the question of how to determine the impact of delivery methods vs the overall proven effectiveness of IPT was unresolved.

Conclusions and Clinical Implication Points

We are aware of the addressed limitations of current knowledge on IPT-T as alternative to conventional IPT. However, despite the above-mentioned weaknesses in a number of areas, it is clear that the evidence base of IPT-T is encouraging. Given the cost-effectiveness of IPT-T intervention, it is surprising that many countries, including many developed nations, have not yet adopted IPT-T as an option, at least, for example, for the less severe forms of depression, or for rural communities, individuals with mobility concerns, or in times like the one we are living, with the COVID-19 pandemic that is strongly limiting the face-to-face approaches.

In order to achieve a deeper knowledge in this field, we suggest the following recommendations for future research:

- Further efforts should be devoted to clinical trials focusing on the long-term treatment with IPT-T.
- Randomized clinical trials should be carried out to compare IPT-T with other forms of IPT or with other psychotherapies, and not only with TAU or no-treatment conditions. It could be interesting to compare with similar populations when IPT is delivered in person or by telephone, which is a missed opportunity in present studies.
- It could be of interest to collect information about the adherence and/or quality measures comparing conventional IPT vs IPT by telephone.
- Randomized clinical trials should be carried out to investigate more in detail whether the sequential or the combined approach with IPT-T and/or pharmacotherapy is preferable.

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