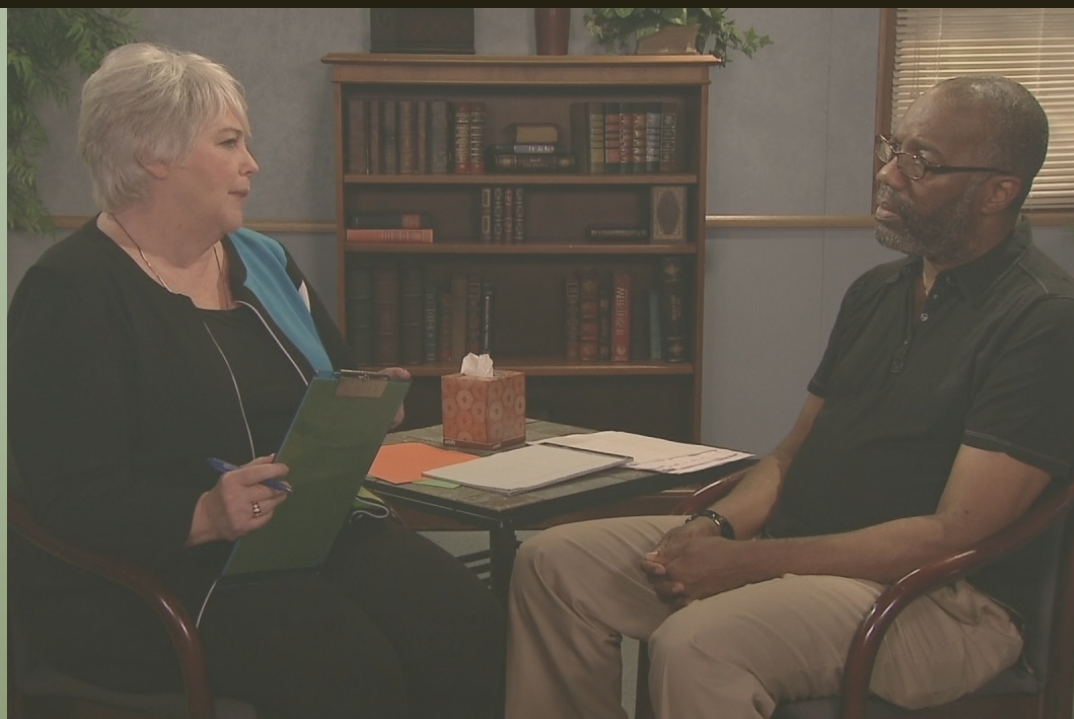


Interpersonal Psychotherapy for Depression in Veterans

Therapist Guide



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Preface

To promote the availability and delivery of evidence-based psychotherapies (EBPs), the U.S. Department of Veterans Affairs (VA) is nationally disseminating and implementing more than 15 EBPs throughout the VA health care system (Karlin & Cross, 2014). As part of this initiative, VA has implemented competency-based staff training programs in each of these therapies. To date, VA has provided training in one or more EBPs to more than 8,000 mental health staff. Interpersonal Psychotherapy (IPT) – demonstrated to be among the most effective treatments for depression in decades of efficacy trials – is one psychotherapy being nationally disseminated to promote the treatment of Veterans with depression, which is the second most common mental health diagnosis among Veterans receiving care in the Veterans Health Administration (VHA).

In 2011, VHA launched a national IPT Training Program. The program includes a competency-based training model similar to other VA EBP training programs, involving participation in an in-person experientially-oriented three-day training workshop that is followed by six months of weekly consultation with expert IPT training consultants who provide feedback to training participants on their implementation of the therapy. Notably, program evaluation results from the VA IPT Training Program reveal that IPT has yielded large overall reductions in depression and improvements in quality of life among Veterans treated by clinicians undergoing IPT training (Stewart et al., 2014). Program evaluation results also demonstrate high and increasing levels of the therapeutic alliance that is emphasized and regularly assessed in this IPT protocol over the course of treatment. The success of many Veterans who have received IPT is very encouraging and supports the belief that IPT has particular utility for Veterans.

This Therapist Guide describes the IPT treatment protocol including IPT's core components and strategies for treating Veterans with depression. This protocol is being nationally disseminated in VHA, the health care arm of VA. The Therapist Guide is a VA-specific implementation of IPT. *Comprehensive Guide to Interpersonal Psychotherapy* (Weissman, Markowitz, & Klerman, 2000) is the IPT treatment manual and is provided to clinicians participating in the VA IPT Training Program.

This Therapist Guide is designed to serve as a training resource to both clinicians participating in the VA IPT Training Program and to other clinicians learning to deliver IPT to Veterans. In addition to this Therapist Guide, there is a companion IPT therapist training video (U.S. Department of Veterans Affairs, 2014) that demonstrates the core IPT processes and strategies with four of the case examples presented in this guide. It is the developers' hope that this Therapist Guide and companion video will be helpful to readers in the process of learning or expanding their skills in IPT for Veterans.

Introduction to IPT

Introduction

Facts about depression. Depression is a relatively common mental health condition. Among American men, one in six will experience a major depressive disorder (MDD) during his lifetime. Among women, the lifetime prevalence is one in four. Depression is associated with both morbidity and mortality. Ninety percent of those with recurrent depression stated that their social and occupational functioning was very much impaired by depression (Burcusa & Iacono, 2007). The rate of suicide is 20 times higher among people with depression compared with the general population (Burcusa & Iacono, 2007). Depression is often recurrent. Those who have had one episode of depression are at 50% risk of having another episode. The risk of recurrence for individuals with two depressive episodes is 80% (American Psychiatric Association, 2000). Among those with recurrent depression, studies find that they experience, on average, five to nine depressive episodes over their lifetimes (Burcusa & Iacono, 2007). Among Veterans younger than age 65 receiving care in Veteran Health Administration (VHA) facilities in Fiscal Year 2009, 8.4% had a diagnosis of MDD and 18.9% a diagnosis of dysthymia. Veterans 65 years and older had lower rates of diagnosed depression than younger Veterans (MDD, 1.9%; dysthymia, 7.5%; Karlin & Zeiss, 2010). In Fiscal Year 2010, 233,000 unique Veterans had a depression diagnosis.

What is IPT? IPT is a manualized, brief psychotherapy developed to treat outpatients with non-suicidal, non-psychotic, non-bipolar depression. It was originally designed as weekly, individual psychotherapy delivered over 16 sessions. There are three phases of treatment: the Initial Sessions, the Intermediate Sessions, and Termination. There are four interpersonally-relevant problem areas, one or two of which are the focus of treatment: Role Transitions, Interpersonal Role Disputes, Grief, and Interpersonal Deficits.

Organization of this guide. This Therapist Guide summarizes the IPT treatment protocol with Veterans including the three phases of treatment, the four IPT problem areas, and their associated goals and strategies. The Therapist Guide also reviews and illustrates the most commonly used IPT treatment techniques. It discusses the theoretical and empirical origins of IPT, salient research, and use of IPT with varied clinical populations. As noted below, the Therapist Guide also contains six clinical cases, which are composites of Veterans treated for depression with IPT. Common implementation challenges and therapeutic tips for IPT are provided throughout the Therapist Guide. *Motivational enhancement* strategies promote initial and ongoing engagement of Veterans in treatment. Strategies include assessment of symptoms, functioning and therapeutic alliance, as well as implementation of suicide safety planning with at risk Veterans. Throughout the Therapist Guide the reader will see that when IPT relevant terms are introduced they are italicized. Italicized terms are listed and defined in the glossary.

Cases. Throughout this Therapist Guide, the authors use six composite cases to illustrate the use of IPT with Veterans. Case summaries of the entire course of IPT treatment and illustrative dialogue are provided for each of four IPT problem areas in the clinical vignettes section (see page 35) at the end of the Therapist Guide. Excerpts of these same cases are used throughout to illustrate how IPT techniques are implemented. The companion video includes four of these cases to illustrate the use of IPT in the treatment of the problem areas: Role Transitions (Ray), Interpersonal Role Disputes (Thomas), Grief (Eva), and Interpersonal Deficits (Will).

IPT Model

Theoretical and empirical origins of IPT. In the 1970's when Gerald Klerman, Myrna Weissman and their colleagues developed IPT, research evidence had begun to document the impact of social and interpersonal factors on depression. IPT developers drew upon that research, along with John Bowlby's (1982) attachment theory and associated research, as a rationale for targeting interpersonal problems in the treatment of depression. Work from the interpersonal school of psychiatry, best known by the writings of Harry Stack Sullivan (1953), was also cited because it underscored the importance of interpersonal issues in the origins and treatment of mental health problems. While IPT was being developed, the field of social psychiatry had considerable influence in the mental health field (see Blazer, 2005 for a review). Social psychiatry placed less emphasis on the individual early familial determinants of mental health problems than, for example, Freudian and post-Freudian models, and more on the social and environmental origins of mental health conditions.

There were other developments in theory and research related to interpersonal issues and depression during this time. James Coyne (1976) theorized a “downward interpersonal spiral” between depressed persons and their significant others that gradually resulted in relationship strains. Subsequent research generally supported Coyne’s formulation (Gottlieb & Beach, 1995). Myrna Weissman found that depression in women impaired their ability to function in different social roles (Weissman & Paykel, 1974). After conducting a major longitudinal study of depression, Coryell and colleagues (Coryell et al., 1993) concluded that social impairment associated with depression was “surprisingly severe, enduring, and pervasive” (p. 725). In related work that began in the 1970’s, British “expressed emotion” researchers documented that hostile or critical behavior directed by parents toward their children with psychiatric disorders increased risk of another psychiatric episode (Vaughn & Leff, 1976). Subsequent work found that persons with depression who had spouses who were critical or hostile toward them had a significantly increased risk of another episode of depression (Butzlaff & Hooley, 1989; Hooley, Orley, & Teasdale, 1986; Leff & Vaughn, 1985). The critical and hostile behaviors described in the expressed emotion literature are similar to those Coyne (1976) posited in his downward interpersonal spiral of depression.

At the time that IPT was being developed, the field of biological psychiatry was also gaining influence. There was increasing evidence to support the efficacy of psychotropic medication in the treatment of mental health conditions. From an IPT perspective, depression is an illness that has social/interpersonal and biological origins and concomitants. IPT was developed during a period of important theoretical and empirical developments related to the connection between interpersonal issues and depression. This relationship was supported by subsequent research.

As noted above, IPT was developed originally as a psychotherapeutic treatment for depression by Klerman, Weissman and colleagues (Klerman, Weissman, Rounsaville, & Chevron, 1984). Several studies were conducted by Klerman and colleagues in advance of what might be considered IPT’s first major professional debut which was its use in the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Study. The NIMH Collaborative Study (Elkin et al., 1989) was a large, landmark, multisite investigation of the efficacy of medication, psychotherapy, and the combination of the two, in the treatment of depression. IPT’s demonstrated efficacy in that study (which will be discussed later) catalyzed sustained research and clinical interest in IPT that has continued to the present.

IPT overview. IPT is a manualized intervention. The first published IPT manual was *Interpersonal Psychotherapy of Depression* (Klerman et al, 1984). As noted, IPT was developed as a 16-session time-limited weekly treatment of an acute episode of major depression with the sessions to be conducted in three phases: the Initial Sessions (weeks 1-3), the Intermediate Sessions (4-13), and Termination (14-16). There are four interpersonal problem areas that may be the focus of treatment: Role Transitions, Interpersonal Role Disputes, Grief, and Interpersonal Deficits.

In IPT, clinicians identify one or two of the above problem areas that appear to be the most salient for the individual, which then become the focus of treatment. The IPT model outlines treatment goals and strategies for the therapist in each of the problem areas and provides detailed information about the psychotherapeutic techniques used during treatment. Throughout IPT, the clinician monitors depressive symptoms, maintains therapeutic focus on recent events that are relevant to the identified problem area(s), and highlights the bi-directional relationship between depression and life events. When working with Veterans, the IPT therapist is active, collaborative, supportive, and hopeful.

In the Initial Sessions, the clinician gathers information about the Veteran’s history and symptoms, diagnoses depression, assigns the “*sick role*,” and provides a rationale for IPT. Links are made between the onset of depression and one or more life events, and an inventory of relevant past and current relationships is conducted. At the end of the Initial Sessions, the therapist presents the Veteran with an *Interpersonal Formulation*.

In the Intermediate Sessions, goals and strategies are implemented to address one or two of the IPT interpersonal problem areas. These include Role Transitions (a major life change), Interpersonal Role Disputes (conflict with a significant other), Grief (complicated bereavement), and Interpersonal Deficits (problems initiating or sustaining relationships). Multiple therapeutic techniques are utilized to achieve treatment goals for each of the problem areas.

In Termination, there is explicit discussion regarding the end of therapy, review of treatment progress, discussion of skills gained, review of post-therapy life issues that may emerge, identification of depression warning signs, and evaluation of the need for any further treatment. As noted previously, the initial development of IPT was for treatment of an acute episode of depression. Since that time, a maintenance treatment has been developed. Research indicates that monthly maintenance sessions, based on the

original focus of the acute treatment, are helpful in reducing the likelihood of relapse. As other interpersonally-relevant problems arise, maintenance sessions may also focus on a new IPT problem area. Maintenance treatment should be considered for Veterans who have had a good response to the initial 16-week course of IPT and who have a history of recurrent depression.

Empirical support for IPT. A recent review of research on IPT in the treatment of depression concluded, “There is no doubt that IPT efficaciously treats depression, both as an independent treatment and in combination with pharmacotherapy. IPT deserves its place in treatment guidelines as one of the most empirically validated treatments for depression” (Cuijpers et al., 2011, p. 581). IPT has been found to yield an overall moderate to large effect in the treatment of acute depression (Cuijpers et al., 2011). The *VA/Department of Defense (DoD) Clinical Practice Guideline for Management of Major Depressive Disorder* (2009) recommends IPT at the highest level and as a first-line treatment for depression. Many other professional guidelines, including the *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium* (2006), also recommend the use of IPT in the treatment of depression.

As noted above, numerous studies have documented the efficacy of IPT in the treatment of depression. IPT studies of the treatment of depression fall into two major categories: acute and continuation/maintenance studies. Acute treatment is when the patient presents with an episode of depression and is treated to improve the depression. The protocol outlined in this Therapist Guide is an example of the treatment of acute depression in which the patient is treated for 16 sessions. In psychiatric research continuation treatment is provided to patients who have shown significant improvement during the acute treatment phase. The goal is to maintain gains and to reduce the likelihood that the patient will have a relapse of that same episode of depression. Once that depressive episode has ended (defined within a research protocol) the patient may receive maintenance treatment to reduce the likelihood of recurrence of another episode of depression.

The first two major studies that examined IPT in the acute treatment of depression were: The Boston- New Haven Study (Weissman et al., 1979) and, the NIMH Treatment of Depression Collaborative Study (Elkin et al., 1989). These studies demonstrated that IPT, as well as antidepressant medication, were more effective in the treatment of depression than control conditions. The first major studies that examined IPT as continuation/maintenance treatment of depression were: The Boston-New Haven Collaborative Study (Klerman et al., 1974) and, the University of Pittsburgh Continuation/Maintenance Study (Frank et al., 1990). These studies demonstrated that both IPT and antidepressant medication were useful in preventing relapse and reducing the likelihood of recurrence of depression.

Furthermore, program evaluation results from the national VA IPT Training Program demonstrate that IPT has yielded large overall reductions in depression and improvements in quality of life among Veterans treated by clinicians receiving training in IPT (Stewart et al., 2014). These findings provide strong support for the use of IPT with Veterans in real-world clinical settings and extend the empirical support for IPT demonstrated in randomized, controlled clinical trials.

Applications of IPT. Since its development, IPT has been used in the treatment of mood disorders other than major depression and in the treatment of other mental disorders. IPT has been found to be effective in the treatment of adolescents, primary care patients, HIV positive adults, women with ante/postpartum depression, persons with bipolar disorder, and other populations and mental disorders. IPT has gained international recognition and has been studied and adopted in a variety of countries. The format for delivering IPT has also been adapted to group, couples, and for durations shorter than the “standard” 16-week format. Additional information on the research studies examining the efficacy of IPT can be found in Weissman et al. (2000) and Cuijpers et al. (2011).

Treatment Considerations

Motivational enhancement. Motivational enhancement is an important component of the IPT protocol used with Veterans, though it is not incorporated into traditional IPT protocols. The authors believe that a motivational interviewing style and the use of motivational enhancement techniques are consistent with IPT, and particularly useful in promoting initial and ongoing engagement of Veterans in IPT who are often unfamiliar with evidence-based psychotherapies. The motivational enhancement principles and approaches discussed here are consistent with strategies used in Motivational Interviewing (Miller & Rollnick, 2013), though they are not the same as Motivational Interviewing, which involves a more extensive and advanced level of clinical change strategies. The motivational enhancement strategies presented here are adapted from *Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers* (Wenzel, Brown, & Karlin, 2011).

Veterans are more likely to engage and follow through with therapy if they are motivated to change. Motivational enhancement can be especially important and effective with Veterans who often do not have experience with evidence-based psychotherapy, or psychotherapy in general. In advance of initiating IPT with a Veteran, the therapist is encouraged to utilize a motivational enhancement approach to assess and enhance the Veteran's motivation to engage in IPT. This effort may increase the likelihood of success. Often used in VA, the goal of motivational enhancement is to help a Veteran resolve ambivalence related to engaging in therapy. It is helpful to have an open discussion about the Veteran's reasons for change and empathize with any ambivalence the Veteran has about changing or engaging in treatment. Sometimes Veterans may come to therapy at the request of a family member or therapist. The process of motivational enhancement can elicit a Veteran's own internal motivation to change and elucidate the benefits of going through treatment. Discussing a Veteran's values – and acknowledging the pros and cons of making a change – will often encourage a Veteran to examine the change more openly.

A key approach to motivational enhancement involves **eliciting** information from the Veteran as opposed to **providing** information, which can be perceived as lecturing. Open-ended questions may be helpful in this regard. Examples include: What problems has the depression caused you recently? What do you avoid because of the depression? How does the depression affect your work life, your relationships, and your satisfaction with life? The pros and cons of engaging in treatment and reducing the severity of depression can also be utilized to enhance motivation. For example, "If you were less depressed, how would your life be different?" In addition, framing the discussion in the form of questions rather than statements fosters a collaborative relationship with the Veteran. For example, "Would it be okay if I tell you a little bit about what being in treatment might be like?" It may be helpful to explore potentially negative attitudes and expectations about psychotherapy, as well as problem-solve potential obstacles to attendance or engagement in therapy. Readers may wish to refer to Wenzel et al. (2011) for additional information regarding the use of open-ended questions and the process of implementing motivational enhancement, more generally.

Assessment of symptoms, functioning, and therapeutic alliance. During the Initial Sessions, Intermediate Sessions, and Termination, the therapist takes an active role in *symptom monitoring*, assesses functional change in quality of life, and attends to the therapeutic relationship. Initial program evaluation results for the VA IPT Training Program (Stewart et al., 2014) have shown that, on average, Veterans evidence significant decreases in depressive symptoms, improvement in perceived quality of life, and development of a strong therapeutic alliance. A summary of the following measures and an assessment schedule is included below (Table 1).

Symptom monitoring. At the beginning of each session the therapist briefly assesses the Veteran's mood since the previous session. This is accomplished by conducting a brief mood check, and by using an established self-report symptom measure to cover symptom status over the previous week. The functions of symptom monitoring are to (a) enable the Veteran and therapist to track progress over time, and (b) serve as a basis for discussion of the *bi-directional link* between depression and recent life events, particularly those that are relevant to the problem area that is the focus of IPT. A brief mood check entails asking the Veteran to rate his or her mood over the past week, including the day of the therapy session, on a scale from 1 (no depression) to 10 (very depressed).

In conjunction with the brief mood check, the Veteran also completes a structured self-report symptom inventory, such as the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). The PHQ-9 consists of 9 items that assess the existence and severity of depressive symptoms. Scores are based on symptom frequency during the past two weeks from 0 (not at all) to 3 (nearly every day), yielding a total scale score that ranges from 0 to 27. PHQ-9 scores greater than 4 indicate depression symptoms that are clinically relevant. Scores of 5, 10, 15, and 20 represent symptom severity levels corresponding to mild, moderate, moderately severe, and severe depression, respectively. The PHQ-9 score is discussed along with notable changes in specific symptoms that have been particularly problematic for the Veteran (e.g., "I noticed an improvement in your rating of depression this past week. Has anything happened recently that might be connected to that?"). Therapists should be mindful of the Veteran's score on item 9 (thoughts of death or hurting oneself) and engage the Veteran in the development of a suicide safety plan if needed.

Functioning. In addition to symptom monitoring, assessment of functional changes, such as the Veteran's perception of quality of life, can aid in identifying and discussing problematic areas for the Veteran as well as a means for noting improvement over the course of treatment beyond that of depression symptoms. The World Health Organization Quality of Life – BREF (WHOQOL-BREF; World Health Organization Quality of Life Group, 1998) is a 26-item self-report instrument that assesses the effects of health conditions and health interventions on an individual's perception of quality of life and health.

The WHOQOL-BREF has been associated with improvements in treatments for Veterans with depression (e.g., Karlin et al., 2012; Stewart et al., in press; Walser, Karlin, Trockel, Mazina, & Taylor, 2013). The WHOQOL-BREF contains two global items (“How would you rate your quality of life?” and “How satisfied are you with your health?”), and 24 additional items covering four domains: physical health, psychological, social relationships, and environment. When responding to this measure, the Veteran should be instructed to consider his or her experiences over the past two weeks. Administration of the WHOQOL-BREF is recommended when initiating therapy, at mid-point of the therapy, and then again at termination of treatment. Clinically, the therapist can discuss with the Veteran high or low scores and changes in an item or domain across administrations (e.g., “It seems your satisfaction with your personal relationships (social domain) has improved since we started working together. How is that related to what we have been working on in treatment?”).

Therapeutic alliance. Developing and maintaining a strong therapeutic relationship between the Veteran and therapist is paramount to successful psychotherapy. In IPT, the therapeutic stance is that of being supportive, warm, nonjudgmental, hopeful, active, and collaborative. Inquiring about the therapeutic alliance can be beneficial for assessing the strength or degree of collaboration of the therapeutic relationship. One measure of the therapeutic alliance is the Working Alliance Inventory (Horvath & Greenberg, 1989), which is based on Bordin’s (1979) pantheoretical model of change-inducing relationships. The therapeutic alliance is conceptualized as patient and therapist mutually agreeing on the goals of therapy (i.e., the overarching purpose and outcomes of the therapy); the tasks of therapy (i.e., the way in which the therapy proceeds will address the problems brought to treatment); and the quality of the interpersonal bond between the patient and therapist (i.e., care, respect, and appreciation). An abbreviated measure of the therapeutic alliance that can be easily incorporated into IPT for depression is the Working Alliance Inventory – Short Revised (WAI-SR; Hatcher & Gillaspay, 2006).

The WAI-SR is completed by the Veteran and is comprised of 12 items that enable calculation of a total score and subscale scores for agreement on the goals and tasks of therapy, and the Veteran-therapist bond. Each item is rated on a 5-point scale ranging from 1 (seldom) to 5 (always), with the scale and subscale scores calculated as the item mean, ranging from 1.0-5.0. The WAI-SR should be completed at the end of the session in order to account for that session’s material (recommended in sessions 1, 3, 7, and 11 in the IPT protocol). The therapist may either choose to allow some time at the end of that session to review the alliance with the Veteran or may review and discuss as needed at the next session. Therapists should attend to items that seem to indicate areas of disagreement that need to be resolved (e.g., a low score on an item such as “My therapist and I respect each other.”), and/or enhance areas of particular strengths; relative changes over the course of treatment can be a guide. The intent is to accelerate the therapeutic work by resolving problems in the therapeutic alliance.

Table 1

Measure	Domain Assessed	Administration
Brief mood check	Overall mood	Beginning of each session
PHQ-9	Depression symptoms	Beginning of each session
WHOQOL-BREF	Functioning/Quality of life	Beginning of sessions 1, 7, & 16
WAI-SR	Therapeutic alliance	End of sessions 1, 3, 7, & 11

Suicide risk assessment and safety planning. Veterans who are seeking mental health treatment may be at risk for suicide. It is typically recommended to conduct a suicide risk assessment prior to or during the initial phase of treatment, as well as when clinically indicated throughout the course of therapy. Potential risk factors for suicide include (but are not limited to): hopelessness, depression, anxiety, recent stressful life events, anger, changes in mood, withdrawal from family or friends, impulsive behavior, history of trauma, substance abuse, history of suicide attempt(s), history of non-suicidal self-injury behavior, history of aggressive or violent behavior towards others, suicidal ideation, homicidal ideation, preparations to harm or kill self (e.g., buy a gun), or current suicidal plan.

Suicide safety planning is widely used in VHA with the goal of lowering imminent risk of suicidal behavior when the clinician has concerns that the Veteran may be at risk. A *suicide safety plan* includes a prioritized, written list of coping strategies and resources (in the Veteran’s own words) that the Veteran can use before or during a suicide crisis. It is developed through a collaborative problem-solving effort between the Veteran and therapist/treatment team. A suicide safety plan should be developed when

- a previous suicide attempt is disclosed,
- current suicidal ideation is expressed,
- a positive suicide risk assessment is made,
- the Veteran is otherwise deemed to be “high risk” for suicide, or when
- local VA facility policies and procedures require it.

Suicide safety planning includes six steps

- recognize warning signs (e.g., staying in bed past noon),
- use of internal coping strategies without needing to contact another person (e.g., get up and go for a walk),
- engagement in social contact and settings that may distract from the crisis, without discussing the crisis (e.g., go to the donut shop),
- contact family members or friends who may offer help to resolve a crisis (e.g., call best friend Tony: 555-2568),
- contact mental health professionals or agencies (e.g., call Dr. Jones: 555-9314, call Veteran Crisis Hotline: 800-273-TALK, go to the Emergency Room), and
- reduce the potential for use of lethal means (e.g., give guns to neighbor to hold on to).

Readers may refer to the *Veteran Safety Planning Manual* (Stanley, Brown, Karlin, Kemp, & VonBergen, 2008) for more detailed information on the development of safety plans.

Chapter 1:

IPT Treatment Protocol: The Initial Sessions (1-3)

The Initial Sessions are the first phase of IPT and generally constitute the first three meetings. A variety of tasks need to be completed in the Initial Sessions that for the most part are completed sequentially. Usually taking history, making a diagnosis, providing *psychoeducation* about depression and the likelihood of its improvement, and discussing the sick role are completed in the first session. Typically the *Interpersonal Inventory* is completed in the second session but may continue into the third session. Identification of the major problem area(s), provision of the treatment formulation, and discussion of plan of treatment are done in the third session. Some tasks may take more or less time with a given Veteran, and the clinician uses his judgment about the pacing of tasks in the Initial Sessions.

Tasks of the Initial Sessions

- Conduct a history, review relevant assessments, and make a diagnosis.
- Provide psychoeducation about depression, its treatment, and likelihood of improvement.
- The Sick Role: Discuss functional impairment of depression and encourage temporary reprieve from some responsibilities.
- Conduct the Interpersonal Inventory.
- Identify the major IPT problem area(s).
- Provide the Interpersonal Formulation and treatment plan.

History and Diagnosis

Clinicians will most likely have access to the Veteran's mental health background and relevant diagnoses via the Computerized Patient Record System (CPRS), which may include a relatively recent diagnostic and assessment interview. If not, review and update this information. During the first session discuss with the Veteran relevant mental health history including the diagnosis of depression. Although many Veterans will have co-existing mental health disorders, the primary focus of the discussion is on the Veteran's depression and depressive symptoms. The process of history taking with Veterans does not need to be modified for IPT. However, it is recommended to inquire about Veteran-specific issues including service history, combat exposure, traumatic experiences, the transition from military to civilian life, and other related topics.

Psychoeducation About Depression

This stage involves providing basic psychoeducation to the Veteran about depression and its treatment. Psychoeducation includes a discussion of the common causes and course of depression and the importance of interpersonal issues in the onset and maintenance of depression. Review treatments for depression including psychotherapy and medication. Provide hope to the Veteran about the likely favorable outcome of treatment. It may be helpful to note that over 30 years of research support this optimism. The Veteran may already be taking psychotropic medication. If the Veteran is not on medication and the clinician judges this might be useful (e.g., the Veteran has had a prior favorable response to antidepressant medication, somatic symptoms of depression are severe and likely will improve with medication), make a referral to a VA prescriber of medication. Encourage the Veteran to ask questions throughout this process.

Information About Depression That May be Given to the Veteran

- Depression is a common illness. One in six men and one in four women will have major depression during their lives.
- Depression is common among Veterans who seek services from the VA health care system.
- Depression usually affects someone's ability to function day-to-day.
- Depression is treatable. Most people treated for depression improve.
- There are many different kinds of medications for the treatment of depression.
- There are several psychotherapies that have been shown to successfully treat depression.
- IPT is one psychotherapy that has been found effective in treating depression.
- Depression affects the way a person feels (depressed, sad), acts (hard to function), thinks (hopeless, helpless), and even physically (sleep, appetite).

Impairment of Functioning and the “Sick Role”

Help the Veteran to understand that depression impairs functioning in the same way that serious medical problems do. An analogy may be used to illustrate this (e.g., “If you had a broken arm it would be hard to complete certain tasks and people wouldn't expect you to until your arm healed”). Ask the Veteran to identify certain responsibilities that he may have difficulty completing because of his depression. Then review with the Veteran options of how he might obtain some assistance to complete them, or give himself permission to temporarily suspend some activities until his depressive symptoms improve. In IPT this is referred to as giving the sick role to the Veteran. The sick role notion comes from sociology literature, which documented that when individuals have physical health problems, it is socially normative to be given a temporary reprieve from daily responsibilities until the health problem improves. For example, the Veteran may get some help with childcare or household responsibilities.

Some Veterans may resist the notion of the sick role, viewing it as an admission of weakness or as evidence of inability to care for self or family. Some may also view the sick role as inconsistent with the military ethos of “completing the mission.” Other Veterans might embrace the sick role notion as permission to care for themselves, and in caring for themselves, better care for their families. Some clinicians may be uncomfortable with the sick role concept for fear that the Veteran may view it as a reason not to actively address life problems. However, during the Intermediate Sessions the clinician is directed to quickly engage the Veteran in working on the problem area(s) that is identified as the focus of IPT. Working on those problems usually results in decreased depression and enhanced capacity to function.

The Interpersonal Inventory

The Interpersonal Inventory includes a broad, but brief, review of relevant past and current relationships with important others who are alive or deceased, both positive and negative. The Inventory gives an overall impression of the Veteran's interpersonal functioning, helps to identify current interpersonal issues that may be the focus of the Intermediate Sessions, and assists in identifying potential supports. This Inventory is especially useful in identifying the absence of supports, as may be evident in Veterans who are having difficulty reconnecting with others after deployment. Ask the Veteran to spend about 10 to 15 minutes on each person (except for perhaps the most important person(s) who may require more time). The Inventory can usually be completed in 1 or 1.5 sessions.

The Interpersonal Inventory: Sample Questions to Use

- Who are the important people in your life?
- What do you like about the relationship?
- What don't you like about the relationship?
- What has changed in the relationship?
- Are you having difficulties in this relationship?
- How would you like the relationship to be different?
- What is the affect of this relationship on your depression?
- How does your depression affect this relationship?
- Before we move onto talking about another important person in your life, is there anything else you think I should know about "x"?

Common Implementation Challenge:

Completing the Interpersonal Inventory in 1 to 1.5 sessions

Some clinicians are used to doing fairly extensive psychosocial evaluations and may find it difficult to complete the Interpersonal Inventory in the equivalent of one session. Sometimes clients find it difficult to stay-on-task and may get into tangential issues as they try to discuss persons central to their lives. Older Veterans often have many current and past relationships and the challenge is to identify those that are most salient and relevant.

Clearly tell the client what will be expected during the Interpersonal Inventory. For example: "I am going to briefly review the important persons in your past and current life – individuals with whom you have had positive or not-so-positive relationships. We've got about an hour to do this and will usually spend no more than 10 minutes on each person." If the Veteran spends extended time on a given individual, he should be reminded that this is a brief review of relationships. If the Veteran begins to get into details of current issues in a specific problem, it should be indicated that there will be plenty of time to discuss these issues if this problem is the focus of IPT.

Identification of Major Problem Area(s)

A key task is to identify one, or possibly two (but no more), problem areas that will be the focus of treatment. Sometimes Veterans have many problematic issues in their lives and the therapist may wonder which IPT problem area would be the most useful. Identification of the IPT problem area is guided by (a) the apparent interpersonally-relevant precipitant of the current depressive episode and/or interpersonal problems that developed after the onset of depression; and (b) the interpersonal issue(s) that are of most concern to the Veteran. In Session 1 or 2, some Veterans identify a problem that clearly maps onto just one of the four IPT problem areas. Be mindful of not making a premature conclusion that an issue that is brought up at that time will be the IPT problem area. Later in the Initial Sessions – perhaps during the Interpersonal Inventory – the Veteran may raise other issues that could be a better focus of treatment than those initially mentioned. For other Veterans, the IPT problem area is not so apparent.

The Interpersonal Inventory is often helpful in clarifying the likely IPT problem area. Although rare, some Veterans with depression do not have problems that reflect any of the IPT problem areas and are not good candidates for IPT, but may be appropriate for other therapeutic modalities developed for the treatment of depression. As discussed in the next section, identification of the IPT problem area(s) is central to the Interpersonal Formulation.

The Interpersonal Formulation and Plan for Treatment

At the end of the Initial Sessions provide an Interpersonal Formulation to the Veteran, consisting of a succinct statement of understanding of the Veteran's depression, the likely cause and consequences of it, likely problem area(s) that will be the IPT focus, and the goal(s) of treatment. For example:

“As we discussed earlier, you have a major depression. Your symptoms are (list the symptoms the Veteran has noted). Your depression appears to have begun on your return from Iraq four months ago. Since your return, you and your wife have been having increasing difficulties about how the children are being raised and responsibilities for who will run the household. All you could think about when you were in Iraq was how much you wanted to go home. And now that you are home you are having problems that didn't exist before you were deployed. What has made things worse is that because of your depression it is hard to do your work because of irritability, lack of motivation, and difficulty concentrating. And now you're worried you might lose your job. Did I understand things correctly?”

After seeking and incorporating the Veteran's input about the formulation, discuss the problem area(s) that will be the focus of treatment based on information gleaned throughout the Initial Sessions. The *treatment plan* will include the goals of improvement of depression and improved ability to deal with the identified problem. Discuss with the patient the collaborative nature of IPT and the active role of the patient in treatment, provide a brief statement of research support for the effectiveness of IPT, including with Veterans, and convey hopefulness that treatment will be successful. Discuss the structure and format of treatment (e.g., present focused, time-limited, weekly sessions, expected attendance at all planned sessions), and any other relevant administrative issues.



Example of an Interpersonal Formulation and Plan for Treatment

“We've spent the last three sessions talking about your depression and what is happening in your life. Now I'd like to tell you how I understand what has been contributing to your depression. First, I just want to repeat that you have depression, and your symptoms are (list the specific symptoms that the Veteran has). Your depression began about a year after you came back from deployment. At that time you were taking care of your children and the home while your wife went to work. You and your wife are getting into conflicts over how to raise your children and how to handle the household responsibilities. Do you agree with me? Over the next 13 sessions we will focus on helping you to deal with the problems you are having at home with your children and running the household. Does that make sense to you? OK, so we'll meet every week. It's important that you come in every week, so please try not to miss sessions. We have a little time remaining today. Why don't we start talking about what's happening at home?”

Common Implementation Challenge:

Veteran feels hopeless about change (and so might the therapist!).

Some Veterans are hopeless that psychotherapy can help. This may be the case especially for those Veterans who have received mental health treatment in the past and were disappointed with the results. Hopelessness is one of the common symptoms of depression. It is important to be mindful of this and discuss with the Veteran. Sometimes it is useful to say something like: *“It makes perfect sense to me that you feel hopeless that therapy can help. Feeling hopeless is part of depression. When you are feeling less depressed, I’m confident that you will feel less hopeless.”*

Transition from the Initial Sessions to the Intermediate Sessions

After presenting the Interpersonal Formulation and reviewing the IPT plan, it is time to transition to the Intermediate Sessions. Typically the Intermediate Sessions commence in the fourth session. However, if all the tasks of the Initial Sessions are finished before the end of the third session, work may begin on the Intermediate Sessions. Demarcate the end of Initial Sessions from the beginning of the Intermediate Sessions. This can be accomplished by saying something like, “Now we have finished the information gathering part of IPT and we’ll begin the work of addressing the problem(s) that we’ve agreed to work on together to improve your depression.”

The Initial Sessions have a clearly outlined series of tasks that must be covered. The Intermediate Sessions have broadly defined goals and strategies and some clinicians puzzle over how to begin and sustain their implementation.

Some psychotherapies, such as Cognitive Behavioral Therapy (CBT), have a well-defined session structure (i.e., brief mood check, bridge from previous session, agenda setting, review of prior homework, discussion of agenda items, homework, and summary/feedback). Many of these elements also exist in IPT. Each session begins with a mood check. In the Intermediate Sessions, inquire about relevant events from the prior week, make links between mood and recent events, and discuss the issues tied to the identified problem area. In advance of sessions it is useful for the clinician to review the goals and strategies of the identified problem area(s). This review should help maintain focus on issues central to IPT implementation. If during a session there is a question of whether the discussion is wandering off, it is useful to mentally consider, *“How is this discussion relevant to the identified problem area?”* If the answer is that it’s not relevant or it’s not clear, then it is usually best to redirect the Veteran to the chosen problem area(s).

Therapeutic Tips for Initial Sessions

The following are tips for implementing the Initial Sessions. These therapeutic tips are integrated into the six case narratives that are found later in this Therapist Guide.

Therapeutic Tip: A referred Veteran does not feel he needs mental health services

Sometimes Veterans are referred to mental health care providers but are not clear why they have been referred, don’t want to come, don’t believe they are depressed, or don’t believe mental health services will be useful. Motivational enhancement may be especially useful in helping the Veteran understand the impact of depression on his life and what he might gain by taking part in treatment. Even for those Veterans who have taken part in motivational enhancement and who start IPT, reluctance to begin psychotherapy may remain. The Veteran’s questions and concerns can often be addressed using psychoeducation within IPT.

Therapeutic Tip: Veteran blames self for depression symptoms

It is common that people who are depressed blame themselves for problems with functioning. It is also possible that others begin to blame the Veteran for lack of motivation, failure to “look in the bright side,” or difficulty taking objective stock of those things that are actually going well. Self-blame is a symptom of depression along with hopelessness, helplessness, lack of motivation, and discouragement. A useful clinical response to self-blame is to remark, “That’s the depression talking.” This approach may help the Veteran begin to disentangle the symptoms of depression from who he “really is.” Veterans sometimes express discouragement about the likelihood of improvement in therapy. Rather than getting into a struggle with the Veteran (“Yes, you will get better.”), it may be helpful to say something like, “Oh, it makes perfect sense that you would feel that way. When people are depressed they are very likely to be hopeless. When feeling less depressed, most people look at things differently.”

Therapeutic Tip: Psychoeducation

Providing information about depression and its treatment is an important component of the Initial Sessions. Some Veterans may need ongoing input to understand their own depression and other health conditions. At some point it may become clear that the Veteran lacks a basic understanding of co-existing medical conditions and that he might consider seeking information from other relevant health care providers or institutional resources (e.g., organizations that provide information and resources about a specific disease.). For Veterans providing care to family members with health or mental health problems, an accurate understanding of that problem may better enable the Veteran to provide care that is more beneficial to the family member and enhance the Veteran’s own feeling of mastery. Sometimes health care personnel have provided relevant information to the Veteran, yet may have done it in a way that was not understandable to the Veteran, or the Veteran was too emotionally upset to handle the information at that time.

Therapeutic Tip: The sick role and Veterans

The sick role as described in the *Comprehensive Guide to Interpersonal Psychotherapy* (Weissman et al., 2000) does not suit many Veterans, especially those who pride themselves in coping with challenges and in not being “weak.” Veterans may find it difficult to accept the message that because of an illness they can be temporarily excused from normal activities. It may be helpful to acknowledge that in the military the ethos is to “complete the mission,” but that the Veteran might consider going a little easier on himself until he is feeling better.

Therapeutic Tip: Making the transition to the interpersonal inventory

In the Initial Sessions, the most elegant transition, from discussing the past week’s events to starting the Interpersonal Inventory, is to find a segue from what happened during the week with a specific person to finding out about the relationship. If that isn’t possible, at some point it may be necessary to redirect the Veteran and advise that some specific tasks must be done in Session 2. Remember, the purpose of the Interpersonal Inventory is to get breadth of information about the important people in the Veteran’s life rather than depth. The clinician is not conducting treatment at this point, but rather gathering information.

Therapeutic Tip: Disentangling discussion of multiple persons at once in interpersonal inventory

It is common when conducting the Interpersonal Inventory that Veterans begin to discuss several people in conjunction with each other. It is the therapist's job to get the Veteran to talk individually about each person while being mindful of the connections among persons. If the Veteran combines one or more persons in a discussion, ask the Veteran to talk about each person individually. Also remember, when doing the Interpersonal Inventory, be sure to ask questions that will help to determine if each important person in the Veteran's life is associated with a dispute, a transition, or a death.

Therapeutic Tip: Premature identification of the problem area

In IPT it is important not to determine the focus of treatment too early. Collect information from the history and Interpersonal Inventory before determining the problem area(s) that will be the focus of the therapy.

Therapeutic Tip: IPT with multiple problem areas

It is common in IPT that Veterans have multiple problem areas. In fact, some Veterans seem to have all four problem areas triggering or maintaining depression. IPT research indicates that clinical outcomes are better if the therapist concentrates on one or two problem areas rather than all four. A key decision in the Initial Sessions is to determine which one or two problem(s) has the most impact on the Veteran's mood and functioning. One clue for determining which problems are the most fruitful focus of treatment, is to look at how much affect the Veteran evidences when talking about specific people or events. Generally, there will be one problem area that is primary and one that is secondary in importance to the Veteran. In treating a Veteran with two problem areas, link the depression to both problem areas. Also, remember to address both problems during the Intermediate Sessions. During some Intermediate Sessions the Veteran may explore just one of the problems; in other sessions, the Veteran may talk about both problems. Regardless, it is always the job of the therapist to keep both problems in mind. If the Veteran has not discussed one of the problems for several sessions, raise the issue of the second problem area.

Therapeutic Tip: Creating the interpersonal formulation

A key task is to identify one or possibly two problem areas that will be the focus of treatment. Identification of the IPT problem area is guided by the interpersonal problem that developed before or after the onset of depression, and the interpersonal issues that most concern the Veteran. Identification of the IPT problem area(s) is central to the Interpersonal Formulation. At the end of the Initial Sessions, provide an Interpersonal Formulation to the Veteran. The formulation is a brief statement of the Veteran's depression, likely causes and consequences, and goals for IPT treatment.

Chapter 2: IPT Treatment Protocol: The Intermediate Sessions (4-14)

Overview

Each of the four IPT problem areas (Role Transitions, Interpersonal Role Disputes, Grief, and Interpersonal Deficits) has therapeutic goals and strategies. In the coming sections, the goals and strategies tied to each of the IPT problem areas will be discussed. A variety of techniques are utilized in implementation of these goals and strategies. Some IPT techniques are commonly used in the respective problem areas. These include *Communication Analysis*, *Decision Analysis*, *Role Play*, *Interpersonal Skills Building*, and *Work-at-Home*. The cases of Mike, Thomas, Eva, and Will are used to clinically illustrate the use of these techniques in each of the four IPT problem areas. In addition to those noted above, refer to Chapter 8 (Specific Techniques) of *Comprehensive Guide to Interpersonal Psychotherapy* (Weissman et al., 2000) for an extended review of IPT techniques. Many of these techniques may be familiar to clinicians although some techniques may have somewhat different meaning when implemented in IPT.

Tasks of the Intermediate Sessions

- Review depression symptoms.
- Focus on identified problem area(s).
- Use specific techniques to achieve goals.

Commonly used IPT techniques.

Communication analysis: A detailed and in-depth review of a recent conversation that the Veteran has had to help him to: Understand the verbal and non-verbal feelings he conveyed in an interpersonal communication, understand the impact of his communications on others, understand the impact of others' communications on himself, and improve ability to change these interactions and associated feelings.

Decision analysis: An approach to problem-solving that includes: Identifying a situation that is causing a problem, generating options and ways of managing the issue, evaluating the pros and cons of identified options, and selecting one option or a combination.

Role play: Enactment or reenactment of a recent or planned conversation with another person to help the Veteran better understand his feelings and behavior as well as those of the other person. In a "modified" Role Play the Veteran plays both roles (his and the other person's).

Interpersonal skills building: Efforts to teach fundamental interpersonal communication skills to the Veteran including: Finding an optimal time to discuss issues of concern, focusing on a specific situation, clarifying expectations, understanding the other person's point of view, anticipating how the conversation might go, and making a plan to respond to different contingencies.

Work-at-Home: Between-session efforts by the Veteran to address issues associated with the identified problem area.

Common Implementation Challenge:

Therapist Drops Discussion of Depressive Symptoms

After the Initial Sessions, some beginning IPT therapists stop actively discussing depression and its relationship to recent events. Use of the PHQ-9 and mood check will automatically prompt the IPT clinician to ask about depression. It's important for the therapist to make the connection between change in depressive symptoms and events of the last week (the "bi-directional link" between depression and events).

During each session look for opportunities to link depression and events (e.g., *"It sounds like you felt more depressed and hopeless after the dispute with your wife and for several days afterwards. Clearly the way things go with your wife strongly affect your mood. Do you agree?"*) This is a psychoeducational message that may help the Veteran understand why addressing current interpersonal problems will likely result in improved mood.

Problem Area: Role Transitions

Life transitions happen to all persons – going to college, having a first child, starting a new job, divorcing a spouse, retiring from a job, dealing with health problems – and are interwoven with relative periods of stability throughout life. Some theories of adult development and aging argue that life transitions can be especially stressful for people, may prompt asking fundamental questions about self, relationship to others, and life meaning, and require a reorganization of life patterns (Levinson, 1986). As noted earlier, research demonstrates that stressful life events increase risk for depression and other mental health symptoms.

Common Role Transitions For Veterans

- Return home from active duty
- Missing camaraderie of military service members
- Resumption of parenting role after deployment
- Unemployment
- Financial difficulties
- Going back to school
- Assumption of caregiver role later in life (e.g., spouse, grandchild)
- Dealing with injury (physical or mental) and change in ability

Goals and Strategies of Role Transitions

Goals:

Help the Veteran...

- come to terms with the loss of the old role;
- see positive (or more tolerable) aspects of the new role; and
- acquire needed skills for the new role.

Strategies:

Help the Veteran...

- review depressive symptoms;
- link depressive symptoms to problems coping with current life issues;
- review both positive and negative aspects of old role (the way things had been) and the new role (the way things are now);
- emotionally come to terms with the loss of the old role;
- explore options in the new role;
- express feelings; and
- develop new skills for the new role.

Therapeutic Goals and Strategies for Role Transitions. Therapeutic goals for Role Transitions include: (a) Mourn and accept the loss of the old role; (b) See positive aspects of the new role; and (c) Develop any new skills necessary to gain mastery of the new role and restore self-esteem (Weissman et al., 2000). These broadly framed goals are implemented through specific strategies in conjunction with IPT techniques. IPT strategies in the treatment of Role Transitions include:

- **Review depressive symptoms.** At the beginning of each session, discuss the Veteran's current depressive symptoms in conjunction with review of the PHQ-9. For example: "How has the depression been this past week?" "So it looks like (name of symptoms) have been worse in the past week, yes?"
- **Relate depressive symptoms to difficulty in coping with current, problematic life situation.** In each session specifically link events from the last week to the current depressive symptoms. For example: "It sounds like you became more depressed when you lost your job and you didn't get the other job for which you were applying."
- **Look at positive and negative aspects of the old role (the ways things had been) and the new role (the way things are now).** Encourages the Veteran to look at both negative and positive aspects of old and new roles. Notice the sociological language that is used in IPT. Social roles provide the structures through which people live their daily lives. Social roles also are tied to norms and values. Loss or acquisition of a new role can result in social and emotional disequilibrium. By reviewing negative and positive aspects of roles, the Veteran will hopefully achieve a more balanced view of the life change – in contrast to, for example, viewing the old role as all good and the new role as all bad. For example: "*There are advantages and disadvantages to post-deployment life. Let's talk about them both.*"
- **Mourn the loss of the old role.** Ask the Veteran to express thoughts and feelings related to loss of the old role. It is assumed that most people experience a sense of loss about the way that life was before the change in role and that expression of those feelings can be therapeutic. For example: "*You haven't mentioned what you miss about no longer being in the military. Let's talk a bit about that.*"
- **Explore opportunities in the new role.** Some Veterans feel stuck in the view that their former life was better than their current circumstances. This feeling of being stuck is compounded when they are depressed. Help the Veteran to more realistically evaluate what new opportunities and options might be available in current life circumstances. The word "options" is often used in IPT and conveys the message that despite difficult life circumstances, possibilities always exist to deal with those circumstances. For example: "*Despite your military-related injury, what are some options for making your life more interesting, productive, and meaningful?*", "*I understand that you feel there are few options. From my point of view, there are always options but depression makes it less likely that you can see those options.*"

- **Encourage affect.** In addition to encouraging the Veteran to express feelings of loss about the old role, also encourage the Veteran to express other feelings about the change. Some Veterans may feel relieved that they no longer have certain role-related responsibilities. For example, some Veterans may miss the camaraderie of military service members but are happy to no longer have daily responsibilities of the role. Some older Veterans may experience retirement as a loss but also feel unburdened by the daily stresses of a job. For example: *“It sounds like you really feel sad that you no longer have your old job. What other feelings do you have about not working?”*
- **Support development of new skills that will facilitate movement into the new role.** New life circumstances often require new skills. A Veteran returning to school will need to acquire academic skills and ways of relating to “civilian” peers that are different than those with military service members. An older Veteran, who begins caring for his now infirm wife, will need to acquire many new skills (e.g., providing physical care, negotiating with health care providers, dispensing medication, managing his wife’s emotional distress). For example: *“What would you need to know to do that better? How might you go about learning how to do that better?”*

Frequently Used IPT Techniques in Role Transitions. Decision Analysis, Role Play, and Work-at-Home are important and frequently used techniques in Role Transitions. Each of these techniques will be discussed with clinical illustration using the case of Mike. A description and an illustration of 16 sessions of IPT with Mike are provided in the Case Vignettes section (see page 36) of this Therapist Guide.

Frequently Used Techniques in the Treatment of Role Transitions

- Decision Analysis
- Role Play
- Work-at-Home

IPT Technique: Decision Analysis. As noted earlier, Decision Analysis is an approach to problem solving that is commonly used in many psychotherapies. It is often a critical first step in helping the Veteran to think through a life problem and options to address the problem.

Conducting a Decision Analysis

1. Select an interpersonal situation that is causing a problem.
 - Identify a specific, recent life problem that likely affects the Veteran’s mood.
2. Encourage the Veteran to generate options and ways of managing the issue.
 - Ask the Veteran to think about different ways of handling the problem that might result in improvement of both mood and problem.
3. Evaluate pros and cons of each option.
 - Help the Veteran take stock of advantages and disadvantages of engaging in different options.
4. Select one option or a combination to try first.
 - Encourage Veteran to select an option(s) that most accords with what he would like to achieve and that has a reasonable possibility of being accomplished.

Clinical Example of Mike: Illustration of Decision Analysis, Role Play, and Work-at-Home in Role Transition
Problem Area

Case Synopsis: Mike is a 75-year-old Korean War Veteran whose wife is showing increasing signs of dementia. While he was out on an errand, she left home, wandered into the street, and was almost hit by a car. He doesn't feel that he gets as much support from his children as he would like, especially from his daughter. Increasingly Mike has felt that his wife needs supervision and yet he thought he could leave her alone briefly to refill a prescription. The Veteran confronted a common issue faced by family members providing care to relatives with cognitive impairment. The Veteran needed to find a way to ensure his wife's safety and yet accomplish a myriad of practical responsibilities that took him away from the home. The therapist encouraged the Veteran to think of options. The options the Veteran identified included: (a) Lock his wife in the house when he goes out; (b) Get his daughter to care for his wife when he goes out; or (c) Find a day program for his wife (suggested by a friend whose wife also has dementia). The therapist then encouraged the Veteran to examine the pros and cons of each option.

Option 1: Lock his wife in the house.

Pros: She wouldn't be able to wander.

Cons: If there was a fire, she would be trapped. Wife might get upset about being locked in the house.

Option 2: Get daughter's help.

Pros: He trusts his daughter to supervise his wife. He would feel better about his relationship with his daughter if she helped out more.

Cons: Would be difficult to get his daughter to come to the house since she works.

Option 3: Find day program.

Pros: Day program seems to provide a safe environment.

Cons: Not sure if she would like it, or would adjust to a program where there are so many "strangers." The program may not be affordable.

After due consideration, the Veteran decided that he would check out a day program.

IPT Technique: Role Play. As noted earlier, Role Play helps the Veteran to better understand his own behavior and feelings in dealing with others. Role Play also helps the Veteran to better understand the likely behavior and feelings of the other person. A Veteran may use a Role Play to reenact a recent conversation with someone or a planned conversation with someone. In Role Play, the Veteran enacts what he said or would like to say to another person. In a modified Role Play, the Veteran plays both his role and that of the other person.

Continued Clinical Example of Mike: Role Play. Drawing on the clinical example above, the Veteran found a day program for his wife, which was very helpful. However, he was still disappointed that he did not receive as much support from his daughter as he would like. The Veteran would like to have a conversation with his daughter about this issue but fears a discussion will lead to conflict. The therapist concluded that roleplaying a conversation with his daughter would be a useful technique to use. Since the Veteran had never experienced role playing, the therapist discussed the reason for role plays and anticipated the Veteran having some initial discomfort. The therapist helped the Veteran clarify what he'd like to say and the hoped for result of the conversation. Then in the role play, the therapist played the role of the daughter and the Veteran the role of himself. The clinician provided feedback to the Veteran and helped him to tailor his message. Later the Veteran and therapist switched roles. Multiple roleplays were needed to prepare the Veteran for a conversation with his daughter.

IPT Technique: Work-at-Home. As noted earlier, Work-at-Home constitutes between session efforts to address issues associated with the IPT problem area.

Implementing Work-at-Home

- Explain that the Veteran will be experimenting with new skills that emerged from the Decision Analysis, Role Play, and/or Communication Analysis (discussed later in this Guide). Work-at-Home is a result of prior efforts with the therapist in the office.
- The Veteran will return the following week to discuss the outcome of Work-at-Home.

Continued Clinical Example of Mike: Work-at-Home. As in the prior example, the Veteran role played the planned conversation with his daughter about his desire for more support related to care for his wife who is suffering with dementia. The therapist discussed with the Veteran his readiness to have a conversation with his daughter based on the Role Play he did in the office. The Veteran felt he knew how to convey his concerns to his daughter in a way that made it more likely she would be able to hear him. The therapist advised the Veteran that the outcome of the conversation was not guaranteed but that he had done his best to make a good plan. The therapist also told the Veteran that in the coming week, he might decide that he's not quite ready to talk to his daughter. In any case, they will discuss what happened in the next session.

Problem Area: Interpersonal Role Disputes

Conflicts with other persons are a common issue that VA and non-VA clinicians see in practice. As discussed in the *Comprehensive Guide to Interpersonal Psychotherapy* (Weissman et al., 2000), early research documented that interpersonal disputes and absence of social support were tied to increased risk of depression. Research findings that emerged after the development of IPT have continued to support the link between interpersonal problems and risk for depression. As noted earlier in this document, even if interpersonal disputes are not the precipitant of a depressive episode, depression itself can damage close relationships because of the complicated interpersonal dynamics of depression.

Common Interpersonal Disputes for Veterans

- Longstanding disputes with spouse or partner
- Onset or exacerbation of disputes after return from deployment
- Disputes with family members
- Disputes with friends
- Disputes with employers

Goals and Strategies of Interpersonal Disputes

Goals:

Help the Veteran...

- clarify what the dispute is;
- make a plan for addressing the dispute and clarify what is desired;
- acquire needed skills to improve the dispute, if expectations are realistic; and
- modify expectations, if expectations are not realistic.

Strategies:

Help the Veteran...

- review depressive symptoms;
- tie depressive symptoms to the dispute;
- establish the stage of the dispute;
- clarify how differences in expectations are tied to current dispute; and
- examine possible parallels in other relationships.

Therapeutic Goals and Strategies for Interpersonal Role Disputes. The therapeutic goals for this problem area are: (a) Identify what the current dispute(s) is and with whom, (b) Choose a plan of action for addressing the dispute that involves clarifying what the Veteran wants, (c) If the Veteran's expectations are realistic, help him to acquire needed skills to address the dispute (Weissman et al., 2000). If the Veteran's expectations are not realistic (e.g., "I want you to change my wife"), help the Veteran to modify expectations.

IPT strategies associated with implementation of goals for Interpersonal Role Disputes are listed below.

- **Review depressive symptoms.** This is the same procedure for all of the IPT problem areas. As noted earlier, the clinician discusses current depressive symptoms in conjunction with review of the PHQ-9 and mood check at the beginning of every session.
- **Relate symptoms to the current dispute.** As needed, continue to educate the Veteran that depressive symptoms are tied to the dispute identified at the beginning of treatment. Each week, link specific incidents (e.g., argument, disagreement with the other party) to the current depressive symptoms (and make the bi-directional link between events and mood).
- **Establish stage of the dispute.** As discussed in the Weissman et al., 2000, IPT roughly divides disputes into three stages. The *stage of the dispute* will determine how to work with the Veteran around the hoped for resolution of the dispute. The stages reflect a continuum of engagement to disengagement.
- **Look at nonreciprocal expectations and how they tie into the current dispute.** "Expectations" is a relatively neutral term that connotes that people often view things and want things that are different from the other person. These nonreciprocal expectations often lead to conflict. Moving the discussion of relationship difficulties beyond global characterization of the problem ("It is useless, she won't change.") and impugning the character of the other person ("She's impossible.") often yields a clearer sense of issues that could be the focus of possible resolution or partial resolution.
- **Possible parallels in other relationships.** Be attuned to the possibility that issues in the current dispute have been, or currently exist, with other people. If this is the case, gently guide the Veteran to a better understanding of recurring relationship problems with the goal of improving his ability to resolve issues in the current identified dispute.

Stages of Interpersonal Role Disputes

STAGE

RENEGOTIATION: Ongoing and heated disputes with an important person in which both parties are emotionally engaged.



IMPASSE: Emotional disengagement in which one or both parties are resigned to an unsatisfactory relationship.



DISSOLUTION: Consideration by one or both parties that relationship cannot be improved and should likely end.



THE THERAPIST HELPS THE VETERAN TO...

- Cool down the dispute with the other person to increase dialogue and enhance problem solving skills.
- Reengage the other person in discussion of issues of concern which may involve emotionally heat things up.
- Clarify whether this conclusion is based on current depression or a realistic reckoning that all reasonable options for dispute resolution have been explored. If other options might exist to improve relationship, help Veteran to explore them. If other options do not appear feasible, help the Veteran with the process of relationship dissolution.

Frequently Used IPT Techniques in Interpersonal Role Disputes. Commonly used IPT techniques in the treatment of Interpersonal Role Disputes include: Communication Analysis, Decision Analysis, Role Play, and Work-At-Home. These techniques often follow sequentially. Each of these techniques will be discussed with clinical illustration using the case of Thomas (“Tom”). Note that a description of IPT with Thomas and accompanying dialogue are provided in the Case Vignettes section (see page 50) of this Therapist Guide. Thomas’ case is also illustrated in the companion video.

Frequently Used Techniques in the Treatment of Interpersonal Role Disputes

- Communication Analysis
- Decision Analysis
- Role Play
- Work-at-Home

IPT Technique: Communication Analysis. As noted earlier, Communication Analysis is used to help the Veteran to: (a) understand the verbal and non-verbal feelings he conveys in interpersonal communications, (b) understand the impact of communications on others, (c) understand the impact of others’ communications on himself, and (d) improve his ability to change these interactions and feelings about the relationship with associated decrease in depressive symptoms.

Clinical Example of Thomas: Communication Analysis, Decision Analysis, Role Play, & Work-at-Home

Case Synopsis: Thomas (“Tom”) is a 38-year-old Veteran who served two tours of duty in Iraq. He had difficulty finding employment upon returning home. Since his wife had a well-paying job, they mutually decided that he would be the primary caretaker for their three children. Increasingly, he and his wife Jessica had differences over their parenting styles. He felt that the children needed more discipline and Jessica felt that he was treating the children as if they were members of his platoon.

Tom and his wife were arguing frequently and at times in front of their children. Tom grew increasingly depressed as he felt disrespected by his children and disempowered by his wife.

Clinical Example of Thomas: Communication Analysis. Tom prepared dinner for his children. After dinner he told his oldest daughter that it was her turn to clean up the dishes. She refused and said that it was not her turn. When his wife arrived home from work, the daughter complained to her mother about her father. Tom felt his wife sided with his daughter. In this situation, the therapist moved Tom beyond a broad description of this dispute, as one in which he felt disobeyed and disrespected, to a much more detailed understanding of how things unfolded. Reluctantly, Tom said that before the incident he was angry with his wife for often coming home late for dinner. Although his older daughter argued with him that it was not her turn to do the dishes, he initially failed to say that his youngest daughter volunteered to do the dishes. In anger, Tom rejected her offer (“You’re not going to do what your sister is supposed to do.”), went ahead and did the dishes himself, and told the children to leave the table. He met his wife at the door by saying she was “always late.” His oldest daughter then complained to her mother that Tom was unfair at which point his wife told Tom to “lay off the kids.”

Continued Clinical Example of Thomas: Decision Analysis. Note: Decision Analysis was previously defined and discussed. Tom would like to reduce conflict with his wife Jessica and their children, but feels strongly that the children have certain responsibilities that they should perform. In discussion with the therapist, Tom generated some options:
Option 1: Go along with whatever Jessica wants: Let the house get messy, and let the girls do what they want to do.
Option 2: Tell his wife that he’s going to look for a job. It will then be her turn to stay at home and take care of the children.
Option 3: Don’t immediately express anger at Jessica when she comes home. Wait to talk with her at a more opportune time.
Tom reviewed the pros and cons of each option.

Option 1: Go along with what Jessica’s wants.

Pros: Might reduce open conflict.

Cons: Children might not get a clear message about how they should behave.

Option 2: Go back to work.

Pros: Would have more money. Tom would be relieved of child care responsibilities.

Cons: He likes his role of being a “stay-at-home” dad. Would have to pay for child care. He doesn’t have good job prospects right now.

Option 3: Don’t express anger when Jessica comes home, wait to talk to her later.

Pros: If he speaks with Jessica, he might convince her to be stricter with their children.

Cons: Talking with her might lead to more conflict if she isn’t convinced.

Continued Clinical Example of Thomas: Role Play. Note: Role Play (and modified Role Play) have been previously defined and discussed. Tom chose Option 3 and was successful in holding back his anger on his wife’s arrival home. Now he wanted to know how to talk with his wife about his concerns. The therapist discussed with Tom what he would like from the interaction with his wife (less conflict, improved behavior from the children). The therapist encouraged Tom to rehearse what he might say to his wife. He helped Tom to better tailor his message and offered some general suggestions on how to improve his communication skills using elements of Interpersonal Skills Building technique. (This technique will be clinically illustrated with a case in the upcoming section on Grief.) The clinician played the part of his wife and Tom played himself in a series of practice conversations. Then Tom played his wife and the therapist played Tom. They tried to anticipate different ways that the conversation might go including the possibility that Jessica would be defensive and angry toward Tom.

Continued Clinical Example of Thomas: Work-at-Home. Note: Work-at-Home was previously defined and described (see pp. 14, 19). Tom believed he was ready to have a conversation with his wife. The therapist prepared Tom for different outcomes of the planned conversation including the possibility of not having the conversation. In the next session, the therapist reviewed with Tom the outcome of the conversation and likely next steps.

Problem Area: Grief

As conceptualized in IPT, Grief is tied to the death of an important person in the Veteran's life. It is not used as a problem area for feelings of loss tied to issues unrelated to death (e.g., loss of the life one had hoped for, feelings of loss related to changes in one's life). Most people who are grieving the loss of an important person do not develop depression or require mental health care. "Normal" grief may transition to "complicated grief" (also referred to as "complicated bereavement"), become interwoven with a major depressive episode, and thus require clinical care. In IPT, if it is determined that the depression is connected to the death of an important person, Grief will most likely be the IPT problem area. Assessment requires a careful evaluation and awareness of those emotional, cognitive, and behavioral factors associated with normal grief, complicated grief, and major depression. Further, it is important to keep in mind that there is not always a clear demarcation of what distinguishes normal from complicated grief (Jacobs, Masure, & Prigerson, 2000).

Veterans – especially those with combat exposure – are likely to have experienced the loss of fellow service members. For some, these experiences result in complicated grief. Many older veterans contend with loss of family and friends that is part of the course of life. Some Veterans evidence complicated grief that is temporally close to the death; others may experience grief from losses many years earlier.

Common Causes of Grief among Veterans

- Death of spouse or partner
- Death of child
- Death of friends
- Death of fellow service members
- Death of parents, siblings, or other family members

Goals and Strategies of Grief

Goals:

Help the Veteran...

- grieve the loss; and
- establish interest and engagement in new relationships.

Strategies:

Help the Veteran...

- review depressive symptoms;
- connect symptoms to the death of the important person;
- reconstruct the relationship with the deceased;
- describe the circumstances surrounding the deceased's death;
- express both positive and negative feelings about the deceased; and
- explore ways to engage with others

Therapeutic Goals and Strategies for Grief. In the treatment of Grief, IPT's goals are twofold: Facilitate the mourning process, and help the Veteran re-establish interest and engagement in new relationships (Weissman et al., 2000). In essence, the goals are to help the Veteran come to terms emotionally with the loss and then begin to reestablish a new life structure. IPT strategies associated with achievement of IPT goals in the treatment of Grief include the following:

- **Review depressive symptoms.** This technique has been discussed earlier and is used in conjunction with all four IPT problem areas. Engage the Veteran in a discussion of current depressive symptoms in every session.
- **Relate symptom onset to the death of the important person.** In the Initial Sessions, the connection between the death of an important person and the onset of depression is discussed. For some Veterans, further discussion of the connection may be needed. During the Intermediate Sessions, point out the connection between recent depressive symptoms and loss-related issues, as well as the absence of meaningful relationships or activities that might substitute for the death of the important person.
- **Reconstruct Veteran's relationship with the deceased.** Engage the Veteran in a discussion of the deceased. Recent and remote recollections of the relationship are encouraged. The Veteran may be asked to bring in memorabilia related to the deceased such as photographs to facilitate recollections of the deceased.
- **Describe the events just prior to, during, and after the death.** Encourage the Veteran to talk about circumstances surrounding the death of the deceased. Such a discussion can be highly meaningful and emotionally laden for the Veteran. Some writers have characterized grief as a type of trauma. Some grieving individuals may be avoidant of painful memories and experiences tied to the deceased. Other Veterans find family or friends have signaled that they do not want to hear of painful memories. Guide the Veteran into a discussion of these recollections.
- **Explore the Veteran's positive and negative feelings about the deceased.** This strategy extends and deepens the Veteran's reconstruction of the relationship with the deceased by encouraging the Veteran to share both negative and positive feelings about that person. While experiencing acute feelings of loss, some Veterans may only portray the deceased in positive terms. Yet all relationships have both positive and negative aspects, and IPT proposes that a balanced understanding of the relationship will facilitate the grieving process.
- **Encourage and explore possible ways to engage with others.** For many, the loss of an important person is associated with reduced social involvements and emotional connections with others. Veterans who are providing extended care to an infirm spouse or partner, for example, often reduce their involvements with others as they provide increasing care to the spouse. Upon the death of the spouse, they confront not only the loss of the spouse's companionship but also the daily structure of the caregiving role. The scope of the Veteran's social connections may have decreased over time as he devoted more and more time to care responsibilities – what the caregiving literature calls “role engulfment” (Skaff & Pearlin, 1992). Reduction in social engagement is often compounded by depression that can attenuate interest in being with others. Ask the Veteran to identify past activities and relationships that have reduced in frequency and intensity, explore possible means of engaging or re-engaging with others, and as part of Work-at-Home, take concrete actions to engage.

Common Implementation Challenge:

Veteran Avoids Painful Memories about Deceased

Some clients avoid or stall discussion of especially poignant and painful memories of the deceased. The therapist may be the only person in the Veteran's social world who evidences interest in hearing about these memories. IPT strategies integral to the treatment of grief include discussion of the deceased and the events surrounding the death. Therefore, it is important to clearly communicate to the Veteran that discussion of the deceased will take place during treatment (rather than vague inquiries like *"Would you like to talk about (name of deceased)?"*)

For Veterans who evidence reluctance to discuss the deceased, or who abruptly end a discussion that is evidently painful, say something like: *"I know how hard it is for you to talk about (deceased name). If you feel that you don't want to continue with this discussion today we can stop and pick up the discussion next session."*

Frequently Used IPT Techniques in Grief. Decision Analysis, Interpersonal Skills Building, and Work-at-Home are often used in the treatment of Grief. In addition, often the therapist will help the Veteran express affect related to the loss and, at other times, help the Veteran manage the affect if it becomes too intense. Each of these techniques will be discussed with clinical illustration using the case of Eva. Note that a summary of IPT treatment with Eva and accompanying dialogue is provided in the Case Vignettes section (see page 65) of the Therapist Guide. Eva's case is also illustrated in the companion video.

Frequently Used Techniques in the Treatment of Grief

- Decision Analysis
- Interpersonal Skills Building
- Work-at-Home

IPT Treatment Technique: Interpersonal Skills Building.

As noted earlier, these are efforts made by the therapist to teach the Veteran fundamental communication behaviors that help to engage others, sustain interactions, and productively address interpersonal difficulties.

Implementing Interpersonal Skills Building

Find an optimal time to discuss issues of concern with an involved individual

- ◆ Help Veteran to think about the best time to have a conversation with other party to increase likelihood of having a productive discussion.
 - *“When do you think your husband would be most open to talking about this?”*
- ◆ Use “I” statements – Discuss with Veteran the communications advantage of using “I” statement rather than “you” statements (which may be heard by others as criticism).
 - *“I felt left out when you didn’t ask me to come on the trip” vs. “You are so selfish to go on the trip without me. You only think of yourself.”*

Focus on a specific situation

- ◆ Encourage Veteran to discuss one or two issues of current concern vs. multiple issues (“kitchen sinking”).

Clarify expectations

- ◆ Encourage Veteran to gain greater clarity about what expectations he has of the other party – Explore how realistic the Veteran’s expectations are.

Attempt to understand (but not necessarily accept) the other person’s point-of-view

- ◆ Ask Veteran to verbalize how the other person sees the current situation.
 - *“What would he say if he were here now?”*

Help Veteran anticipate how the conversation might go, and think about how to respond to issues that might arise. Have a few options in mind of how the conversation might go.

The art of negotiation: Give to get

- ◆ Give recognition to other persona’s concerns before asking for what you want.
 - *“I appreciate how hard this has been for you.” “I know that you have also made efforts to try to deal with the problem.”*

Clinical Example with Eva: Decision Analysis, Interpersonal Skills Building, and Work-at-Home

Case Synopsis: Eva is a 34 -year-old Hispanic Veteran. She is married, and a mother of three young children. She serves in the National Guard as a nurse and was deployed to Iraq. While in Iraq her fellow service member and best friend, Marcy, was killed. Eva did not witness this event. She continues to grieve the death of her friend. Eva had intended to contact Marcy’s family once she returned, but has not done so. Further, she found it difficult to transition home.

Clinical Example of Eva: Decision Analysis. Eva felt badly that she had not yet contacted Marcy’s family. She and Marcy had promised each other that if something happened to either of them, they would help their respective children. While in Iraq Marcy frequently talked about her children. Eva wanted to meet her children and thought it would help her to get over Marcy’s death. However, she was still grieving Marcy’s death and was uncertain about whether she was capable of visiting them. She was also uncertain whether Marcy’s family would welcome a visit from her since they were also likely grieving Marcy’s death. The therapist engaged Eva in a review of her options: (a) contact Mary’s family now; (b) never contact Marcy’s family; or (c) delay contacting Marcy’s family.

Option 1: Contact Marcy's family now.

Pros: Might decrease Eva's guilt about not having reached out to them and possibly help with her own grieving.

Cons: Eva might feel more upset after seeing them. Marcy's family may feel upset about seeing Eva.

Option 2: Never contact Marcy's family.

Pros: Would help her avoid having to deal with possible upset.

Cons: She would not fulfill the promise she made to Marcy. She may miss the opportunity to meet Marcy's family and share common grief.

Option 3: Delay contacting Marcy's family.

Pros: Later she might be better able to handle a meeting with them when she felt better prepared to see them.

Cons: The family may feel disappointed and alienated from her for waiting so long.

Continued Clinical Example of Eva: Interpersonal Skills Building. Eva decided to delay contacting Marcy's family until she felt prepared enough to do it. The therapist worked with Eva to clarify her expectations about a visit with Marcy's family and whether her expectations were realistic. Eva wondered whether she wanted to contact them to receive support from them, support them, or reduce her own guilt that she lived and Marcy died. The therapist encouraged Eva to think about how Marcy's family might view a visit from her. For example, might they feel comforted by such a visit, ambivalent, or confused why someone they had never met might want to see them? In view of these possibilities, what might the outcome of such a visit be? They could be unwelcoming, welcoming, or have mixed feelings in response to contact from her. How might Eva respond to each of these possibilities? If unwelcoming or ambivalent, what might she say?

Continued Clinical Example with Eva: Work-at-Home. Eva decided that she would contact Marcy's family. The therapist helped Eva with the timing and content of a call to Marcy's family. She prepared Eva for different outcomes of the call:

- Eva decides not to make the call.
- Eva calls the family and they are not receptive to her request to get together.
- Eva calls the family and they are receptive.

The next week, the therapist discussed the outcome of her plan to call Marcy's family and possible next steps.

Problem Area: Interpersonal Deficits

Some people want connections with others but don't have adequate skills to initiate or sustain them. As a result they may feel isolated, lonely, and depressed. These individuals are different than those who do not enjoy or want close relationships, and who prefer solitary pursuits. Veterans with Interpersonal Deficits may think of themselves as "never good with people" but might reluctantly acknowledge that they wish they were better at it. Young Veterans with Interpersonal Deficits may have gone from high school to the military where they were part of organizations that offered work routines and social structures that facilitated interpersonal contact. Once discharged from the military, some may lack the social skills needed to make and maintain interpersonal connections in civilian settings. For other Veterans, Interpersonal Deficits have been long-standing. These deficits may become evident when the Veteran has lost a key relationship, through death or divorce, with someone who played a critical role in initiating and sustaining their social relationships. It has been found that Interpersonal Deficits are not uncommon among Veterans seeking treatment.

Common Causes of Interpersonal Deficits in Veterans

- On return from deployment, alienation from existing relationships and increasing social isolation (e.g., “civilians don’t understand me and I don’t understand them”).
- Loss of key relationship because of divorce or death of someone who played a central role in initiating and sustaining social relationships.
- Difficulty adjusting to the interpersonal aspects of civilian life after being part of a military culture that included clearly defined roles, expectations, and organizational structures.

Goals and Strategies of Interpersonal Deficits

Goals:

Help the Veteran...

- reduce loneliness and social isolation; and
- form new relationships or reengage in earlier relationships.

Strategies:

Help the Veteran...

- review depressive symptoms;
- connect symptoms to loneliness and isolation;
- look at past and present relationships to identify strengths and problems in them ;
- look at patterns in relationships; and
- explore ways to engage with others.

Therapeutic Goals and Strategies for Interpersonal Deficits. IPT goals for the treatment of Interpersonal Deficits are to reduce the Veteran’s social isolation, and encourage the Veteran to form new relationships (Weissman et al., 2000). Strategies associated with achievement of IPT goals in the treatment of Interpersonal Deficits include:

- **Review depressive symptoms.** As with all IPT problems areas, depressive symptoms are discussed weekly in conjunction with the PHQ-9 and mood check that were discussed earlier in this Therapist Guide (see page 4).
- **Relate depressive symptoms to isolation.** Although a link may have clearly been made between limited social interactions and depression in the formulation, it is worth repeating throughout treatment. Also point out the connection between changes in the Veteran’s symptoms and his level of social contact during all phases of treatment.
- **Look at present and past significant relationships.** Although an Interpersonal Inventory would have been conducted in the Initial Sessions, subsequently it is useful to gain more detailed information about the Veteran’s current and past relationships. Some Veterans may have no current relationships, so obtaining detailed information about past relationships is especially helpful in identifying interpersonal strengths and problems.
- **Look at repetitive patterns in relationships.** Information from the Interpersonal Inventory, and subsequently obtained in-depth information about the Veteran’s relationships, will provide a picture of characteristic relationship problems and strengths. For example, some Veterans demonstrate solid skills in making initial contact with others (e.g., are good at informal small talk to get interactions going) but don’t possess the skills to move beyond. Other Veterans can initiate interpersonal interactions, but find that others begin to eventually distance themselves for reasons that are not entirely clear to the Veteran.

- **Encourage the Veteran’s socialization.** Work with the Veteran to identify social events or connections that will increase opportunities for building interpersonal connections. Initially, an effort might be to simply be in the presence of other individuals (e.g., attend a Veteran-related activity, go to the movies) without an expectation that the Veteran will make an active effort to connect with others. Once comfortable with simply being among people (with expected improvement in mood), work with the Veteran to build skills to initially engage others in conversation. As possible, more advanced skills can be built to facilitate sustainment of relationships.
- **If necessary, use the therapeutic relationship to demonstrate how the Veteran relates.** As outlined in Weissman et al. (2000), discussion of “therapeutic transference” (as used in some psychodynamic therapies) is not part of IPT. However, some Veterans with Interpersonal Deficits have so few relationships they have limited opportunities for interactions to discuss in therapy. In fact, the therapist may be the only person with whom they have sustained contact. Therefore, it may be necessary to provide feedback to the Veteran on his behavior in sessions. Providing this feedback must be done skillfully to minimize the likelihood that feedback will be heard as criticism. Some interpersonally relevant behaviors for which feedback might be provided include making little or no eye contact, speaking very softly, misreading therapist behaviors (e.g., concluding that the therapist finds the Veteran boring because he intermittently looks at his watch), and being overly self-critical about how he comes across to other people (e.g., “*I sound boring to other people*” when, in fact, the Veteran is relatively engaging).

Frequently Used IPT Techniques in Interpersonal Deficits. Decision Analysis, Interpersonal Skills Building, Role Play, and Work-at-Home are often used in the treatment of Interpersonal Deficits. Interpersonal Skills Building and Work-at-Home will be discussed in this section with clinical illustration using the case of Will. Note that a description of IPT with Will and accompanying dialogue are located in the Case Vignettes section (see page 92) of the Therapist Guide. Will’s case is also illustrated in the companion video.

Frequently Used Techniques in the Treatment of Interpersonal Deficits

- Decision Analysis
- Interpersonal Skills Building
- Role Play
- Work-at-Home

Clinical Example with Will: Interpersonal Skills Building, Work-at-Home

Case Synopsis: Will is a 70-year-old, African American, Vietnam Veteran, with four grown children. His beloved wife of 40 years died one year ago after a prolonged illness. During the time of his wife’s illness he provided considerable hands-on care and lost contact with their friends. He is very disappointed that his oldest son avoided seeing his mother during her illness. Currently he has little contact with his oldest son and his family. Will also has limited contact with his other children who live out of town. He is depressed and socially isolated. He wants contact with others, but has made no efforts to connect with them. Friends have called him but he has not responded.

Clinical Example with Will: Interpersonal Skills Building. Note: Interpersonal Skills Building was previously defined and discussed (see pp. 14, 26). Will’s friends, Connie and Bob, have left repeated messages on Will’s answering machine inviting him to dinner with them and others. Will has not responded to the invitation. Will has put off replying, because he’s especially uncomfortable going to a dinner party where he will have to socially engage with people other than Connie and Bob. Since his wife had always handled social engagements, Will didn’t know how to proceed. The therapist worked with him to understand the steps involved in responding to a social invitation including: returning the call, expressing appreciation for the invitation, and asking if he might bring something.

Will called Connie and Bob and accepted the invitation. At this point, he said he was unprepared how to interact socially at the dinner party. The therapist guided Will through some basic skills that would help him socialize in a larger gathering. The therapist helped Will to prepare for engaging in a variety of conversational topics that would be comfortable for him.

Continued Clinical Example with Will: Work-at-Home. Will's Work-at-Home was to try to attend the dinner party. Will did attend the dinner and the therapist reviewed his efforts in the next session. The engagement was easier than he anticipated and Will reported improved mood. The therapist linked his improved mood with his effort to increasing socialization.

Transition from the Intermediate Sessions to Termination

For most, the transition from the Intermediate Sessions to Termination proceeds smoothly. Termination is discussed with the Veteran in the Initial Sessions, and the Veteran is periodically reminded of the number of remaining visits during the Intermediate Sessions. Difficulties can arise if the Veteran has not been adequately reminded of the number of remaining sessions, and termination is abruptly introduced in Session 14. So, it is imperative to keep the Veteran aware throughout treatment.

The Termination phase begins in Session 14. During that session simply mention that two sessions remain. The work of Termination begins at the start of Session 15 and continues through Session 16. A full description of the Termination protocol sessions follows in Chapter 3.

Therapeutic Tips for Intermediate Sessions

The following are tips for implementing the Intermediate Sessions. These therapeutic tips are integrated into the six case narratives that are found later in this Therapist Guide.

Therapeutic Tip: Symptom and mood ratings

In IPT the symptom and mood ratings are integral to the treatment. Use the ratings to help the Veteran monitor changes throughout the course of treatment. Changes in symptoms and mood provide an excellent starting point for focusing on what happened during the week that affected mood.

Therapeutic Tip: Making the link between mood and events

Except for Session 1, every IPT session begins the same way. There is a review of the PHQ-9 (that, if possible the Veteran completed just prior to beginning the session) and the mood rating. Based on the PHQ-9 and mood rating, ask the patient to discuss what happened during the last week that affected the scores. The task at the beginning of the session is to make the link between what has happened during the week with how the Veteran feels; or to make the link between how the Veteran feels and what happened during the week. For some Veterans this will seem obvious, while others may have not made the connection. This is the beginning of an essential part of IPT, when the therapist helps Veterans make the bi-directional connection between life events and mood.

Therapeutic Tip: Caution about advice-giving

Some therapists are prone to give advice to Veterans. In part, such efforts reflect the therapist's desire to be helpful to the Veteran. As most experienced therapists learn, even "good" advice is often rejected (e.g., "that would never work," or "I've tried that before."). It is likely that Veterans have also received advice from family members or friends. Most people don't like to be told what to do. It is best to try to draw out possible options to address a problem from the Veteran himself. If the Veteran does choose an option to proceed, it will have come from him. This conveys the message that he has the capacity to deal with life problems rather than looking to someone more knowledgeable than himself. It is especially tempting to forgo an exploration of an option when that option seems ill advised. If a Veteran gets really stuck and can't come up with options, then provide some tentative ideas. Offering these ideas, while acknowledging how challenging the situation would be for anyone to try to figure out, reduces the likelihood of leaving the Veteran with the feeling that he is inadequate to deal with problems that other people could easily figure out.

Therapeutic Tip: What to do when the Veteran does not have much to talk about

When working with a Veteran who has Interpersonal Deficits, it is common to encounter a situation that feels like "pulling teeth." It is difficult getting the Veteran to describe how he spent his week. It is important to see this as further confirmation of the problem area of Interpersonal Deficits. The Veteran likely doesn't have much to discuss in-session since he has not had an interpersonally active week. In IPT this is generally not thought of as resistance. The therapist's role is to help the Veteran understand that his lack of interaction is, in part, what is contributing to his depression. Aim for small interpersonal gains. The Veteran who has Interpersonal Deficits is not going to become a highly social person overnight, and probably never will. Small gains may be enough to help the Veteran lessen his depression symptoms.

Therapeutic Tip: Conducting a communication analysis

To facilitate the process, ask questions such as:

What did you say?

How did he respond?

How did it make you feel?

How do you think your words made the other person feel?

Is that the message you wanted to send?

How could you have said it differently?

What do you think he meant?

Chapter 3: IPT Treatment Protocol: Termination (15-16)

Overview

Termination is the third phase of IPT. Since IPT is a time-limited therapy, the Veteran is advised intermittently throughout treatment of the number of remaining sessions. One advantage of a time-limited therapy is that each session counts. For people in general, avoidance of directly dealing with life problems is fairly common. For Veterans, knowledge that time in therapy is limited, rather than indefinite, may enhance motivation to actively address identified problems. Experience has shown that termination can typically be completed in two sessions (sessions 15, 16), with a reminder to the Veteran during session 14 that the last two sessions are termination sessions.

Termination is explicitly discussed from the beginning of treatment. As noted, periodically reminding the Veteran of the number of remaining sessions is especially helpful as the planned end of therapy is getting closer. For example, during session 14, the therapist might say: *“This is our 14th session and we have two remaining sessions during which we’ll be wrapping things up. In the next session, I’ll be asking you about your thoughts and feelings about ending, review with you what you’ve done in therapy, check on changes in your depression, and talk with you about the future.”*

Common Implementation Challenge:

Therapist does not Remind Veteran of Remaining Sessions

Some therapists do not remind clients of remaining sessions during the course of therapy, and only bring up the issue just prior to termination. Some Veterans may express surprise that they only have, for example, two remaining sessions – or may even have forgotten that the therapy is time-limited.

It is helpful to mentally note (or on the weekly schedule of appointments) the number of IPT sessions. Regular reminders of remaining sessions convey that much work remains to be done in a limited amount of time – a message that hopefully motivates the Veteran to make maximum use of each of session.

Tasks of Termination

- Explore feelings about termination
- Review depressive symptoms and changes over treatment
- Review problem areas
- Review warning sign of depression and future triggers
- As needed, discuss partial or non-response
- As needed, discuss additional treatment

Feelings about termination: Explore the Veteran’s feelings about termination. The therapeutic relationship may be a unique experience for some Veterans. Strong feelings about the therapist or the process of therapy may develop. Most Veterans have thoughts and feelings about the planned end of therapy – fear, relief, gratitude, abandonment, ambivalence, sadness, or excitement. Some Veterans may convey indifference about the end of therapy when actually they experience many feelings. If sensing that this is the case, then further exploration can be helpful. For example: *“Most Veterans I work with have some feelings about ending therapy and often have a mix of feelings.”*

Symptom change: Discuss changes in symptoms over the course of treatment. PHQ-9 scores and subjective mood ratings are available from the beginning until the end of treatment. These are rich data to discuss with the Veteran. Some VA clinicians graph PHQ-9 and mood ratings to show the Veteran changes in symptoms over time. Review the symptom clusters associated with the depression diagnosis for which the Veteran initially met criteria and see if he continues to meet those criteria. For example: *“On your first visit here your PHQ-9 score was 21, which meant that you were in about the severely depressed range. The PHQ-9 you completed today is 9, which represents mild depression. On a scale of 1 to 10, your mood rating when you first started therapy was 8 – close to the most depressed you have ever been. Today it is 4. On both the PHQ and the mood rating, you have half of the depression symptoms you did when you began therapy. You might also recall, that when you first came, I told you that you had what we call a ‘Major Depression.’ Today you don’t have enough symptoms to qualify for that diagnosis.”*

Review of problem area(s): Also review with the Veteran the problems that have been the focus of treatment. It is helpful to simply ask the Veteran to say what the problem(s) is that he has been working on. This isn’t a test – it is a way to discern whether the Veteran has a clear sense of the goals of therapy. Most Veterans can clearly identify the problem area in their own words. Then ask the Veteran to provide a description of how he addressed the problem and what he learned. The Veteran may need a reminder of some salient issues that he may not have identified.

Warning signs of depression and future triggers: Some people have early signs of depression that are typical for them when they are entering into an episode of depression. If that is the case, it is helpful to review specific warning signs with the Veteran. For example: *“Let’s think about the changes you noticed when you first started getting depressed. If I recall correctly, you began to lose interest in playing basketball, were more irritable with your wife and kids, and really had to push yourself to get your work done. If one or more of those things begin to happen in the future, it might mean you’re getting depressed again. Does that make sense to you?”* Also discuss with the Veteran future life circumstances that might increase the likelihood of depression and how to best handle them. For example: *“Based on your past experience, what is most likely to trigger another depression?”* or *“If that happens, what are some things that you might do to handle it so you can try to head off a depression?”* If the Veteran can’t identify possible triggers, collaboratively discuss some possibilities. For example: *“I know that things are going very well with your wife now, and that’s great. Based on what you’ve told me, when you and your wife are fighting, it really takes a toll on your mood. If problems come up with your wife in the future, what are some of the things you’ve recently tried with your wife that might settle things down?”*

Attribute interpersonal success and symptom improvement to the Veteran’s effort. Veterans often express appreciation for the therapist’s help. *“You’ve helped me a lot.”* Since the IPT ethos is self-empowerment, emphasize the active efforts that the Veteran has taken to deal with life problems. For example: *“I think we’ve been a good team. I’m most impressed by all that you’ve done to deal with the issues you were concerned about. You’ve worked very hard, things are better, and you’re less depressed. Congratulations go to you.”*

Partial or non-response to IPT: If the Veteran did not respond to IPT, (e.g., did not show a reduction in depressive symptoms, or improvement in the identified problem area; showed reduction in depressive symptoms, but not improvement in the problem area) explore feelings about that and alternative treatments. The IPT perspective on those who don’t respond to treatment but made reasonable efforts is: You didn’t fail IPT. IPT failed you. IPT therapists often say during treatment: *“There are always options.”* This therapeutic mantra is meant to counteract negativity often associated with depression and encourage action. For Veterans who do not respond to IPT, note (as was done in the Initial Sessions) that there are many effective treatments for depression.

Possible Treatment Options for IPT Non-Responders

- Start an antidepressant medication, for Veterans who initially refused
- For Veterans taking an antidepressant, encourage a review of current medications
- Recontract for a specific number of additional IPT sessions
- Change therapists
- Change therapeutic modality

Maintenance treatment: Depending on the VA facility, it might be possible to offer time-limited *maintenance IPT*. If this is the case, discuss the rationale for maintenance treatment, its format, and that research supports its usefulness in reducing the frequency or duration of depressive episodes particularly for those with recurrent depressions.

Therapeutic Tips for Termination

The following are tips for implementing Termination.

Therapeutic Tip: Gains are attributed to medication, not therapy

Some Veterans who are on psychotropic medication attribute therapeutic gains to the medication and not psychotherapy. Objectively, it may be impossible to know what has had the most impact on improvement of depression symptoms. Research findings testify to the utility of IPT, medication, and the combination. Consistent with the IPT ethos of “empowerment,” it is important to point out the active role that the Veteran has taken in seeking treatment and following through on therapeutic recommendations, including taking medication. Studies of patient adherence to prescribed medications indicate that, in fact, many are not adherent but those who are increase the likelihood of improvement. If the Veteran’s depressive symptoms improve, be mindful of whether he has made gains in the identified problem area. Continued problems may increase the likelihood of a relapse or recurrence.

Therapeutic Tip: Therapist preparation for termination sessions

Prior to starting Termination, it is very helpful to prepare a list of skills the Veteran acquired during treatment that helped him to improve or resolve the identified problem area(s). Also list possible future triggers for depression. The lists would be used if the Veteran cannot identify learned skills and future triggers.

Chapter 4: Clinical Vignettes

Overview

This section contains clinical vignettes for each of the IPT problem areas. The vignettes provide a description and narrative of the entire course of treatment with six Veterans. The vignettes are accompanied by examples of selected dialogue between the therapist and the Veteran as well as case commentary. “Therapeutic tips” accompany the narratives that offer suggestions to the reader on how to handle common issues that arise in implementation of IPT. Four of the Veterans portrayed in these vignettes are also presented in the companion IPT video.

Role Transitions

- Mike A 75-year-old Veteran who provides care to his wife with dementia. He finds caretaking increasingly difficult. (Note: This case was used earlier in this Therapist Guide to illustrate use of IPT techniques.)
- Ray A 67-year-old Veteran who had a mild stroke, retired from his job, and now faces financial problems including possible loss of his home. (Note: This case is part of the IPT video.)

Interpersonal Role Disputes

- Thomas A 38-year-old Veteran who returned from two tours in Iraq and assumed the role of “stay-at-home dad” while his wife works outside of the home. Conflict exists between Tom and his wife relating to different expectations about child rearing and household responsibilities. (Note: This case was used earlier in this Therapist Guide to illustrate use of IPT techniques. This case is also part of the IPT video.)

Grief (primary) & Role Transitions (secondary)

- Eva A 34-year-old Veteran who returned from deployment in Iraq where a friend and fellow service member was killed. She is grieving the loss of her friend and having difficulty transitioning back to her roles as wife and mother. (Note: This case was used earlier in this Therapist Guide to illustrate IPT techniques. This case is also part of the IPT video.)

Interpersonal Deficits

- Matthew A 32-year-old Veteran who is retired from the military. He is divorced and has two young children with whom he has limited contact. He has little contact with others and feels socially isolated.
- Will A 70-year-old Veteran whose wife died after a long period of illness during which time he provided care to her. He has four children with whom he has limited contact and has grown increasingly socially isolated since his wife’s death. (Note: This case was used earlier in this Therapist Guide to illustrate of IPT techniques. This case is also part of the IPT video.)

Problem Area: Role Transitions – Case Vignette: Mike

Case Summary

Mike is a 75-year-old, white, married Korean War Veteran who has an adult daughter and adult son. The onset of depressive symptoms appeared to be tied to a recent diagnosis of dementia in his wife. An initial intake noted that Mike had been providing care to his wife for the last three years because of her increasing physical health problems following a mild stroke. Six months ago his wife was referred for a neurological evaluation because of short-term memory loss and episodes of confusion and agitation. She was diagnosed with vascular dementia. Mike is in relatively good physical health. He expresses distress, anger, and frustration related to the increasing level of care that he provides to his wife. He is disappointed by the lack of support from his two adult children (especially his daughter), and that his friends at the local VFW no longer call him. He is also self-critical over his inability to maintain the household as well as his wife had done previously.

The Initial Sessions

Session 1: In this session the therapist reviewed with Mike the available information about his depression and current life circumstances. Mike generally concurred with the summary information provided by the therapist. The therapist also noted that Mike had been referred for IPT, briefly discussed the modality, and said they would talk more about IPT in the coming weeks. Most importantly, the therapist talked with the Mike about his depression. He reviewed the symptoms noted in Mike's chart, clarified whether the symptoms had changed since referral, discussed his PHQ-9 score, and explained that Mike has an illness called major depressive disorder that is impairing his ability to function.

Therapist: Mike, according to your medical records you've been depressed for about three months. The depression seems to have begun a few months after your wife was diagnosed with dementia. Do I understand this correctly?

Mike: Yes, that's what I told the other doctors.

Therapist: I also understand that you've been feeling sad, lost interest in the things that you used to enjoy, feel like you've had to push yourself to get responsibilities done, had problems concentrating, and at times feel things are hopeless. You also have had less interest in food, lost about 10 pounds, and found it hard to sleep. Is this correct?

Mike: Yeah, but since I took that medication my doctor gave me for my mood, my appetite is a bit better and I sleep a little better at night.

Therapist: That's good to hear. Also I understand you've felt disappointed with friends and family, sometimes get upset with your wife, and have been down on yourself because you can't keep the house as clean as your wife used to.

Mike: Yes. It's even worse now – our house is a pig sty.

Therapist: It makes perfect sense to me that it's so hard for you to get things done because you have what we called a major depression.

Mike: Major? How's that?

Therapist: Mental health professionals call it major depression because it's the more serious form of depression. It's an illness that affects the way people think, feel, and act. It can also affect sleep and appetite.

Mike: If I just tried harder I think things would be better.

Therapist: I think you're trying awfully hard right now. If you broke your arm, you wouldn't expect yourself to get all the things done you normally do. It's the same kind of thing here. You've got this illness called depression – it makes it harder to do things. I'd like to recommend that in the coming weeks you give yourself a bit of a break – not push yourself so hard. When you're feeling less depressed, you'll be able to do the things you need to, like get that house in better order.

Mike: You mean I can feel much better than I am now?

Therapist: Major depression is a very treatable illness. Studies show that medication, psychotherapy, and the combination, help most people get better from depression. I see improvement in most of the depressed patients I work with.

Mike: Even an old guy like me?

Therapist: Yes, older people who are depressed also can improve. Remember that questionnaire that you filled out before our appointment today? It's called the Patient Health Questionnaire or PHQ. The PHQ measures how severe your symptoms of depression are. It's kind of like a thermometer for depression. On that scale you filled out, you scored 12 which is "moderate depression." When we finish psychotherapy I expect that your score will be much lower – like when a fever goes down.

Therapeutic Tip: Veteran blames self for depression symptoms

It is common for people with depression to blame themselves for problems with functioning. It is also common that eventually others begin to blame the Veteran for lack of motivation, a failure to "look in the bright side," or take objective stock of the things that are actually going well. Self-blame is a symptom of depression along with hopelessness, helplessness, lack of motivation, and discouragement. A useful clinical response to self-blame is to remark, "That's the depression talking." This approach may help the Veteran begin to disentangle the symptoms of depression from who he "really is." Veterans sometimes express discouragement about the likelihood of improvement in therapy. Rather than getting into a struggle with the Veteran ("Yes, you will get better."), it may be helpful to say something like, "Oh, it makes perfect sense that you would feel that way. When people are depressed they are very likely to feel hopeless. When feeling less depressed, most people look at things differently."

Session 2: In the second session, the therapist first reviewed with Mike his PHQ-9 and mood rating. In this session the therapist primarily conducted the Interpersonal Inventory. Using the Inventory, the therapist did a broad review of important current and past relationships.

Therapist: Today I'd like to talk with you about the important people in your life – now and in the past – including relationships that have gone well, or not so well. Since we've got a lot of ground to cover, we'll usually spend no more than about 10 to 15 minutes on each person. Who would you like to start with?

Mike: My daughter. I talked with her this week and was disappointed that she didn't ask more about how things are with me, and her mother.

Therapist: It sounds like this week you and your daughter had different expectations about how your conversation would go. Is that often the case?

Mike: She's a good kid. Well, I guess she's not a kid anymore. We got along as a family. She has a family of her own now but they're pretty much grown up. It's just that the last few years have been really tough taking care of my wife. I just wish she'd come by more often and ask me how things are going.

Therapist: Are there other areas where you have different expectations about the way things should go?

Mike: Oh, when she was younger she did crazy things at college. But she's been a good daughter and a good mother to her own children.

Therapist: Tell me about those things that are most satisfying and dissatisfying in your relationship with your daughter.

Mike: I always liked the fact that she was such a good mother to her kids – it made me proud. And she always tried to make us part of her life. Her husband is a pretty good guy too. Like I said, I’m disappointed that she hasn’t been around more to help her mother – it’s almost like she doesn’t want to know. It’s all pretty upsetting. I can see why she might not want to know.

Therapist: What would you like to change in the relationship?

Mike: Just call me more often. She always tells me what she and her family have been doing and sometimes asks about how her mom’s doing. But she doesn’t ask very often about how I’m doing. She doesn’t even know that I take those pills for my mood. And I just wish she’d realize that it would really help if sometimes she would come and spend the weekend and help out with her mother.

Therapist: Have you asked her to do those things?

Mike: No. A daughter should know.

Therapist: I think we’ll probably talk some more about that in the coming weeks. Who would you like to discuss next?

At the end of the second session, the therapist learned that Mike had generally good relationships with others throughout his life. He had problems being direct in his communications with others, including his wife, daughter, and son. He heavily relied on his wife to arrange social engagements with friends and family, and now that she is impaired, there have been fewer and fewer social engagements. He was actively involved in the VFW for many years, but rarely attends gatherings there now. He expressed disappointment that his VFW friends stopped calling him, but acknowledged that the calls stopped after he failed to return messages from those friends for several months.

Session 3: The therapist began the session by inquiring about Mike’s depression during the past week and how things more generally went during the week. Issues in caring for his wife were of most concern. During the session the therapist talked more with Mike about whether there were other issues in his life that might have contributed to, or were sustaining, his depression. He said that care for his wife was the most pressing issue in his life and made him feel “lousy.” The therapist concluded this session by providing the Veteran with the Interpersonal Formulation, discussing treatment goals, finding out whether Mike agreed with the therapist’s sense of things, and then outlining how IPT would be conducted in the coming weeks.

Therapist: Mike, we’ve been talking together over the last three weeks and now I’d like to tell you what I think. You have depression. (Clinician describes symptoms.) Your depression is related to your wife’s increasing health problems. It sounds like you’ve been providing additional help to your wife since she had the stroke three years ago. You’ve had a new role in your life that you didn’t have before that includes helping with the cooking, shopping, and cleaning that your wife used to do all by herself. Sounds like you did these things pretty well after her stroke. But, things have changed again in the last year, when your wife had more and more memory problems and there have been times when she was confused and upset. The doctor told you that she has dementia, which will likely get worse over time. You then became increasingly depressed as well as more frustrated with your wife, critical of yourself, and disappointed that your children and friends didn’t seem to be as concerned about you and your wife as you had hoped. Did I get that right so far?

Mike: That’s exactly what happened.

Therapist: I’m glad that I understood you correctly. So I think that it’s the change in responsibilities – especially those connected with your wife’s dementia – that triggered your depression. And that’s why I’m recommending that we focus on how you can better deal with those caregiving responsibilities.

Mike: And how my kids can help me more.

Therapist: Exactly. You make a very good point. So what I’m suggesting is that one important goal of therapy is that you will be less depressed. You remember that score that you got on the questionnaire you filled out when we first met? Our

goal is that it will be lower when you're done with therapy. We also would work together so that you are no longer in an episode of what we call major depression.

Mike: Do you still want me to take those pills?

Therapist: That's a decision between you and your primary care doctor. But it sounds like you felt a bit better after taking them. I'd suggest that you make another appointment with your primary care doctor to evaluate the medication. As discussed, I spoke with your doctor yesterday and told him that we are working together. He said that he was happy to hear that.

The other important goal of working together is that you have a better handle on how to deal with the responsibilities in the care of your wife. We'll talk more about how your life has changed, look at different options to handle the problems that come up with your wife, think about possibilities for how to get some support from your kids and your friends, and get to a place where you feel like all of this is more manageable. How does that sound?

Mike: That's sounds good, but I'm not so sure things will improve.

Therapist: It makes perfect sense to me that you're not so hopeful that things can improve. That's the depression talking. When people are depressed they see the glass half empty. But I'm hopeful because, as I said before, research has found that psychotherapy, medication, or the combination, help reduce depression in most people and we've found that to be the case with Veterans too.

Mike: I hope you're right.

Therapist: So let me say just a little bit about how this will all work. We plan to meet for a total of 16 sessions – that gives us 13 more. We'll meet weekly, mainly focus on things that happen during the prior week – especially those things having to do with care of your wife. We'll also talk about how things are going with your family and friends since you have concerns about that. I'll expect that we meet every week. Is that clear?

Mike: Yes, I understand.

The Intermediate Sessions

Session 4: The therapist reviewed the PHQ-9 and obtained the mood rating from Mike. He said that he was feeling more depressed since his wife had again wandered from their home. The police brought his wife home and said she had crossed a busy street inattentively, and bystanders reported that she was almost struck by a car. During the session the therapist worked with Mike to better understand the circumstances surrounding this unsettling event, explore different options, and help him understand the link between daily events and his mood.

Mike: It's all my fault. I should have never left her alone.

Therapist: Why was she alone?

Mike: I had to get a prescription for her around the corner at the drug store. I thought it was safe to leave her at home for a half-hour. When I came back she was gone. She told me that she didn't know where I was and she went to look for me. It's all my fault.

Therapist: I'm not so sure that putting fault on yourself is the best way to go. You're understandably upset. Let's put our heads together to think about ways in which you can deal with things in the future so that something like this is unlikely to happen again.

The therapist talked with Mike about dementia and it became evident that he did not fully understand what the diagnosis of dementia meant, and more generally what the neurologist had told him. The therapist arranged for Mike to get some informational materials from the Alzheimer's Association, and noted that the local VA hosted a monthly meeting of the organization.

Therapist: Mike. Let's think about some options to make it less likely that your wife will wander away from the house again.

Mike: I don't have any options. It's just me and her, and sometimes I have to go out without her.

Therapist: When you say that you don't have any options I think that's because you are depressed. Depression can make people feel hopeless and helpless. There are always options. Can you think of one thing that you might do?

Mike: I could lock her in the house when I go out.

Therapist: That's an option. So let's think about the advantages and disadvantages of that.

Therapeutic Tip: Caution about advice-giving

Some therapists are prone to give advice to Veterans. In part, such efforts reflect the therapist's desire to be helpful to the Veteran. As most experienced therapists learn, even "good" advice is often rejected (e.g., "that would never work." Or, "I've tried that before."). It's likely that Veterans have also received advice from family members or friends. Most of us don't like to be told what to do. It's best to try to draw out possible options to address a problem from the Veteran himself. If the Veteran does choose an option to proceed, it came from him – and conveys the message that he has the capacity to deal with life problems (vs. looking to someone more knowledgeable than himself.) It's especially tempting to forgo an exploration of an option when, to the therapist, that option seems ill advised. In Mike's case, the therapist did not feel it was prudent to lock his wife in the house because of safety reasons. It was optimal for Mike to come to that conclusion himself. If a Veteran gets really stuck and can't come up with options, then provide some tentative ideas. Offering these ideas, while acknowledging how challenging the situation would be for anyone to try to figure out, reduces the likelihood of leaving the Veteran with the feeling that he is inadequate to deal with problems that other people could easily figure out.

They discussed the option of locking his wife in the house when he left. Mike concluded that it would not be a good idea, because if there were a fire his wife would be trapped in the house. Mike had trouble coming up with other ideas. The therapist asked Mike to think about other possibilities in the coming week to discuss in the next session. In the meantime, Mike said that he would not leave his wife alone. The therapist concluded the session by pointing out the link between what happened during the week and an increase in his depressive symptoms.

Therapeutic Tip: Psychoeducation

Providing information about depression and its treatment is an important component of the Initial Sessions. Some Veterans may need ongoing input to understand their own depression and other health conditions. At some point it may become clear that the Veteran lacks basic understanding of co-existing medical conditions and should encourage him to gain that information from other relevant health care providers or institutional resources (e.g., organizations that provide information and resources about a specific disease). For Veterans providing care to family members with health or mental health problems, an accurate understanding of that problem may better enable the Veteran to provide care that is more beneficial to the family member, and enhance the Veteran's own feeling of mastery. Sometimes health care personnel have provided relevant information to the Veteran, yet may have done it in a way that was not understandable to the Veteran, or the Veteran was too emotionally upset to handle the information at that time.

Sessions 5 - 7: During these sessions the therapist discussed with Mike options to safeguard his wife. At first it was difficult for him to come up with options, but over several sessions the following ideas were discussed. In addition to his initial idea of locking his wife in the house, Mike talked about getting his daughter to be with his wife, and learning more about a day program he had heard about for people with dementia. He weighed the pros and cons of each option. Mike decided to call the program, and his wife was scheduled to attend the program three mornings a week. During the course of these sessions, Mike began to talk about his life with his wife before she became sick. He said the early years together after retirement were satisfying, and they

were able to travel together to places they had always wanted to see. He became tearful during one of these discussions, said that he missed the wife he knew before she got sick, and said that he felt cheated out of more years with her. Also during this time period, Mike saw his primary care physician who increased the antidepressant.

Session 8: Prior to the eighth session, Mike completed the PHQ-9 and mood scale. The therapist reviewed his scores and his progress in treatment to this point.

Therapist: Thanks for completing the PHQ. You remember that you took this when we first started. Your score of 12 meant you had “moderate depression.” Your score now is 6, indicating that you have “mild depression.” That means that you’re showing improvement. You’ve also gained 5 pounds, sleep pretty well through the night, and seem to have more energy and interest in things. Also, when you first came in you rated your depressed mood as 8, now it is 5.

Mike: I actually do feel a bit better.

Therapist: Why do you think that is?

Mike: I don’t know – maybe because of those pills that the doctor gave me?

Therapist: You said that they were beginning to help when we first met. And then the doctor increased the dose of the medication too. I’m sure that has helped. Anything else?

Mike: I’m glad that my wife will be starting that program next week. I can sure use three mornings a week to get things done. I’m already planning to clean that house.

Therapist: I think the medication helped. And I know that you have helped. First, you’ve taken the medication. You’ve also helped lower your depression because you thought about different options to deal with care for your wife. You called the day program. Now you can go out without having to worry about your wife wandering off. You can get things done at home that you’ve planned. It may be time to think about some things that you can do for yourself – like maybe begin to see your VFW friends a bit.

Mike: I miss those guys. But when could I do that?

Therapist: We’ve got eight more remaining sessions. Let’s use those sessions to think about that. There’s one other thing. You said that you wanted your children more involved but you haven’t done that. It struck me that when your wife wandered off you didn’t tell your children.

Mike: I knew they would blame me and I didn’t want to hear it from them.

Therapist: I know that you’ve been prone to blaming yourself for things especially since you’ve been depressed. I don’t know your children, so I don’t know if they would blame you. I think this is the time to start thinking about what you’d like from them, and how to go about asking for it. After all, that’s what you wanted, right?

Therapeutic Tip: Gains are attributed to medication, not therapy

Some Veterans who are on psychotropic medication attribute therapeutic gains to the medication and not psychotherapy. Objectively, it may be impossible to know what has had the most impact on improvement of depression symptoms. Research findings testify to the utility of IPT, medication, and the combination. Consistent with the IPT ethos of “empowerment” it’s important for the clinician to point out the active role that the Veteran has taken in seeking treatment and following through on therapeutic recommendations including taking medication. Studies of patient adherence to prescribed medications indicate that many are not adherent, but those who are increase the likelihood they will improve. If the Veterans’ depressive symptoms improve, be mindful of whether he has made gains in the identified problem area. Continued problems may increase the likelihood of a relapse or recurrence.

Sessions 9 - 13: During these sessions Mike’s wife attended the day program. His wife enjoyed the program, her spirits brightened, and Mike welcomed this “free” time. One of his VFW friends telephoned him. Mike apologized for not having returned his prior calls and explained his situation. They made a plan to have breakfast on a morning when his wife attended the day program. Much to his surprise, several other friends joined them. Also, during these sessions, the therapist helped Mike focus on issues with his adult children, especially his daughter.

The Veteran decided that he would talk with his daughter about his concerns. He role played the conversation with the therapist and decided to speak with his daughter. He returned the following week, and said he didn’t feel ready to talk to his daughter, and wanted to talk further with the therapist about his daughter. It eventually became clear that despite the fact that Mike wanted more support from his daughter, he failed to tell her that his wife had been diagnosed with dementia because he didn’t want to “bother” his children. Mike asked if he could invite his daughter to join a therapy session and have a conversation with her with the therapist present. The therapist said he thought that was a good idea. In advance of the session, Mike again practiced what he wanted to say to his daughter, including the fact that he wanted her to call more often, come by on weekends, and go with him to a meeting of the local chapter of the Alzheimer’s Association. During the joint session, his daughter expressed surprise and disappointment that her father had not been more forthcoming about the dementia diagnosis and increasing problems her mother was having. She agreed to be more engaged but asked her father to be more honest about what was going on.

Termination

Sessions 14 - 16: As the therapist had done throughout therapy, he continued to remind Mike of the number of remaining sessions. In session 14 the therapist said that they would be finishing therapy in the next two weeks. The therapist encouraged Mike to share feelings about ending. He said that he was surprised that things had gone as well as they had. At first, Mike said that he was happy to end therapy. In the next session, however, he said that he was nervous about ending and wondered if he could handle things himself. His concerns were clarified, and the therapist advised that it was common, that on ending therapy some people feel apprehensive about ending. Mike said that he and his daughter attended a recent meeting of the Alzheimer’s Association that had a twice-monthly support group for family members. He planned to attend the support group. He also felt that his daughter was more engaged and supportive of him. He had also established a routine of having breakfast once a week with his VFW friends. Mike completed the PHQ prior to the 16th session.

Therapist: I just added up the scores on the depression questionnaire you completed. Your score has gone from 12 to 4. Your depression mood rating has gone from 8 to 3.

Mike: That’s good, right?

Therapist: Yes, that shows your depression is much improved since you started. Decreasing depression symptoms was one of our goals of therapy. Remember, I also said that you had the diagnosis of major depression when you started therapy? Right now we say your depression is in “remission.” That means that you don’t have many of the symptoms of major depression that you did when you first started therapy.

Mike: You and the other doctor helped me so much. I’m grateful for that.

Therapist: I think we all worked pretty well together as a team. But I want to emphasize all that you have done during the last four months. You took the medication that was prescribed. You came here to talk together with me each week. You thought about different options to deal with care of your wife. You found a day program for your wife that made life easier for you and your wife. You agreed to get together with your friends. And, you engaged your daughter in an important conversation about what you wanted from her. I’m impressed by all that you have done. Now you’re much less depressed, and are better handling care for your wife.

Case Commentary

Among older adults, role transitions are common. Among those role transitions, acquisition of the caregiver role is one frequently seen in clinical practice. Research shows that prolonged family caregiving can be especially stressful for the caregiver and increases the risk of depression. Caregiving for someone with dementia is especially challenging, but even more difficult for a caregiver who is depressed. The roles and responsibilities of caring for someone with dementia usually are learned on-the-job. Research also finds that caregivers who feel they are competent in provision of care are less likely to become depressed.

For Mike, his wife's wandering from the home signaled that a new level of care was required to safeguard her. The therapist engaged Mike in a discussion through which he could take stock of existing options and then decide which of those options to pursue. He found that a day program worked best for him and his wife. The program offered him some respite from caregiving demands, increased pleasurable activities for his wife, and provided an opportunity to reconnect with his friends. Although Mike complained of the lack of concern and involvement on the part of his daughter, an analysis of his communication with her revealed that he had not shared important facts about his wife's condition. Therapy provided an opportunity to engage his daughter in a discussion of his wife's condition and request her assistance in care of her mother and support for himself. Since dementia is associated with a progressive loss of mental and functional abilities, the level of care his wife needs will change over time. This change will require ongoing adaptation by him in provision of higher levels of care. Being less depressed and having a positive experience in addressing current caregiving problems will likely prepare Mike to better handle future caregiving issues.

Problem Area: Role Transitions – Case Vignette: Ray

Case Summary

Ray is a 67-year-old, Caucasian, Vietnam Veteran who had a mild stroke while he was working one year ago. Several months later he started to become depressed. He had no lasting physical impairment because of the stroke. He is married and has three adult children. He has a solid history of employment, generally good relations with his wife and children, and made a relatively smooth transition from military to civilian life after his service in Vietnam. Ray, his wife, and his children all worried that the stress of his job was a contributing factor to his stroke. In consultation with his family, Ray decided to retire from his job despite the fact he needed that source of income. Now Ray and his wife, Marge, are having difficulty meeting monthly expenses and fear they may lose their house. Because of financial problems, Marge returned to work. Ray feels he has disappointed her because he is no longer the primary bread-winner. He has taken over household responsibilities that he thinks of as “women’s work.” Further, Marge is reluctant to have sex with him for fear that it will lead to another stroke.

The Initial Sessions

Session 1: During the first session the therapist reviewed with Ray the medical and mental health information in his chart. The therapist asked Ray to fill out the PHQ-9. He then totaled the score, discussed Ray’s symptoms, gave him the diagnosis of major depression, and noted that this appeared to be the first episode Ray had ever had. The clinician requested that Ray give an average subjective mood rating for the prior week. She also asked Ray to arrive 10 minutes early to future weekly appointments in order to complete the PHQ-9. She advised that each week Ray would also be asked to rate his mood. The therapist provided further information about depression and its treatment including its impact on ability to function. She then encouraged Ray to try to temporarily reduce some of his household responsibilities (“giving the sick role”) until his depression improved. Ray was uncomfortable with this, and reluctant to ask his wife to help since she was now working part-time.

Therapist: Ray, you mentioned that you’ve really had to push yourself to get things done at home, and even with that everything doesn’t get done. And then you criticize yourself for being lazy. Did I get that right?

Ray: Why wouldn’t you think I’m lazy? I don’t work anymore.

Therapist: I disagree. You are doing a lot at home even though it doesn’t meet your expectations. When you were in the hospital after your stroke, did you or others expect you’d bounce right back and go to work?

Ray: No, I was sick. I was in the hospital, went to rehab, and then went back to work – but I had to retire.

Therapist: Having depression is an illness too that affects your ability to get things done. In fact, I’m impressed that you’ve done as much as you have given the fact that you’re as depressed as you are. Remember, you have what we call a major depression. This is a serious condition that makes it hard to function. I’d like you to give yourself permission to recuperate from the depression before you expect yourself to be running on all cylinders. Does that make sense?

Ray: But who is going to do get all the housework and shopping done? Marge is working now and my kids are busy. I can’t ask for help.

Therapist: Is there any one job that you find especially stressful for you?

Ray: That’s an easy one. I hate grocery shopping. I never did this before. I don’t even know the difference between a lettuce and a cabbage. Marge likes yogurt and I can’t figure out which one to buy – what’s Greek yogurt anyway?

Therapist: So this is stressful for you.

Ray: Don’t tell me to ask Marge to do that.

Therapist: I won’t tell you what to do, but you did read my mind. What I would like you to do is think about this, because it would take some stress away from you if you got some help with grocery shopping.

The session continued in this fashion until the end.

Session 2: After reviewing the PHQ-9 and conducting the mood rating, the therapist noted that Ray’s depression had improved. She asked what had happened that week that may have contributed to his mood improvement. Ray said he told Marge that “the therapist said” that she should do the grocery shopping. Much to Ray’s surprise, Marge said she would be happy to since she passed the market on the way home from work. Ray said that Marge was probably happy to do the shopping since he often came home with the wrong items. The therapist did clarify with Ray, however, that she did not ask Ray to tell Marge to do the shopping, but is glad that things worked out. The therapist made the link between the improvement in Ray’s depression and a reduction in the stress tied to grocery shopping. She also wondered whether getting support from Marge contributed to his improved mood. The therapist began the Interpersonal Inventory in session 2 and completed it in the middle of session 3. The Inventory revealed that Ray had a long history of satisfying relationships with family, friends, and co-workers. Results of the Inventory reaffirmed the therapist’s hypothesis that the major contributing factors to Ray’s depression were his transition from bread winner to the role of homemaker, and the associated financial stresses.

Session 3: The therapist completed the Interpersonal Inventory and provided Ray with the Interpersonal Formulation. Since there was time, she also began the work involved in the Intermediate Sessions.

Therapist: Ray, we’ve spent the last two-and-a-half sessions talking about your depression and possible triggers for it. Let me tell you what I think. First of all, it’s clear that you have a major depression. Your symptoms are (list symptoms). This is the first major depression that you’ve had. It seems to have started shortly after you retired from work. Even though it was a relief not to have to deal with the stress of work, it was hard making the transition to having primary responsibilities for care of the home. Your depression has made completing those responsibilities harder. Further, you have much less money coming in than when you worked, and you haven’t been able to make mortgage payments on time. Does that make sense?

Ray: You got it.

Therapist: And finally, you haven’t resumed your sexual relationship with your wife, because she’s afraid that having sex might lead to another stroke.

Ray: Well, with how frustrated I am now, I’d take that chance!

Therapist: So over the course of the next 11 sessions we’ll focus on helping you to get a better handle on your financial concerns, your new role in the household, and finding a more satisfactory arrangement with your wife regarding sex. We have 20 minutes left to the session, so which of these would you like to start talking about now?

Ray: Money.

Therapeutic Tip: Moving from the initial to the intermediate sessions

Sometimes the work of the Initial Sessions is completed before the end of Session 3. Some therapists are unsure about how to move into the work of the Intermediate Sessions. The best approach is simply to tell the Veteran that you’ll begin to talk about one of the problems you’ve identified in the formulation. If more than one problem area is identified, it is best to ask the Veteran which one he would like to talk about first.

The Intermediate Sessions

Sessions 4 - 7: During these sessions, Ray wanted to focus on financial issues that he identified as a substantive contributor to his depression. He and Marge were two months behind in their mortgage payments and he feared they would get an eviction notice. He wasn’t sure what to do. Over the course of these sessions, the therapist engaged Ray in a Decision Analysis and Work-at-Home to identify possible options. Throughout this work the therapist made connections between Ray’s financial concerns and his depression.

Session 6:

- Therapist: Let's continue talking about your financial problems.
- Ray: OK. We're two months late on our mortgage payments. I'm afraid we're going to lose our home. I'm thinking about that all the time.
- Therapist: Ray, that sounds stressful.
- Ray: My wife Marge is back to work and she's thinking about going full time. I feel badly about that. I'm at home. I'm not making any money. These things have been bugging me all week. I just don't know what to do.
- Therapist: Let me stop you there. I hear that this is really difficult and it's affecting your mood. You don't like the way that things are going at home and that your wife is considering working full time. You're not sure what to do about it. Have you ever heard of the term "brainstorming"?
- Ray: Sure...
- Therapist: As you may know, brainstorming is considering the options that you have to deal with a problem. You might recall that I talked with you earlier about how important it is to think of options to deal with life problems in a way that combats depression. I think what would be helpful for us right now is for you to brainstorm about all sorts of possibilities around dealing with your financial problems. We'll go through each one and you'll decide whether or not it's a good choice. That is, we'll look at the advantages and disadvantages of each possible option. How does that sound?
- Ray: OK, let's do it.
- Therapist: OK. So now let's brainstorm about the possibilities around your financial problems.
- Ray: I could just go back to work.
- Therapist: Would that mean going back to your old job?
- Ray: No, I could never go back to that job. It's way too stressful. I was on call for any emergencies in the building. But I guess I could go back to some other place full time.
- Therapist: So that's one possibility.
- Ray: I don't know if I could actually get a job.
- Therapist: OK. But before we go into the details of that, let's just keep coming up with ideas. So, one idea is working full-time, but not at the old job. How about some other possibilities around work?

Notice that the therapist is keeping the Veteran focused on idea generating before jumping into a decision.

- Ray: I guess I could get some part-time job to bring in some money.
- Therapist: So, rather than the pressure of a full-time job, a part-time job? Any other possibilities?
- Ray: In some ways, I don't even want to go back to work again. Maybe I don't go back to work and just leave things the way they are. But then how am I going to pay that mortgage?
- Therapist: So, there are really three options that you see. One, go back full-time, but not at the old job. The second is part-time work. And the third is leave things the way they are and not work. So let's look at the advantage and disadvantages of each of those. First, let's take a look at the advantages of working full-time.

Ray: If I worked full-time I could get enough money, along with what my wife is making, to pay that darn mortgage each month.

Therapist: And that would then relieve some financial pressure. Any other advantages of working full-time?

Ray: It would get me out of the house. Frankly I'm bored at home.

Therapist: Yes, you've talked about this now for a couple weeks. You feel like all you do is what you call "housewife stuff." As you said, you're bored. If you work full-time you'd be back in the workplace, which even though stressful, you still enjoyed. Any other advantages to full-time work?

Ray: I think that's it.

Therapist: Let's look at the disadvantages of full-time work.

Ray: The last job I had was very stressful and I had a stroke during that time. I don't want to have another stroke. I'm nervous about that. My doctor wants me to watch my stress.

Therapist: Yes, the downside of working full-time – as you see it – is feeling too stressed. And I know that your doctor is worried about that too. Any other downsides to working full-time?

Ray: No, I guess not.

Therapist: One thought that comes to mind for me, is that you like going to the coffee shop to see your friends. That's something you didn't do when you were working full-time. What you like about being home is that you have time to go to the coffee shop and see friends.

Note that the therapist offered a "con" of working full-time that Ray had not considered.

Ray: You're right I do like that. I don't like being at home all the time, but I do like the fact that I can see my friends.

Therapist: So that's a disadvantage of a full-time job. Let's take a look at the advantages of part-time work.

Ray: I wouldn't have all the pressure of work. I actually like having some free time, but I don't like being at home all the time.

Therapist: So that combination of working and some free time could be enjoyable.

Ray: And there would be some money coming in. I don't know if it's enough to pay the whole mortgage each month, but it's better than nothing.

Therapist: I think that after we finish this, one thing we need to talk about is how much money you need to have coming in. That might affect whether or not you need to work full-time.

Notice how the therapist kept the flow focused on the Decision Analysis, but she told the Veteran that they would talk about his finances at another point.

Ray: Marge and I were thinking about talking to a financial person. We've never been good with money.

Therapist: I don't want to get side tracked with that now. But I'm going to make a note of that. I'm not going to talk about that today but in another session. We still have time. Any more advantages of working part-time?

Ray: No, I just need some money.

Therapist: It sounds like the downside of working part-time is the worry that you wouldn't have enough money. Any other disadvantages?

Ray: Can't think of any. Part-time sounds like it could help.

Therapist: Yes, part-time may be an option.

Ray: Well looking at my options, part-time work may help bring in money.

Therapist: Right. It makes sense based on what you said. It would also be less stressful, get you out of the house, and still give you some free time to do the things that you enjoy.

Ray: But how much of a part-time job would I need to cover the mortgage?

Therapist: How would you find that out?

Ray: I told you that we weren't any good with money. You know those places where you can pay to do your taxes? I have a friend who does that during the tax season.

Therapist: An accountant of some sort?

Ray: Maybe. He knows about money.

Therapist: Have you ever talked with him about money?

Ray: I was always sort of embarrassed, since I was so bad with money. But maybe I could talk with him to see if he had some ideas about how much money I'd need to cover that mortgage.

Therapist: That sounds like a good plan. I understand this is kind of complex. What I'm hearing – and tell me if you agree with this – one part of this decision is that you are thinking that the best thing for you would be part-time work. What is complicated about it is that you don't know if you'd make enough money. And, of course, there's the whole issue of talking with Marge about this, but you've laid the ground-work for that.

Ray: Yeah, we talked a little.

Therapist: Good that's a start. It seems like there are three steps here. Talk with Marge to see if she's on board. Figure out what kind of part-time job, how much you might make, and if that's enough money to cover expenses – with both you and Marge working. That may be way too much to do in a week.

The therapist helped the Veteran break down the task into manageable segments.

Ray: I can talk with Marge and I can look in the paper to see if there are any part-time jobs.

Therapist: That sounds reasonable to me. Do you think you could do that this week?

Ray: I could do that. Talk with Marge and just look at the paper.

Therapist: So this is what I'd like to suggest. Go home and try to find a time to talk with Marge, and look in the paper or search on-line for part-time jobs. Then come back next week and let's talk about how that went.

Ray: OK.

Therapist: Now, I just want to say, sometimes people feel absolutely positive that they are going to go through with a plan but something gets in the way. Either it isn't the right time or it doesn't feel OK. If that happens to you, it's no problem.

So, whether you go home and talk with Marge and look in the paper or not, I want you to come back and talk about what happened. If you weren't able to do it, we'll talk about why you weren't able to do it. If you did talk with Marge, and did look in the paper, we'll talk about how that went. Does that make sense?

Ray: Yeah, makes sense. I think I can do this.

Therapist: Good.

Sessions 8 - 14: Ray made progress in sorting out his financial difficulties. The focus of treatment through the latter half of the Intermediate Sessions shifted to another aspect of Ray's transition – the absence of a sexual relationship with his wife. Over these sessions, the therapist utilized a sequence of IPT techniques to help Ray address his concern. First, she helped Ray clarify what he wanted, which was to resume his sexual relationship with his wife. A Decision Analysis aided in identifying possible options to move in that direction. Ray decided that he wanted to engage his wife in a conversation about this but wasn't sure what to say. The therapist used a combination of Interpersonal Skills Building and Role Plays to prepare Ray for the conversation. The culmination of this was Ray's Work-at-Home – the conversation with his wife. The therapist used a Communication Analysis to assess how the conversation went. Ray felt that he clearly communicated his concerns and more fully appreciated his wife's worries. They mutually agreed to meet with his neurologist to discuss potential dangers of resuming their sexual relationship. The neurologist did not have medical concerns about Ray reengaging in sexual activity. They resumed their sex life despite some ongoing concern by his wife.

Termination

Therapeutic Tip: Therapist preparation for termination sessions

Prior to starting Termination, it is very helpful to prepare two lists. The first would be the skills the Veteran acquired during treatment that helped him to improve or resolve the identified problem area(s). The second is a list of possible future triggers for depression. These lists would be used if the Veteran is unable to identify learned skills and future triggers.

Session 15: Session 15 began the task of Termination. The therapist showed Ray a graph of his completed PHQ-9 and mood ratings over the course of treatment that illustrated considerable improvement. The therapist discussed with him that he no longer met criteria for major depression, and evidenced very few depression-related symptoms. Following this, the therapist engaged Ray in a discussion of the transition issues that originally brought him into treatment. Although Ray obtained a part-time job, he and Marge continued to have financial difficulties. They began to consider the possibility of selling their home and buying a less expensive apartment. Since both Ray and Marge were working, they redistributed household responsibilities in a way that was less burdensome to Ray. Marge's concerns about perceived health risks of sex lessened as they reestablished their sexual union. From this review, the therapist encouraged Ray to discuss what skills he had built to achieve these successes. Finally, the therapist engaged Ray in a discussion of his feelings about ending psychotherapy.

Session 16: In this session, the therapist once again talked with Ray about his feelings about termination. She also asked Ray to think about future situations that might trigger another depression. When Ray couldn't come up with any, she suggested that he needed to be alert to the possible stresses associated with any future medical or financial problems. Ray concurred. She then asked Ray what skills he had learned during psychotherapy that could be used to deal with these possible future stressors.

Case Commentary

Changes in health, finances, and sexual engagement are common issues seen among older Veterans seeking mental health services. The therapist first helped Ray to understand the impact of his stroke, retirement, assumption of housekeeping responsibilities, and relationship change with his wife on his depression. Concurrently, she pointed out that the depression made it even more difficult for him to deal with these stresses, but encouraged him to be hopeful about the likely improvement. She quickly engaged him in a review of options to address pressing financial concerns, about which he made a number of successful efforts that were tied to reduction in symptoms. Renegotiation of household responsibilities, and a resumption of his sexual relationship with his wife, led to further symptom improvement. Even though Ray continued to contend with financial difficulties, his depression remitted.

Problem Area: Interpersonal Role Disputes – Case Vignette: Thomas

Case Summary

Thomas (“Tom”) is a 38-year-old Veteran. He was in the Army Reserve, served two tours in Iraq as a medic, and separated from the military two years ago. Tom’s wife is a successful accountant. Since Tom’s separation from the military, he has been the primary caretaker for their three children ages 5, 8, and 11 years. Initially, Tom enjoyed his role as a “stay-at-home dad” and the family functioned smoothly for about a year. Since then, however, Tom reported gradually escalating family tensions, especially with his wife. The tension became evident in frequent arguments and a decrease in their sexual activity. Tom said that most of the difficulties with his wife centered on disagreements over parenting. Tom wanted to “run a tight ship” and insisted that the children perform regimented chores and adhere to strict rules. He believed in enforcing swift and significant consequences when one of the children disobeyed. His wife preferred a more lenient approach to parenting. She felt that Tom expected everyone to be a part of his “platoon” and refused to compromise with her on his parenting style. During the past few years, Tom felt increasingly left out of family decisions by his wife and felt like a “stranger” in his family. The children sought permission to do things from their mother even if they had previously discussed the issue with their father. Tom had not talked about his family situation with any friends or relatives and seemed very reluctant to provide details at his mental health intake session. The primary care physician (PCP) noted that Tom appeared depressed and that he had significant symptoms of anhedonia and social withdrawal.

Initial Sessions

Session 1: During the first session the therapist reviewed with Tom information from his intake including reported depression symptoms. The diagnosis of depression was shared and discussed, as was information about depression and IPT treatment. The therapist expressed hopefulness about the likelihood that Tom’s depression would improve with treatment. The impact of the depression on Tom’s ability to function was reviewed and he was encouraged to temporarily reduce some of his responsibilities until he was feeling better – what IPT calls “giving the sick role.” The therapist concluded the session with a brief introduction to IPT.

Therapist: Good afternoon, Tom. It’s good to meet you. I’d like to start today by finding out about what brings you here.

Tom: I’m here because I don’t know what to do. Things in my marriage suck. Sometimes I think I should just leave, but I love my kids. And I’m not sure my wife would let me take them even though I take care of them most of the time. Sometimes she tells me I should just leave. We just don’t get along.

Therapist: How long has this been going on?

At this point, the therapist was mindful of the need to get specific details about what brought Tom for treatment. These details helped the therapist to get an initial impression about the connection between interpersonally relevant recent events and Tom’s depression.

Tom: It started when I got back from Iraq. Before that we both worked. But once I got back we decided that it would make sense for me to stay at home with the girls.

Therapist: How many girls do you have?

Tom: Three. It would have cost too much to get a sitter or put them in day care and I liked the idea. My wife got a new job while I was in Iraq. She became head of her accounting department. She was making good money. I was having trouble getting a job. While I was away she was mom *and* dad. She made the money and took care of the house and the kids. When I got back, I wondered if I was even needed. But they all seemed happy to see me.

Therapist: So things were good at first when you returned.

Tom: Yeah, mostly. But then after a while, Jessica and I began to argue.

Therapist: After about how long?

Tom: Oh, I'd say about a year.

Therapist: Tell me, what did you argue about? Do you remember particular arguments from that time?

Tom: Just little things. The girls, especially my older daughter, would leave her clothes on the floor in her room. When I'd tell her to pick them up, she wouldn't do it right away. So I'd punish her. I wouldn't let her go to her friend's house after school. I like a neat house and if you can't keep the house in order, who knows what else will go wrong. Jessica is very messy. So she doesn't make the girls clean up after themselves. When I would tell her that the house should be "ship shape," she tells me we're not in the Army and that I should chill out. Things are really bad now.

Therapist: Has anything happened recently that made things worse?

The therapist asked this question to see if there had been any recent change in Tom's life that might be contributing to making the problems worse at home.

Tom: Well, I don't know. I'll have to think about that. Not really. It's just getting worse. We just argue and she takes the girls' side. She disrespects me.

Therapist: Give me a recent example. Perhaps something from this week or last week.

The therapist continued to get details until satisfied there was enough information about what was happening in Tom's current life at home. Next the therapist reviewed the Veteran's depression symptoms using the PHQ-9. Tom had filled this out prior to coming into the office

Therapist: Tom, I see from the depression questionnaire you filled out that you want to sleep much more than usual; that you feel irritable a lot more now; that you feel pretty hopeless; that you have gained weight; that you're not interested in having sex; and sometimes you feel that it isn't worth going on. On this scale that measures depression symptoms, you have a score of 27. That means that you have moderate depression. No wonder you've been feeling bad. I'd also like to ask you to rate your mood on a scale from 1 to 10. One is the best you've ever felt, and 10 is the most depressed. What number would you give your mood this week?

Tom: I'd say a 7. I feel pretty low.

Therapist: We'll keep tracking your mood every week. Let's work together to decrease your depression.

Note that the therapist gave the Veteran a diagnosis of depression and also a number associated with its severity. This information is often very helpful and, in fact, most people are used to getting basic diagnostic information from health care providers for physical health problems. Next the therapist made an effort to instill hope about the outcome of treatment for depression, provided psychoeducation about the depression, and introduced the notion of the sick role.

The session continued...

Therapist: Depression is common. Do you know how many Veterans have depression?

Tom: No, I don't. But I've read that some Veterans are depressed and I have some buddies who are depressed.

Therapist: About 14% of Veterans have depression. That means that if we had 100 Veterans in this room, 14 of them would be feeling just like you feel. As I said, that's the bad news. The good news is that depression is treatable. People get better from depression. There are lots of treatments. There is medication and there are talk therapies. Here at VA, therapists are trained in several types of talk therapies that work to help people feel better. One therapy is called Interpersonal Psychotherapy or IPT. It was developed in the 1970's to treat people who have depression. As you recall, it's been studied a lot. It works. Most people feel at least somewhat better by the end of treatment. I see that you aren't taking medication for depression. Why is that?

Tom: I don't want to. I already take too many pills.

Therapist: Well, with IPT you may not need to take antidepressants. This is a therapy that can work with or without medication. However, I can't guarantee that this therapy will work, but I am hopeful. The reason I am hopeful is because there seem to be problems in your life that are tied to your depression for which I think IPT would be a good fit. This therapy is based on the idea that there is a connection between what's going on in your life and your depression. Would you like to try it?

Tom: What do I have to lose?

Therapist: I hope you have something to gain. Sometimes we notice that people with depression have trouble doing the things that they used to do. Have you noticed that?

Tom: I'm not doing what I should at home. I was always on top of the chores at the house. I knew where all the girls needed to be after school and I kept a tight budget. Now I'm not even balancing our checkbook and last week I forgot to pick up one of my daughters from soccer. My wife wants to go out to dinner, but I don't have the energy. I think I would probably feel better if I went out with her and it would probably help us, but I just can't.

Therapist: Tom, that's normal for people who have depression. Depression is a medical illness. Often people have trouble doing what they used to do. This is temporary and when you're feeling better you should be able to get back to your old self. In the meantime it is important that you cut yourself a break. Can you put off doing some of the things that you normally do? Could you explain to Jessica that because of how you are feeling, you don't have much energy for going out with her right now? And finally, is there anyone who can help you right now to manage all your responsibilities?

Tom: I don't know. Jessica says she already does too much. I think I just have to suck it up.

Therapist: Giving yourself a break right now might make you feel a little better. Imagine if you had a broken arm. No one would expect you to do everything until your arm healed, right? If you hadn't been in the military, I might be saying to you that it might be temporarily OK that you don't do some of things that you are responsible for until you're less depressed. But I've learned that this suggestion doesn't sit well with a lot of Veterans. Many Veterans are accustomed to taking on responsibilities and completing them no matter what. But I'd like to suggest that you go a little easier on yourself for a while. When your depression begins to lift I expect you'll get back to doing all the things that you've done. But right now, this may not be possible. So if you can lessen your expectations just a little bit I'd recommend that. Any reaction?

At this point the therapist provided some basic information about IPT. While the therapist took a strong position about the importance that Tom ease up on some responsibilities, the therapist did not insist. It was the Veteran's decision. At the end of the Initial Sessions, more details about treatment were provided about the structure of IPT.

Therapist: Now let me explain a little about how IPT works. We'll meet once a week for 16 sessions. It's really important that you come every week. I know that can be difficult, but people who come regularly usually do better. We'll spend the next couple of weeks trying to figure out exactly what some of the triggers are to your depression. It sounds like you have a pretty good idea, but I just want to make sure that we cover all the bases. How does that sound?

Tom: OK, I guess.

Session 2: In this session, the therapist reviewed the PHQ-9, asked Tom to rate his average mood in the last week, completed getting relevant history, and began the Interpersonal Inventory.

Therapeutic Tip: Making the link between mood and events

Except for Session 1, every IPT session begins the same way. There is a review of the PHQ-9 (that, if possible the Veteran completed just prior to beginning the session) and the mood rating. Based on the PHQ-9 and mood rating the therapist will ask the patient to discuss what happened during the last week that affected the scores. The therapist's task at the beginning of the session is to make the link between what has happened during the week with how the Veteran feels; or to make the link between how the Veteran feels and what happened during the week. For some Veterans this will seem obvious but others may have never made the connection. This is the beginning of an essential part of IPT when the therapist helps the Veteran to make the bi-directional connection between life events and mood.

Therapist: Hello, Tom. It's good to see you. Thanks for completing the PHQ. Let's see if there has been any change in your symptoms since last week. It looks like your score on the PHQ is exactly the same – 13. That's not surprising since we just started our work. I also want to check on your mood. On a scale from 1 to 10, where would you rate your mood, remembering that 10 the most depressed?

Tom: I'd say 7.

Therapist: How have you been since we last met?

Tom: How do you think I've been? We had another fight. We hardly talk. All she does is criticize me.

Therapist: It sounds like you had a tough week. How did it affect your mood?

Tom: Worse, much worse.

The therapist was interested in learning more about what happened during the week that made Tom's week "worse, much worse." However, unlike Intermediate Sessions in which the therapist would closely focus on what made Tom feel worse, other tasks needed to be completed in the Initial Sessions, notably the Interpersonal Inventory. Therefore, the discussion between the last week's events and mood was abbreviated.

Therapist: Tom, first I'd like to hear a little about what happened this week that made you feel so much worse. After briefly talking about what happened this week, we will begin what we call the Interpersonal Inventory. The Interpersonal Inventory is a way to find out about the important people in your life. It will help me understand the people in your life and how they affect the way you feel.

The therapist heard about Tom's week. After about 10 minutes the therapist began the Interpersonal Inventory.

Therapeutic Tip: Making the transition to the interpersonal inventory

In the Initial Sessions, the most elegant transition from discussion of the past week's events to starting the Interpersonal Inventory is to find a segue from what happened during the week with a specific person to finding out about the relationship. If that isn't possible, at some point the Veteran will need redirecting to specific tasks must be done in Session 2. Remember, the purpose of the Interpersonal Inventory is to get a breadth of information about the important people in the Veteran's life rather than depth. The therapist is not doing treatment at this point but rather gathering information.

Therapist: Tom, I know that what happened this week with your wife made you feel terrible. But now I need to switch our focus. In IPT during Sessions 2 and 3, we spend a good bit of time talking about the important people in your life. I'm interested in knowing about the people who are important to you including those who are alive and those who have died... as well as those with whom you may have a good or bad relationship. Who would you like to start with?

Tom: I guess my wife, Jessica. What do you want to know?

Therapist: Tell me about your relationship with her.

Tom: I already told you that it's bad. We don't get along. We fight all the time. She thinks I am too strict. She always criticizes me.

At this point, the therapist had questions in mind that would discern if Tom's wife was a possible trigger for his depression. If that were the case, then additional follow-up questions would be necessary to understand what specific issues with his wife contributed to his depression. If she weren't a trigger for his depression, the therapist wanted to see if his wife might be a potential support for him in getting better.

Therapist: Give me a recent example if you can.

Tom: That's not hard. On Tuesday I told Brittany, our oldest daughter, that she couldn't sleep over at her friend's house on Friday night because she hadn't put all the laundry away. That's one of her chores. I think that a girl at that age should do chores. These days, kids aren't expected to do that much. Doing chores prepares you for life...

Therapist: Tom, due to our limited time in the session, I'm going to stop you here and just ask you to explain what happened with your wife.

During the Interpersonal Inventory, the therapist needs to be aware of time, so that he may need to cut short what the Veteran is saying. Notice that the therapist gave an explanation as to why he redirected the Veteran. The therapist will go into detail with problems that the Veteran is having with his daughter, if and when the daughter becomes the focus of treatment.

Tom: Oh, right. Well, Brittany called her mother after I punished her. She cried and tugged at her heart-strings. So, when Jessica got home, she told me that I ran the house like I was still in the Army. I hate when she does that.

Therapist: Does this type of thing happen a lot?

Tom: Yeah.

Therapist: How long has this gone on? You said that things used to be good.

Tom: About the last year.

Therapist: And you said it happens all the time now. How often do you and your wife really get into this sort of argument?

Tom: Several times a week.

Therapist: Do you notice that these arguments affect your mood?

Tom: Now that you mention it, I usually feel worse.

Therapist: Would you say that most of your arguments are about the way you discipline?

Tom: That and the way I like to keep the house. My wife just doesn't think that matters. And she's so busy at work she doesn't even pay much attention to the kids and the house. She says that they did just fine while I was in Iraq, and that nobody worried so much about being perfect. She makes me feel awful when she says that.

Therapist: I hear that. And you even connect these arguments to your mood being worse. I'm interested in knowing how things were different when you first got back. You said that the first year was better. Tell me about that first year.

The therapist asked Tom to talk about another time in his marriage when things were better between his wife and himself. After this, the therapist concluded that adequate information had been gathered about Tom's relationship with his wife and the possible connection to his depression. It was time to move on to the next person.

Therapist: Tom, I think I know enough now about some of the problems that you've been having with your wife. If we decide that your relationship with her is what we'll focus on in therapy, we'll spend much more time talking about you and her. Is there anything else you'd like me to know about your relationship with your wife before we move on to talk about the next important person?

Tom: I don't think so.

Therapist: So now I'd like to hear about some of the other important people in your life. Who is next?

Tom: Well, my girls. I love them so much. I spend a lot of time taking care of them.

Therapeutic Tip: Disentangling discussion of multiple persons at once in interpersonal inventory

It is common when conducting the Interpersonal Inventory that Veterans begin to discuss several people in conjunction with each other. It's the therapist's job to get the Veteran to talk individually about each person while being mindful of the connections among persons. If the Veteran combines one or more persons in a discussion, ask the Veteran to talk about each person individually. Also remember, when doing the Interpersonal Inventory, be sure to ask questions that will help you to determine if each important person in the Veteran's life is associated with a dispute, a transition, or a death.

Therapist: First, tell me about your relationship with your oldest daughter. Her name's Brittany, right?

Tom: Brittany can be a handful but I love her. She reminds me of her mother. She's head strong. We get into it these days. I guess this is what happens as kids get older. I can't seem to get her to obey.

Therapist: Give me some examples.

There was not enough time in the second session to finish the Interpersonal Inventory. However, at this point the therapist knew that the relationship between Tom and his wife was quite strained and that Tom connected his depression to problems he was having with her. He and his wife were actively arguing over their differences about how they wanted to raise their children. The therapist noted that when their children didn't like Tom's parenting style, they went to their mother for help. This dynamic is driving a wedge between the couple. In the next session the therapist continued the Interpersonal Inventory to find out about other important people in Tom's life.

Session 3: In this session, the therapist completed the Interpersonal Inventory with Tom, provided the Interpersonal Formulation, described the treatment contract, and obtained Tom's assent to proceed with IPT.

Therapist: Hi, Tom. How have you been since we last met?

Tom: Maybe a little better. What you said last week made sense to me.

- Therapist: What do you mean?
- Tom: You made me think about the problems that I'm having with Jessica. It looks like all our arguing is making me depressed. What can I do?
- Therapist: Before we figure out what you can do, I want to spend today seeing if there may be other factors that are affecting your mood. And before we do that, let me quickly check on your depression symptoms and your mood.
- Therapist: I see that your depression symptoms have decreased a bit this week. Your sleep is better and you noted that you are concentrating a little better. That's good to hear. Why do you think that is?
- Tom: Jessica and I had a better week. She didn't yell at me. I told her that you said I'm depressed because of her.
- Therapist: Well, I didn't say that. I noted that your depression symptoms increase when you fight with Jessica. But by the end of today I think I'll be able to talk with you about what seems to be triggering your depression. Before I do that I'd like to continue finding out about the important people in your life. Last week you talked about Jessica and Brittany. I'd like to hear this week about other important people including your two daughters, and other important family members and/or friends.

Tom talked about the other important people in his life. From the information that the therapist gathered, Tom was having similar problems with all of his children. As in his relationship with Brittany, the other children bristle under his strict parenting style. They too seek out their mother to intervene when punished by their father. The therapist also learned, since returning from his last tour of duty, Tom has been fairly isolated. He doesn't socialize much with friends and only sees other family members about twice a year. At this point the therapist provided the Interpersonal Formulation, discussed treatment goals, and a contract for treatment.

Therapeutic Tip: Creating the interpersonal formulation

A key task is to identify one, or possibly two, problem areas that will be the focus of treatment. Identification of the IPT problem area is guided by the interpersonal problem that developed before or after the onset of depression, and the interpersonal issues that most concern the Veteran. Identification of the IPT problem area(s) is central to the Interpersonal Formulation. At the end of the Initial Sessions, provide an Interpersonal Formulation to the Veteran. The formulation is a brief statement of the Veteran's depression, likely causes and consequences, and goals for IPT treatment.

- Therapist: Tom, now that you've finished telling me about your life and talking about the important people in your life, I think I have an understanding of what's been going on with you. First of all, you have depression. Your symptoms are sadness and irritability, sleep problems and fatigue, feeling hopeless, guilty, and disappointed. You're also less interested in sex and are having difficulties getting your routine done. And, sometimes you feel like life is not worth living. Your depression began about a year after you returned from active duty. As you describe, before then, you enjoyed being a "stay-at-home dad." But since then, you and your wife have been arguing over how you discipline the kids and how you keep the house. Do you agree with that?
- Tom: Yes I do. I don't know why things went bad.
- Therapist: That's what we're going to find out during the remainder of our time together. We'll take a look at the dispute that you and your wife are having and see what changes you can make to improve your relationship. You said that you and your wife love each other and that you want to work things out. You are still talking and you want to make things work, but you need some new ways of communicating. We'll work together to find options. As things improve in your relationship with your wife, I suspect that things will improve with you kids as well as your depression. Would you like to do that?
- Tom: Sure. But I don't know what we can do. I like things one way and she likes them another.

Therapist: So we'll work together every week for the next 13 weeks to help you improve things with your wife and improve your mood. We'll look to see if you and your wife can find common ground. It's important that you come on-time every week. If you have concerns about how things are going in therapy or with me, I would like you to tell me. Is that OK?

Tom: OK. You got a deal. I just don't want to argue so much.

Therapist: Yeah, we're going to work on that.

The Intermediate Sessions

Session 4: As is always done at the beginning of each session, the therapist reviewed Tom's PHQ-9, obtained the weekly mood rating, asked how the week had been, and noted the connection between mood and events from the past week. During this and other Intermediate Sessions, the therapist helped Tom focus on the problem that was contributing to his depression – that is, the dispute with his wife and associated conflict with his children. The therapist asked Tom to describe a recent dispute with his wife. Next the therapist helped him analyze what happened (i.e., Communication Analysis), looked at possible options to change the interaction (i.e., Decision Analysis), and practiced how he might proceed (i.e. Role Play with some Interpersonal Skills Building). Many of these techniques are familiar to therapists although they may have specific meaning in IPT. This process took several sessions to complete.

Therapeutic Tip: Conducting a communication analysis

To facilitate the process, ask questions such as:

What did you say?

How did he respond?

How did it make you feel?

How do you think your words made the other person feel?

Is that the message you wanted to send?

How could you have said it differently?

What do you think he meant?

Therapist: You said that you and your wife fought this week. I'd like to hear exactly what happened as if there were a videotape of what happened and you are replaying it in the office. When was your fight?

Tom: Monday. I fixed dinner for the girls but Jessica wasn't there because she had to work late again. So she missed dinner. When dinner was done, I told my oldest girl Brittany to clean up the dishes. She argued with me and said that it wasn't her turn. She used to obey me when she was young, but she got into bad habits when I was in Iraq. I told them to get out of the kitchen and do their homework.

Therapist: Is that all that happened?

Tom: My youngest said that she'd do the dishes but I just told them to all get out of the kitchen.

Therapist: So you didn't take up your youngest daughter's offer to do the dishes?

Tom: No, I just had it at that point.

Therapist: What happened then?

Tom: Jessica came home and we got into an argument.

Therapist: What did you say to Jessica?

The therapist knew that it was very important to get details at this point. It was the beginning of a Communication Analysis.

Tom: I told her that I was sick of her coming home late for dinner every night and sick and tired of all the attitude that the girls gave me.

Therapist: What words did she say?

Tom: “Well, that’s some welcome home. Do you know what I had to deal with today at work?” That really made me pissed.

Therapist: You felt pissed. How do you think your wife felt when you said this to her as she walked in the door?

Tom: I get it. You’re on her side.

Therapist: No, not at all. I just want to help you look at how your words and timing affect your wife. These will ultimately help you better communicate. So then, what did you say then and what tone of voice did you use?

Tom: I said I didn’t care about what she was feeling like. I cooked, took care of the girls, went to soccer practice, and all she did was go to work and come home and criticize me. Then you know, she said the usual, blah, blah, blah.

Therapist: I don’t know what you mean by blah, blah, blah.

This discussion continued until the therapist got details of what was said by Tom, and by his wife, and the tone with which it was said. Tom also described what happened after the incident. The fight expanded when Brittany went to her mother and complained about Tom, and said he wouldn’t even allow their youngest daughter to clean up the dishes even when she volunteered.

Therapist: How was your mood prior to your argument with your wife?

Tom: I had had it with all of them.

Therapist: And how did you feel after all of this was over?

Tom: It didn’t bother me. She always says that.

Therapist: Really? It didn’t bother you?

Tom: It’s not new.

Therapist: Not new, maybe, but that doesn’t mean that it didn’t bother you. I’m concerned that these conversations are contributing to your depression. We really need to put our heads together to find a way for you and your wife to work out your differences. Next week we’ll look at options to do that.

The therapist was beginning to make the connection between what happened between Tom and his wife and Tom’s mood. The therapist did this repeatedly during the Intermediate Sessions.

Session 5: During this session, the therapist and Tom reviewed options to better deal with ongoing conflict with his wife over parenting styles. Tom considered a variety of options and their pros and cons. The following is a segment from Session 5.

Tom: I’m here again but not much has improved at home.

Therapist: Well, I’m glad you’re here. You’ve told me over the last several weeks how difficult it is having these fights with your wife and how they affect your mood. You get angry and then afterwards you feel more depressed. You feel strongly that you want your kids to take care of certain things in the house. At the same time, you’d like to try to

stop these fights with your wife. Today, I'd like us to put our heads together to think about some options to deal with this situation.

Tom: Well, I can tell you right now that nothing is going to work. I've tried everything.

Therapist: Given the fact that you're still depressed you feel that nothing will work. People with depression often feel the way you do. And I know you've tried to make things better at home. But would you be willing to give it one more try?

Tom: Why not?

Therapist: At this point, let's just try to think about some possibilities. You don't have to commit to anything right now. We just want to get some ideas on the table. What's the first possibility of what you could do to make it less likely that you and your wife fight?

Tom: I know what would make Jessica happy. Just shut up and go along with what she says. Let the house get messy; let the girls do whatever they want to do. She'd be fine with that. That's what she would want. Yeah, that would be the one thing that she would want for sure.

Therapist: Is that something that you would want?

Tom: Are you kidding? I'd be dead before I'd go along with that.

Therapist: So what about another option?

Tom: Well one thing is that I could stop being Mr. Mom. I could get out of the house and go get a job, and then she'd be faced with having to figure out how to do some of the stuff on her own. That's another possibility.

Therapist: So let's come up with one more possibility.

Tom: I can't really think of anything. If you have anything in mind I'm all ears.

At this point the therapist tried to get the Veteran to come up with other options. If Tom is stuck, the therapist may make a suggestion. However, it's important that the therapist doesn't become the one making all the suggestions.

Therapist: You know, I'm mainly interested in what you have in mind. Do you want to give this a little more thought?

Tom: Well, it would help if when Jessica came home she didn't just tell me everything that I did wrong.

Therapist: That's what you'd like her to do. What about for yourself? What could you do to make things different?

Tom: I guess if I didn't get so angry when she said something. I don't really know how to handle it differently. I wish that we could just not fight when she came home and just have dinner together. Maybe we could talk about things later. Everybody can get so tense when she comes home.

Therapist: Would that be something you'd like to think about as an option?

Tom: Well, yes, because I don't like that we fight so much. We didn't used to fight so much.

Therapist: So let's do the pros and cons of each of these options: Just going along with what you wife wants and not saying anything. The second is getting a job. And the third is to hold off when you're upset with Jessica and discuss it with her later. So let's start with the first option.

Tom: The pro to that is that we wouldn't argue – but I couldn't do that.

Therapist: So it sounds like the first option you mentioned – going along with what your wife wants and not saying anything – isn't something you could really do? So let's go to the second option, getting a job.

Tom: I'd get out of the house, not be so involved with taking care of the girls, and not be so bothered by what they do.

Therapist: Any more pros to that?

Tom: There would be more money coming into the house.

Therapist: Anything else? No. How about cons?

Tom: Well, I sort of hate to say this out loud, but I like being a stay-at-home dad. I like being around the girls when they behave.

Therapist: Are there any other cons?

Tom: Well even though I'd be bringing in more money, we'd have to pay for someone to watch the kids.

Therapist: So there are upsides and downsides to the second option. Let's look at the third option, to wait until after dinner to discuss your concerns with Jessica.

Tom: One advantage would be that we might be less likely to get into a fight before dinner. But I'd have to hold in what I wanted to say to her. But I don't know how to do that. I always feel like I'm going to explode.

Therapist: I wouldn't necessarily expect that you would know how to do that. Maybe that's something we could think about together. But what I'd like to do now is to help you make a decision about an approach that that will help to reduce arguments with your wife. Of all the options that you thought of, is there one that you would like to try?

Tom: I think I could try to wait to talk with her. I can imagine that it would be hard to be yelled at as soon you walked in the door. Let her get settled. Maybe I could step outside for a little bit.

Therapist: OK. So that's a plan. So if you're upset with something while Jessica is at work, you'll wait to talk with her until she gets settled. Maybe even after dinner. If you need, you can step outside to relax a bit. How does that sound?

Tom: Yeah, I'll try it.

Therapist: Let's spend a little time in the office practicing doing that.

Session 6: In this session, Tom reviewed his efforts to try not to discuss issues of conflict with his wife when she first arrives home. The therapist also engaged Tom in a role play to improve communication with his wife. The following is a segment from this session.

Therapist: I'm interested in how things went this week. When we met last we were talking about different options to reduce how often you and your wife fight. One thing that you mentioned was that you would try to avoid blowing up at your wife, especially right when she gets home, and that you would try to wait until later to talk with her. Did you get a chance to try that this week?

Tom: Well, it went fifty-fifty. I held it together. I didn't yell at her when she came in. I did that much.

Therapist: And what was the part that you didn't do?

Tom: The "talk to her later part" that you told me to do. I just couldn't do that. I didn't know how to do it. So I just avoided it and just went to bed.

Therapist: I do remember from the last session, that you said that talking to her was the part you didn't know how to do. It makes sense to me that would be tough for you. And I had suggested that we can think together to practice having a conversation with your wife. So let's do that now.

Tom: Sure. Any tips you can give me would be appreciated. I don't know how to do it.

Therapist: First of all, I'd like to hear what message you'd like to get across to Jessica. Right now don't worry about how you'll say it or when you'll say it.

Tom: Like I said, I wish she would be tougher with the kids and not put herself in the middle of everything. If I've already disciplined them, I'd like her to respect my actions. That's what I'd like to make sure she understands.

Therapist: So, you would like her to not tell the children things different from what you asked them to do?

Tom: Yes. I feel like she takes away my authority and I don't like that at all.

Therapist: So you may be disciplining the children, or telling them to do certain things, and she'll say something that you believe undermines that.

Tom: That happens almost every day.

Therapist: That sounds like an important message to communicate to Jessica. You had some success in not blowing up at her but you didn't talk with her about what was bothering you. Let's work on that conversation now. But before we start that, let's think about the best time for you to have that conversation.

Tom: I know the time would not be at dinner. That just doesn't work.

Therapist: It seems like you've discovered that. So let's just focus on when would be some good times.

Tom: Sometimes we go out on Friday nights. We have somebody watch the kids. We go to the movies or to dinner. Maybe that could be a good time to try. But then again, I don't want to have a fight then because that's when we go out and have fun.

Therapist: So, what about the end of the evening?

Tom: That's makes sense.

Therapist: So how might you bring things up in a way that is less likely to lead to a fight?

Tom: I know I can't tell her she's wrong. That doesn't work. I've said that 100 times. I don't know. I guess I could tell her, I don't like it when I discipline the girls and you say to them, "it's ok, this one time." It's never this one time. And then the girls don't listen to or respect me.

Therapist: Do you think if you said it to her that way she'd be able to hear it?

Tom: I don't know.

Therapist: Let's pretend I'm your wife and you're saying that to me now.

Tom: I don't know – it's kind of funny doing this with you. But OK, I'll try it. "Jessica, you know I don't like it when you let the girls come to you and tell you that I..." No, let me start again, I didn't get that right. "Jessica, it makes me mad when you take the girls aside after I've disciplined them and you tell them that they don't have to listen to me."

Therapist: Now, is there anything else you want to say?

Tom: No, I'd want to hear what she has to say to that.

Therapist: Tom, if I were Jessica I'd say, "Well, I don't like the way you are with the girls and the way you speak to them."

Tom: "Yeah, but Jessica, I'm the one at home so I should be the one who makes the rules."

Therapist: "Tom, it's my home too and I have a right to make rules too."

Tom: "Yeah, but you're hardly ever home."

Therapist: "Yeah, because I'm the one going out and making all the money."

Tom: See, that's just what happens every single time.

Therapist: So, let's just stop here. It sounded like when you began your conversation with Jessica, you wanted to tell her how concerned you are that she contradicts you when you discipline the girls. When you were talking to me, as Jessica, I felt criticized. Now I'm wondering if there might be another way of bringing up this issue with Jessica so it doesn't turn into: "you did this, no you did that."

Tom: That's where I get stuck. I think she's wrong. I don't know how to get that across to her.

Therapist: It does sound like you feel she's wrong. And I appreciate that. Is there a way of saying things to her so that she doesn't immediately feel like she has to fight back?

Tom: I'm kind of stuck.

Therapist: I understand why you might feel stuck. I have an idea of an approach that sometimes works with people. We call it using "I" statements. The way it works is that instead of saying that "you did this" or "you did that and it made me feel mad," you talk more about the way you feel. For example, what if you started the conversation with something like this: "Jessica, is this a good time to talk? I'd like to talk about something that concerns me. I know we both love our kids and we want the best for them. I know that we've gotten into a lot of fights over the way that we each handle the girls. And when I'm doing what I think is the best for the girls, and you say something in front of them that's different, it really bothers me." How does that sound?

Tom: Sounds great. I'm just going to take you with me and you can tell her.

Therapist: You could take this approach home with you. It's just most of us didn't grow up learning how to say things that bother us in a way that another person can really hear them without fighting back. There are things that people can say – it's not always easy to do – which can make it more likely to have a conversation that doesn't turn into a fight.

Session 7: The therapist spent most of the session working on the Role Play. This is a good use of time during the Intermediate Sessions of treatment. Having the Veteran practice in such a detailed and unhurried manner often helps to address communication problems.

Session 8: In Session 8, the therapist reviewed with Tom his progress in therapy so far and its impact on his PHQ-9 score and mood. Building on that progress, they discussed the usefulness of continued efforts to address disputes with his wife.

Therapist: You've been feeling so much better. You said that you and your wife have been listening to each other a little more. Most importantly, it seems like you've worked out a way to discipline your children that works better for both of you. Things aren't perfect – you still feel like your girls go to her when they don't like the way you try to discipline them. You're still unhappy with the fact that your wife often comes home late from work – and then seems exhausted on the weekend to help out with housework and taking the girls to activities. Let's see if you can improve things with your wife in this area.

Tom: I guess we could try. I don't think she'll change.

Therapist: I'm hopeful. Already you've shown that you two can improve things by working together.

Sessions 9 - 14: During these sessions, the therapist and Tom identified some additional problems with his wife, options for dealing with them, and steps that Tom could take to address them.

Termination

A strong connection with the therapist or the therapy process may develop. Most Veterans have a combination of thoughts and feelings about ending therapy: fear, relief, gratitude, abandonment, ambivalence, sadness, or excitement.

In Termination, ask the Veteran about his response to ending treatment. Have the PHQ-9 scores and subjective mood ratings from the beginning until the end of treatment. These are rich in data to discuss changes in symptoms over the course of treatment.

Some therapists graph PHQ-9 and mood ratings to show the Veteran's changes in symptoms over time. Review symptoms that led to the depression diagnosis and discuss with the Veteran whether or not he still meets criteria. Also review with the Veteran problems that have been the focus of treatment. It is helpful to simply ask the Veteran to say what the problem is that he has been working on. Most Veterans are able to clearly identify the problem area in their own words. Then ask the Veteran to describe what skills he used to address the problem area and what was learned. Since the IPT ethos is self-empowerment, emphasize the efforts the Veteran has taken to improve interpersonal skills and to deal with life problems.

Sessions 15 - 16: The therapist continued to monitor Tom's depression symptoms and mood. He reminded Tom throughout the treatment that the therapy would end after 16 sessions, that they would use the last two sessions to sum up all the work that he had done, and then look at what future situations might trigger another depression. In session 15, the therapist compared Tom's first PHQ-9 with his penultimate one and commented on symptom change. Then the therapist focused on what had brought Tom into treatment and how much progress had been made in resolving the problem. The therapist concluded the session by encouraging Tom to examine what skills he learned during the course of treatment that helped him improve disputes with his wife.

Therapist: Tom, as I mentioned last week this is our second to last session.

Tom: Yeah, I know. I can't believe it.

Therapist: So it's gone quickly for you?

Tom: I just don't know what I'll do if I don't see you anymore. I feel like I'm just getting better.

Therapist: You've done a lot in these last few months. We'll talk later about your options for the future. But today I'd like to start by reviewing your first PHQ score with your current one. (Therapist refers to Veteran's original PHQ-9). Do you remember what your first score was on this depression symptom scale?

Tom: I think it was around a 11.

Therapist: You're close. It was a 13. That put you in the moderate range of depression. Your score today is 3. Many people that you passed on the street today probably have a score of about 3. You don't qualify for depression. That's great news.

Tom: I thought it would be low but I didn't know it would be that good.

Therapist: Let's look at the symptoms that you originally had and those which you have now.

The therapist reviewed each symptom. When finished with this, the therapist moved on to talk with Tom about the problems that brought him to treatment.

Therapist: Next, Tom, I'd like to talk about what brought you here in the first place. Do you remember?

- Tom: Of course. My wife and I were fighting all the time. I felt like she never listened to me and that she disrespected my authority.
- Therapist: Yes. The struggle that you two were having about who did what at home, your feelings that she was undermining your authority with the girls, and your concerns about not being the bread-winner were all contributing to your depression. What do you remember that you did that made things better with your wife?
- Tom: I remember that the first thing that helped was that you and I talked about when was the best time for me to talk with her. In the past I'd just explode but I learned that this probably wasn't the best. That really helped.
- Therapist: Anything else?
- Tom: Yeah. It helped me to think about her position. I didn't like doing that but you encouraged me, and it helped.
- Therapist: You did a lot of work to make things better with your wife.
- Tom: I know but it's not perfect.
- Therapist: I agree. And you know, things didn't have to be perfect between you and your wife in order for your depression to lift.

In session 16 the therapist talked with Tom about his feelings regarding termination. The therapist commented that finishing up IPT was like a graduation – it feels good and bad at the same time. The therapist also talked with Tom about future situations that might trigger another depression and his newly acquired communication skills that he could use in resolving potential future problems.

Case Commentary

Role disputes are one of the most common problems that are seen in IPT. First, it is important to assess the stage of the dispute. Are the parties still engaged but lacking the skills necessary to resolve their dispute (i.e., renegotiation)? Have the parties stopped talking and given up hope that the situation can be resolved (i.e., impasse) Or are the parties prepared to end their relationship (i.e., dissolution)? After that, the focus of treatment is on clarifying the problems in the dispute, helping the Veteran think through options on how to deal with specific issues, facilitating better ways of communicating, and encouraging the Veteran to take action.

Tom's case is a typical dispute. He and his wife were caught in a loop of differing expectations. They also lacked adequate communication skills to solve their disagreements. At the beginning of treatment, Tom was openly angry at his wife, but he still wanted to make his marriage work. Like many people involved in a dispute, he believed that his point of view was correct and that the other person's was not. The therapist's first task was to assess the stage of Tom's dispute. He and his wife were at the most workable stage – IPT's "renegotiation stage" of the dispute. They were still talking and arguing but they could not solve the underlying problem. Tom needed to get a clearer idea of how he communicated, clarify what the most important issues were with his wife, think through a plan for engaging his wife in a productive discussion (using Role Play in conjunction with building better interpersonal skills), and then follow through on the plan. Tom had a successful outcome with his wife. By the end of treatment his depression had resolved.

Problem Areas: Grief (Primary) and Role Transitions (Secondary) – Case Vignette: Eva

Therapeutic Tip: IPT with multiple problem areas

In IPT it is common for Veterans to have multiple problem areas. Some Veterans, in fact, seem to have all four problem areas triggering or maintaining depression. IPT research indicates that clinical outcomes are better if the therapist concentrates on one or two problem areas rather than all four. A key decision in the Initial Sessions is to determine which one or two problem(s) has the most impact on the Veteran's mood and functioning. One clue for the therapist, in determining which problems are the most fruitful focus of treatment, is to look at how much affect the Veteran evidences when talking about specific people or events. Generally, there will be one problem area that is primary, and one that is secondary in importance to the Veteran. In treating a Veteran with two problem areas, the therapist needs to link the depression to both these problem areas. Also, the therapist needs to remember to address both problems during the Intermediate Sessions. During some Intermediate Sessions the Veteran may explore just one of the problems; in other sessions, the Veteran may talk about both problems. Regardless, it is always the job of the therapist to keep both problems in mind. If the Veteran has not discussed one of the problems for several sessions, raise the issue of the second problem area.

Case Summary

Eva is a 34-year-old, married, Hispanic Veteran. She is the mother of three young children and works as a nurse. Eva joined the National Guard in her late twenties in order to cover her family's expenses that included her husband's sizeable medical bills. When she joined the National Guard she had not expected to be deployed but was. Eva returned from a nine month deployment in Iraq and began psychotherapy three months later. A close friend of Eva's died from an improvised explosive device (IED) while they were in Iraq. Eva was not present during this event.

Since returning from deployment, Eva felt that her family "isn't the same" and that she didn't "fit in with them." She has found it difficult to transition back to her role as mother. During deployment both her mother and her husband took on her responsibilities, and now that she is home, she feels it's difficult for her children to look to her as their mother in the way they previously had. She returned to work as a nurse, but no longer finds enjoyment in it. Further, she said that she just can't "get over" her friend's death and thinks about her daily. She feels guilty and wonders why she was not the one who died. Eva has a history of past depressive episodes for which she had been successfully treated. Three weeks prior to seeing the therapist she was diagnosed with major depressive disorder at a VA mental health clinic. Her depressive symptoms included sleep disturbance, passive suicidal ideation, anxiety, poor concentration, significant weight loss, hopelessness, and helplessness.

The Initial Sessions

Session 1: Eva's initial mental health assessment was done by another staff member. The therapist reviewed the results of that assessment including the diagnosis. During the first session the IPT therapist reviewed Eva's history and gathered additional information to fill in some gaps. After this, the therapist encouraged Eva to go over recent life events in her own words.

Therapist: Eva, I know you've already met with Dr. K. at our center and that you've spent a lot of time talking about what has been happening to you. I've read your file but as a way of getting to know you, I'd like to hear about why you've come to our center.

Eva: It's so hard to talk about all this. I feel like my life is falling apart.

Therapist: (Nods in support)

Eva: I just haven't been the same since I got back.

Therapist: You got back three months ago? In what ways haven't you felt like yourself?

Eva: I'm not interested in my kids, nobody even notices that I'm around, my husband isn't working enough, and I just don't feel like I belong.

Therapist: It sounds like it's been hard for you to adjust.

Eva: More than you can realize. I feel like I don't deserve to be here, and I'm afraid that I may have to go back to Iraq.

Therapist: I'd like to hear more about why you think you may have to go back, but first I'd like to know what's been happening at home that's making you feel like you don't fit in.

The therapist made a choice to get details about what was happening at Eva's home before getting information about her fear of redeployment. Alternatively, the therapist could have first listened to Eva's fears about redeployment, and then returned to talking about problems at home.

Eva: Just before I came here, one of my children hadn't cleaned up after breakfast. I told her to come back to the kitchen to put her dish in the sink. She ran to her father and told him that I was yelling at her. Instead of backing me up, and yelling at her, he told me to calm down. I stormed out of the house. He's been texting me, telling me to calm down. He said that I'm overreacting but I think I'm right. This never happened before. The kids always listened to me. But they see him as "mom." He's the one that's around. He takes care of them. All I do is work. He's not even working. I want my kids back.

Therapist: It sounds like things are tough at home for you right now. Is what happened today typical since you returned from Iraq?

Eva: Yes. I hate it. I know things weren't perfect before but everything is worse now.

Therapist: Tell me more about what is different at home. I'm interested in hearing what's different with your kids and you, and also what's different between you and your husband.

The Veteran described in detail what was currently happening with her children and husband. When the therapist was satisfied that she had enough information about what was happening between Eva and her husband and children, she shifted to learning about events in Iraq.

Therapist: I see from what I read in your chart and from what you mentioned earlier that you had a hard tour in Iraq. I'd like to hear about that.

The therapist knew from the intake record that Eva was grieving the death of her friend, Marcy, who died in Iraq. She inquired further about this to see if this event was tied to Eva's depression.

Eva: I never expected to go. I joined the National Guard so that I could make a little extra money. We have three kids, my husband has a lot of medical problems along with big doctor bills, and he doesn't work very often. He's in construction. I had trouble right from the beginning while I was in Iraq. I was always frightened and thinking about my kids. While I was there, I saw terrible things.

The therapist didn't interrupt the Veteran at this point since she was staying focused and telling an emotionally laden story about her military experiences. The therapist was mindful of the pacing of questions for Eva since the events were painful and involved death. If judged to be the focus of treatment there would be time to go into these issues in depth during the Intermediate Sessions. Further, the therapist was mindful that the focus of the Initial Sessions was on obtaining information and not on doing an intervention, which is accomplished in the Intermediate Sessions. The therapist was careful not to prematurely judge what the IPT problem area would be.

Eva: I thought I would die. I missed my kids. (She's crying.)

Therapist: It's clear how difficult your deployment was for you.

Eva: Yes, and I might have to go back. How can I do that? It was the longest nine months in my life.

Therapist: I'd like you to say more about your experiences in Iraq.

Eva: What do you want to know?

Therapist: Well, what happened to you there, what you saw, how you coped.

Eva: The worst was that my friend died.

Therapist: Tell me about that. Were you with her?

Eva: No, she was in a convoy that was attacked.

The therapist continued to get details about how Eva's friend died. As noted above, the purpose of the Initial Sessions is to get details about what has happened in the Veteran's life that may be contributing to depression. It is not a time to get into depth about specific issues as the therapist will do in the Intermediate Sessions.

Therapist: How did you hear that she had died?

The therapist asked Eva to give details about how she learned about her friend's death.

Therapist: Do you think your depression is connected to your friend's death?

Eva: Oh, I think that's an important part of it. I just can't get over it. I told her everything. We talked about her kids and her husband. She was the person who knew what I was thinking even before I said anything. I was so lonely after she died. I just stayed to myself.

Therapist: What's your friend's name?

Eva: Marcy.

Therapist: Do you often think about Marcy?

Eva: Every day. I miss her. I just can't get her out of my mind. I wonder how her kids are doing and I promised her that I would see them if something happened to her.

Therapist: So you haven't seen her kids since you've been back?

Eva: No. I can't. I don't know what to say. I live about 100 miles away from them, but I just can't see them.

The therapist concluded she had enough information to assess whether or not Marcy's death was likely connected to Eva's depression. At this point, the therapist believed that the following factors were contributing to Eva's depression: transition from Iraq to home, and death of her friend. The therapist judged that these issues were possible foci of the treatment but needed to gain additional history

Before the end of the session the therapist gave Eva the sick role.

Therapist: Eva, it's almost the end of our session. Before we stop for today, I'd like to explain a little about your depression and what I've heard today. It's clear that you have depression. You also said that you have been having trouble doing some of the things at home that you normally do, like taking care of your kids and getting out of bed to go to work. Lots of people with depression find it difficult to take care of daily responsibilities. For now, would it be possible for you to get someone to help you? Like someone who could help you with your kids? I think that getting some help will make you feel better. It's like if you had just had surgery. You would need some time to recover. Depression is also an illness from which you need to recover. While you are recovering, are there certain responsibilities that might be put on the back burner – or could you get some temporary help from someone else?

Eva: I don't know. I don't have any friends that can help. They're all busy.

Therapist: Well, I'd like you to think about this over the week. We'll talk more about it when we meet next. I'm hoping we can get you to come up with someone to help. Or maybe you could consider not doing as much as you normally do with your kids and around the house until you begin to feel a little better.

Eva: Maybe, I don't know.

Therapist: I'd like you to think about this and see if you can come up with someone to help you. We'll talk more about this next week.

Session 2: As with all IPT sessions except for session 1, the therapist reviewed the PHQ-9 completed by the Veteran, asked for a mood rating, and linked the mood and PHQ-9 score with what happened in the prior week. Since the primary task of Session 2 was to begin the Interpersonal Inventory, the therapist didn't spend too much time focusing on the events from the Veteran's week as would be done in Intermediate Sessions. During the session she obtained important information about Eva's relationship with her family and her close friend Marcy who died in combat.

Therapist: Welcome back. I see that your PHQ score went up since last week. Rate your average mood during the last week on a scale of 1 to 10 with 10 being the most depressed.

Eva: About a 7.

Therapist: As I told you last week, today I'll ask you about the important people in your life; but before I do, I want to spend a little time finding out about why your depression increased this week.

Eva: My husband Rob is not looking for a full time job. We don't have enough money. We have so many bills. It's too much pressure for me.

Therapist: It sounds like it made for a difficult week. In later sessions, we may talk much more about your relationship with Rob, but for now I'd like to learn about the important people in your life. These are people who are alive and those who have died, and those with whom you may have a positive or negative relationship. Who would you like to talk about first? It's important that we do this now because I will learn how people in your life may be contributing to or helping you with your depression. Who would you like to start with?

Eva: My kids, Liliana, Rosa, and my youngest, little Roberto.

Therapist: Let's talk about one at a time. Who's the oldest?

Eva: Liliana.

Therapist: Tell me about Liliana.

Eva: She's my baby even though she's the oldest. I missed her so much when I was in Iraq. She grew up so much when I was away.

Therapist: How so?

Eva: She learned to read. She's in second grade. She now even helps with cooking.

Therapist: Has anything changed in your relationship with Liliana since you returned from Iraq?

Eva: A lot. She sometimes talks back to me. She never did that before. She wants to cuddle with my mother, not me. I hate that. Sometimes I think she forgets that I'm her mother.

Therapist: How does that affect your mood?

Eva: It makes me feel worse. I served, and now I've lost my kids. My husband Rob doesn't seem to understand. He thinks I'm overreacting.

Therapist: I think I'm beginning to get the picture of what's happening with Liliana. Now that you mention your husband, why don't you tell me about your relationship with him? But before we do is there anything else you'd like me to know about Liliana before we talk about your husband?

The therapist continued to explore Eva's relationships with family members and friends to see if any of them may be triggering or exacerbating her depression. The therapist learned that the problems Eva was having with Liliana were similar to those with her other children. The therapist also saw that even though there were strains in Eva's relationship with her husband, she felt affectionate toward him and appreciated his efforts to care for the children while she was away. The biggest problem was trying to regain her role as mother in the family. Eva also described her relationship with her mother that had historically been good. She appreciated what her mother had done for her family while she was in Iraq, but wanted her mother to reduce her involvement so that Eva could regain her central role as mother. The therapist was mindful to have Eva talk about her friend who died in Iraq. Eva most clearly linked her depression with grieving the death of her friend. Therefore, the therapist encouraged her to carefully discuss this relationship.

Therapist: Eva, you've talked about each member of your family but you haven't talked about Marcy.

Eva: I hate talking about her. It just makes me sad, and there's nothing that I can do about it. Do I really have to do this?

Therapist: It is really important for me to know about your relationship with her, understand how you have felt since she died, and know how her death may be connected to your depression.

Eva: Well, I can tell you right now that I wasn't depressed until she died.

The therapist seized upon this opportunity to get Eva to talk about Marcy and started asking her about basic information related to Marcy.

Therapist: Tell me when she died. Were you with her?

Eva: No, I was back at base. She was on a supply mission when her convoy was attacked. She died instantly. They brought her body back. I saw her. She was mangled but her face was peaceful. I just ran to her but I couldn't do anything. It could have been me. It probably should have been me. I was next up. She always had my back and I didn't have hers. We had a ceremony that day and then I went back to work. The Army treated it as if nothing happened. How could they do that? I missed her so much. After that day, no one talked about her. I cried at night.

Therapist: That must have been so hard for you. So you didn't talk with anyone about Marcy?

Eva: No. I emailed my husband but he didn't email me right back. I felt so alone. When I see my kids, I think about her. She had two kids. They are young, like mine.

Therapist: You told me that you haven't seen her kids, right?

Eva: Yes, and at this point they probably don't want to see me. I might remind them of their mother.

After Eva finished discussing her relationship with Marcy, the therapist was mindful to leave enough time for the Veteran to contain some of her feelings before leaving the office.

Therapist: Eva, we're almost out of time for today. Next week we'll be finishing up talking about the important people in your life. I know that it was difficult for you to talk about Marcy. Are there any questions you have before we finish up today?

Session 3: During this session, the therapist completed the Interpersonal Inventory, provided the Interpersonal Formulation, and set the treatment contract. The therapist concluded that the primary problem area was Grief and the secondary problem area was Role Transitions. The loss of Eva's friend Marcy appeared to have the clearest link to the onset of depression. Transition back from Iraq into her family and work role also contributed to depression. Although strains with her husband and mother were evident (and raised the possibility of Role Dispute as a problem area), it appeared that regaining her role as mother was more critical and therefore Role Transitions would be designated as the secondary problem area.

Therapist: Eva, I think I have a good beginning understanding of what seems to have triggered your depression and what seems to be keeping it going. I'd like to spend the first part of our session talking with you about this.

You have depression. Your symptoms are sleep problems, occasional thoughts you'd be better off dead, nervousness, problems with concentration, loss of weight and appetite, and feeling hopeless. From what you said, your depression began almost immediately after Marcy was killed. You lost your best friend. You missed her so much. She was the person "who had your back," you confided in her, and you helped each other out. And you also feel guilty that she died and you did not. Do you agree so far with what I'm saying?

Eva: (nodding) Yes, and I feel so sorry for her kids. They are growing up without a mom. My kids are lucky. Why should my kids have their mom, and Marcy's don't?

Therapist: That's a lot to deal with. Marcy died and now you are adjusting to being back home. You're upset with your husband and mother, mainly because you feel they took over your role as mother, and disappointed that your kids don't treat you the way they used to. And now you're not sure how to get back that role. Do you agree with this, too?

Eva: I do, but what can I do about all this? It's too much.

Therapist: It is a lot, but I think we can work on helping you with your grief and we can work on helping you manage things better at home. Which would you like to work on first?

Eva: Let's talk about what's happening at home.

Therapist: Sounds good.

The therapist and Veteran spent the remainder of the session talking about what was happening at home. The sessions ended with the treatment contract (how therapy would proceed), expectations that Marcy would attend therapy weekly, and importance of raising any concerns she had about the therapist or therapy in the coming weeks.

The Intermediate Sessions

Session 4: Since Eva indicated that she first wanted to address issues at home, the therapist encouraged her to do this during the first of the Intermediate Sessions. During this session, the therapist helped Marcy to clarify issues related to her role transition in the family and options of how to address it.

Therapist: You started our session by saying that you are not sure that this therapy will work. I was wondering why. Did something happen this week to make you feel this way?

Eva: My mother came over, and the kids were so happy to see her. That's the way they used to react when I came home, but not anymore. Now they're that way with her and my husband. I can't even get them to hug me. I'll bet they wish I would go back to Iraq. The children love them more than me.

Therapist: You've said that a few times since we started meeting. Let's talk about why you think that is true.

The therapist encouraged Eva to talk more about why she thought her children loved her husband and mother more and why she thinks this might be. The therapist helped Eva consider other possibilities. This was a collaborative effort between the Veteran

and therapist. The therapist also used the session to help Eva think about ways that she might get close again with her children. She then encouraged Eva to talk about what her relationship was like with her children before she was deployed. The therapist obtained some specifics about what they did together. By the end of the session, the therapist explored with Eva things that she might do to enhance greater closeness with her children. This was Eva's homework for the week. The therapist advised Eva to make her best attempt and that it was possible that the homework might not go as planned. She said that they would talk about the homework the following week, regardless of outcome.

Sessions 5 - 7: During these sessions the therapist kept the focus on helping Eva deal with her multiple transition issues. This effort included helping her to determine, and then experiment with, what she might do to get her children to be more comfortable with and reliant on her as their mother. The therapist also helped Eva find ways to talk with her mother about taking a less active role in the parenting of her grandchildren. During these sessions, the other transitional problem that Eva identified was that she was unhappy that her husband had taken over so many of the household responsibilities. For example, prior to her deployment, she took care of the finances. Now her husband paid the bills and managed the budget. Further, during these Intermediate Sessions, the therapist helped Eva strategize about how to talk with her husband about this issue and role played possible conversations before actually speaking with her husband.

Therapist: Now that you know what you want to say to your husband, I think it would be helpful for you to practice here before you go home and actually speak to him. It's like practice before the big game. How does that sound to you?

Eva: Pretty weird.

Therapist: I know, it usually feels awkward at first but once you get into it, it gets easier. I'll help. I think the best way to start is for you to just describe what you want to get across to your husband. Don't worry about how to say it, just think about what you want your message to be.

Eva: I want him to know that I want my old jobs back. I'm better at managing the finances. I earn the money so I should keep track of it. He's disorganized. And I'm upset with him about that.

Therapist: OK. You're clear about what you want. Our next step is to spend some time talking about how to best get your message across. First it's important to think about timing. What's the best time to talk with your husband?

Eva: (Laughing) I know what you mean, but I don't usually think about this. The best time is when we're having a drink at night, after the kids are asleep.

Therapist: Good, now let's look at what's the best tone to use with him.

Eva: He hates when I sound all bossy.

Therapist: That's important to keep in mind. So now you know what you want to get across, when you want to say it, and the tone you need to use. Why don't you start practicing now? I'll listen and I'll let you know how I think you're coming across. What will you say first?

Eva: [now role playing herself]: "Honey, I want to talk about how you've been handling the finances. I don't want you to do it anymore. I used to do it before I went to Iraq, but now I want to manage our money again." [Eva now playing her husband] "I like managing the finances, and you already do so much." (pause...)

Eva: (With some anger in her voice) "I make the money so I should get to manage it."

Therapist: Let me stop you here. I think you were doing a good job until you brought up that you earn the money so you should manage it. I'm concerned that might not go over well and I'm afraid that by saying this you will get an argument going. I understand that you believe that you have a right to be involved in the family finances but let's see if you can come up with a less confrontational way of saying that.

The Role Play continued until Eva and the therapist were satisfied that she was ready to go home to talk to her husband.

Therapist: It sounds like you're ready to talk with your husband. Do you think you could have a conversation this week? I also want to let you know that it's possible that you won't have a talk with your husband. The timing might not be right or once you get home you won't feel ready. Or you may have the talk and it won't go as well as you had hoped. No matter what happens, I want to encourage you to come back no matter what and we'll talk about it.

Session 8: The therapist reminded Eva that they were halfway through the IPT treatment. She also reminded Eva that so far they had been focusing on making the transition back home. They briefly talked about the progress that she had made in dealing with the transition home, and then the therapist reminded Eva that the other problem that had been contributing to her depression was her ongoing grief for Marcy. The therapist suggested that they spend the next few sessions concentrating on talking about Marcy.

Therapist: Eva, we're halfway through our 16 sessions and we haven't yet talked about your grief over Marcy's death. I think it's time for us to talk about her. Things are going better at home with your kids and your husband.

Eva: I know but I just don't want to bring those memories back.

Therapist: I know it's difficult but when we first met you said that you think about Marcy anyway. So now I think we need to talk about her including your feelings and memories about Marcy. I think that by doing this it will help your depression to improve.

Eva: Do you really think it will help?

Therapist: I do but I also know that it will be hard. We can go at your pace. When you think we need to stop talking about Marcy for the day, just let me know. We'll stop and continue in the next session.

Eva: Where do we start?

Therapist: Well, why don't you tell me about how you two met?

Therapeutic Tip: Discussion of the deceased

Note that in the above dialogue, the therapist did not ask Eva if she would talk about her friend's death. Rather she simply stated that she would like her to talk about her deceased friend. The reason for this is that if the therapist asked if Eva wanted to talk about her friend and Eva declined, then Eva may assume that she can avoid this difficult topic. Often Veterans are reluctant to talk about painful experiences. However, the avoidance of painful issues is usually counter-therapeutic. Since IPT is a brief, time-limited treatment, try to open up difficult topics early on.

The therapist started with an easy aspect of Eva's relationship with Marcy. Over the course of the next few sessions, the therapist helped Eva deal with more of her grief. She encouraged her to talk about positive memories of Eva. At Session 10, she encouraged her to discuss how she learned of Marcy's death, feelings of grief about the death, and any negative feelings she may have toward Marcy. Under most circumstances, the therapist should end the grief part of the session about ten minutes before the session is actually over. By doing this, the Veteran will have an opportunity to contain any raw emotions before leaving the office.

Sessions 9 - 13: The primary focus of these sessions was to help Eva grieve Marcy's death. The therapist also used the last 10 minutes of some of these sessions to check on how Eva's transition at home was going.

The following dialogue from Session 10 is an example of the therapist's encouragement of the mourning process. In an earlier session the therapist asked Eva to bring in a photo of Marcy.

Therapist: Eva, thank you for bringing in this photo of Marcy. When was it taken?

Eva: About a month before she died. We had a day off and we were just hanging out. That's what we liked to do. I miss her so much.

Therapist: Yes, I know you do. It's been some time since you've been coming here. We're at session 10. You've talked about Marcy but you haven't wanted to talk specifically about the day that she died.

Eva: I told you a little at the beginning.

Therapist: You did, and I'd like to pick up on that because your feelings around Marcy's death have contributed to your depression. I know this is hard, but I want to go back to that day and I want to hear more of the details about the day that Marcy died.

Eva: It was really horrible.

Therapist: I know that this is really difficult. We can go slowly, but I actually believe that in order for your depression to improve, we need to talk about that time. So, as I recall, she died in February. Tell me what happened.

Eva: Well, I think I told you that they brought her body back. Somebody told me that she had been hurt, but they didn't tell me that she had been killed. I ran over to try to help her.

Therapist: So at that point you didn't even know that she was dead?

Eva: I didn't. I wanted to go and help her. I saw her body. I told you that her face looked peaceful.

Therapist: Yes. What else did you see, Eva?

Eva: [long pause]

Therapist: I know it's really hard for you right now.

Eva: It was horrible.

Therapist: So her face looked peaceful to you. What about the rest of her body?

Eva: Her body was really screwed up.

Therapist: In what ways?

Eva: It looked like part of her leg had been blow off. This sounds crazy but I wanted to go and find part of her leg. That's crazy, I know, but I wanted to get that part of her and bring it back.

Therapist: Eva, that doesn't sound crazy to me at all. She was your best friend.

Eva: There was blood all over her body and – some of her fingers were missing...

Therapist: So hard to see your friend like that.

Eva: And then they pulled me away from her.

Therapist: What do you remember feeling then?

Eva: I just felt numb. And then I went back to my tent. I kept thinking about her and I really couldn't believe that she had died. I wanted to go see her again just in case they had made a mistake. I went over to talk to the medic, and asked to see her, and he said that she had died. I still said I wanted to see her. They said I couldn't. And then everybody just stopped talking about it like nothing had happened.

Therapist: Yes, that sounds awful.

Eva: Then they took her body away and everything went on like it was normal.

Therapist: And of course nothing was normal for you.

Eva: No. I just kept thinking about her all the time. I missed her.

Therapist: What do you wish you were able to do in terms of a ceremony? What would you like to have done?

Eva: I would have liked to just sit quietly and say goodbye to her.

Therapist: You didn't even have that chance.

Eva: I sort of think that I could say goodbye to Marcy if I could talk to her kids. I promised I would.

Notice that the Veteran shifted from talking about the death scene to talking about how she might manage her grief by doing something in the present. The therapist decided to move in that direction. She did not see this as an avoidance of the "death scene" but as a related aspect of the Veteran's grief.

Therapist: So tell me what you'd like to say to Marcy's children.

Eva: I wouldn't tell them what happened but I could tell them how much I loved her.

Therapist: That makes sense to me. And you haven't seen her kids since you came back?

Eva: I haven't and I know I should, but I don't think that I can right now.

Therapist: Well, Eva, as you're sorting out your feelings about Marcy and the day that she died, you can also be getting ready to take the next step about whether you want to see her children. The good thing is that we have more time here in therapy, but not a lot. So I want us to focus on your plan to see Marcy's children over the course of the next few sessions. OK?

Eva: I didn't think I could talk about this.

Therapist: I'm really glad that you did but I want to know how are you feeling right now?

Eva: Sad but relieved.

Therapist: Yes, well, I'm really glad you're relieved. And of course this was a difficult session talking about the day that Marcy died.

Session 12: In this session the therapist guided Eva through a Decision Analysis related to Eva's conflicted desire to contact Marcy's children.

Eva: Some days are OK, but sometimes I still feel depressed.

Therapist: Eva, I wanted to pick up on something that we talked about a couple of weeks ago when you talked about Marcy – how much you miss her and your feelings about her. You've been grappling with whether you want to go and visit

Marcy's kids. Are you still thinking about that?

Eva: Really that's been on my mind ever since I left Iraq.

Therapist: So it's there most of the time for you?

Eva: Yes, because we told each other that if something happened to either of us we would look after each other's kids.

Therapist: And you've been feeling pretty guilty that you haven't been in touch with them?

Eva: I haven't even called them.

Therapist: Eva, I know this is hard for you. What I'd like to do today is to take a look at the advantages and disadvantages of contacting Marcy's kids. The way we do this is to first take a look at options about whether or not you would contact the kids – without making any decision right now. Does that seem reasonable to do?

Eva: Yes it does.

Therapist: OK Let's take a look at some of the possibilities. Again, don't worry about making a decision right away. Let's look at some of the possibilities around Marcy's kids. What do you see as some options?

Notice that the therapist emphasizes the importance of looking at options before the Veteran chooses a plan of action.

Eva: Well, I could just call them now.

Therapist: You mean like today?

Eva: Just do it. Get it over with.

Therapist: OK, So, one option would be to just jump right in and call them. So that would be one plan. Again, I don't want to take a look at the advantages and disadvantages just yet but just really look at the possibilities. So the first option would be to just jump right into this. What are some of the other options that you might think about?

Eva: Well, I could just never call which is what I've been doing now.

Therapist: That's right, and that has certain consequences for you, and I want to take a look at that with you after we finish up this list. So one option would be just to not contact her kids.

Sometimes in doing a Decision Analysis the therapist will generate an actual written list with the Veteran. This might be especially helpful when working with a Veteran who has a mild cognitive impairment.

Eva: Yeah, maybe they forgot about me already.

Therapist: I know you think about this. And just for right now, let's just talk about options. Do you see any other possibilities?

Eva: Maybe I could think about it some more. Maybe if I had time to think about what to say to them I'd feel more ready to talk to them.

Therapist: So another possibility would be to wait a while longer with a plan to contact them. Is that what you mean?

Eva: Yeah, wait and think about how I would talk to them.

Therapist: And maybe waiting and preparing might be better for you in the long-run.

Eva: I never thought about that, but maybe you're right.

Therapist: So as I hear it, you really have three options that seem fairly straightforward: One is to contact the children today. Another is to never contact Marcy's kids. And then there's this middle ground of contacting them but preparing for it. Right now, Eva, let's look at the advantages of jumping in and contacting Marcy's kids today.

Eva: If I did it now, I'd probably feel relieved because I could just get it over with. Maybe that would make me feel better and I wouldn't feel so guilty.

Therapist: Yes, it might take the weight off your shoulders. Any other advantages to doing it right now?

Eva: I don't think so.

Therapist: I actually can't either.

If the therapist thought there were any other advantages of this option this would be the time to state them.

Therapist: Eva, how about the disadvantages of contacting Marcy's kids right now?

Eva: Guess I could get really upset after calling them and seeing them. Maybe that would make me feel worse and make them feel worse.

Therapist: That actually makes sense to me. Without some preparation you might not feel ready to do it and you also would not be prepared for what the kids might say. We really haven't done any work in that area about how you might react and that does seem like a big downside.

Eva: Yeah.

Therapist: Eva, what about the advantages and disadvantages of never contacting them? As you have mentioned, you haven't contacted them so far. First, let's look at the advantages of this approach.

Eva: If I never contacted them I wouldn't get upset, and they wouldn't either, if it turned out badly. But then again, I'd never be able to talk with them about her, which is important for me to do.

Therapist: It reminds me of something you told me. One of the things you agreed to with Marcy was that you look after each other's kids and you haven't done that. I know this has made you feel guilty.

Eva: Yes, it does.

Therapist: So if you just didn't contact her kids that part of your guilt would still be there.

Eva: I still feel that commitment pretty strongly.

Therapist: And if you contact them, you have the chance to have a connection with Marcy through her kids. There's also that other option of contacting Marcy's girls but preparing for it.

Eva: Yes, you know I could just do it but I'm not sure what to say. I'm not sure what to do if they get upset or if they say to me why did you wait until now to contact us?

Therapist: Right. Well, we could practice how you might respond given what the kids might say to you. An advantage of waiting is that you could prepare.

Eva: I'm sure they are upset too.

Therapist: Do you see any downsides of waiting until you are more prepared?

Eva: No.

Therapist: So, of those three options, which one seems most reasonable to you?

Eva: I think waiting.

Therapist: Waiting with preparation, you mean?

Eva: Yeah. I think it would be good to talk some more about it because I really don't know what to say.

Therapist: So we could actually practice here.

Eva: OK, then I'd know more what to say.

Termination Sessions

Sessions 15 - 16: The therapist mentioned in session 14 that the end of therapy would be coming soon. The therapist explained to Eva that they would spend the last two sessions talking about changes in Eva's depression symptoms, review the interpersonal problems that brought her into treatment, what changes there had been in those problems, and what skills Eva learned during the treatment that helped her resolve these problems. The therapist also said that they would talk about Eva's feelings about completing the treatment, what future situations might trigger another depression, and what treatment options Eva had at this point. They spent most of this session, however, continuing to work on grief and the transition home.

Session 15: The therapist began the session as she always did. By this time Eva knew exactly what to expect, and discussed current depression symptoms and mood. The therapist took this opportunity to review the Veteran's first PHQ-9 with her penultimate PHQ-9 and progress in treatment.

Therapist: Eva, this is almost the last PHQ-9 you'll complete. There's just one more next week. For comparison, I brought in the first one you did 15 weeks ago. Do you remember what score you got on that one?

Eva: All I know is that it was high. I think I had every symptom.

Therapist: Your score was 17. That's moderately high. Do you know what your score is now?

Eva: Not too high. I'm still tired and I still have trouble sleeping. And sometimes I'm irritable but mostly I'm feeling better.

Therapist: Your score now is 4. That's a big change. You no longer have depression. Congratulations. And in my mind there's no magic to that. You have worked so hard to feel better. I'd like to spend today talking about what problems brought you here and where you are in the resolving those problems.

Eva: Well, I was so sad about Marcy's death. I still miss her. I think I always will, but at least now I can go through a day without breaking down when I think about her. And I also was having trouble adjusting at home. Remember that?

Therapist: I do. Let's talk about what you did that helped you with your mourning and then I'd like to talk about what you did to help yourself adjust to being back home.

The session continued with this focus. Remaining Termination tasks were completed in session 16.

Case Commentary

Eva's case is typical of many in IPT, where the Veteran presents with more than one problem area. Two interpersonal problems can be handled during the course of a 16 session treatment if the therapist is well-organized and cognizant of the time-

limited nature of the therapy. Eva clearly felt that grief around her friend's death was the primary and most difficult problem in her life. However, Eva chose to work first on her transition back home. Once she had made sufficient progress with that problem area, the therapist reminded her that her depression was also associated with unresolved grief. One very important aspect of the work was for Eva to make contact with Marcy's children. Eva felt that she wanted to make a connection with Marcy's children and perhaps have a presence in their lives. Eva did, in fact, contact Marcy's family and made plans to see them. These efforts were an important part of Eva's grief work.

Problem Area: Interpersonal Deficits – Case Vignette: Matthew

Case Summary

Matthew is a 32-year-old retired Army Veteran. He left the military in 2010 after serving for ten years. While on active duty, he completed three tours in Afghanistan. Because of the nature of his work, he could not describe the specifics of what he did while deployed except to say that he “saw some awful things,” and that “no one who wasn’t in his unit would ever understand.” Matthew divorced in 2011. He described his marriage as a good one until after his second deployment. At that point his wife began complaining that he was remote from her and their children. His wife told him that he no longer talked to her, didn’t seem to enjoy playing with the kids, and didn’t generally enjoy life. He was no longer going to church with his family and they stopped socializing with their many friends. Matthew agreed with her assessment. After he was called up for his third and final deployment, his marriage fell apart. He and his wife rarely spoke and he didn’t stay in touch with his children and other family members. He has two children ages 10 and 6. His current relationship with his ex-wife is cold, but not openly hostile. He sees his children about once a month. Matthew is employed as a wind turbine builder. He described being satisfied with the physicality and danger of his job, but nonetheless is bored with it. He travels a great deal for his work. This interferes with seeing his children, and with a social life. Matthew doesn’t feel challenged in his life the way he did in the military. He enrolled in college but dropped out after one semester because he “didn’t fit in.”

Initial Sessions

Session 1: An intake was done by a different VA clinician than the assigned IPT therapist. Instead of conducting another full history, the therapist reviewed Matthew’s history with him. He advised Matthew that he was already familiar with his history but wanted to ask him questions to clarify and fill-in information in the chart. The therapist verified that the patient’s diagnosis was accurate. He then informed Matthew that he had depression, explained what “depression” meant, provided hope, and gave him the sick role.

Therapist: Hello, Matthew. I’m (gives name) and I’ll be your therapist. It’s good to meet you. I know that you met with another VA clinician about ten days ago and that you spent a long time talking about your history and what brought you here. So I won’t spend our time having you talk about all of that again, but I do have a few questions based on what I read in your chart. First of all I’d like to hear from you what brings you here.

Matthew: Well, that’s a good question. I’ve been thinking that this might be a bad idea. I don’t really know what I could get out of coming here. I’m fine, really. I just don’t really enjoy myself anymore. Except for work, I just stay around the house. But really I’m OK.

Therapist: How long would you say you’ve been noticing that you’re not enjoying yourself?

The therapist needed to decide whether to ask Matthew about his ambivalence about taking part in therapy or to focus on his symptoms. He chose the latter. If Matthew had continued to be reluctant to come back for treatment, the therapist would address that.

Matthew: At this point it’s beginning to feel like forever. I just don’t enjoy much. I just would rather stay at home alone.

Therapist: When do you remember last feeling any enjoyment?

The therapist tried to zero in on how long Matthew felt this way. Next he would learn from Matthew what was happening at that time. Matthew described feeling anhedonic for a “long time” but he couldn’t offer a specific time frame.

Matthew: I know I had fun in high school and when I enlisted in the Army I really liked it. But things changed.

Therapist: Can you pinpoint when?

Matthew: I know what my ex would say.

Therapist: Yes?

Matthew: She'd say that I changed while I was in Afghanistan. She says that I was one person when I deployed and another person when I got back after my second deployment.

Therapist: Tell me more about that. I'd like to know what she noticed.

Matthew: She said that I was different when I got back after my second deployment. She claims that I just wasn't the same. I didn't laugh or talk with her. She said that I didn't hang out with the kids either.

Therapist: Do you see any truth in what she told you?

Matthew: Pretty much. I just felt out of my skin. I felt different. I think I was different.

Therapist: In what ways?

Matthew: None of you understand. She didn't. I knew how to be while I was deployed. I knew who to rely on. I took care of my team. At home things were different. She wanted me to help with the kids and be with her. I just wanted to be left alone. It was just so different being back home.

Therapist: I read in the notes that you didn't feel this way after your first deployment. The feeling you just described only occurred after your second deployment.

Matthew: Yeah. Not sure why that is.

Therapist: Well, that might be what we try to find out during our work together.

Therapeutic Tip: Premature identification of the problem area

In IPT it's important not to determine the focus of treatment too early. Collect information from the history and Interpersonal Inventory before determining the problem area(s) that will be the focus of the therapy.

Therapist: I'd like more details about how things were different for you once you returned from your second and third deployments. I'm especially interested in how things were between you and your wife and children, and how things were with friends.

Matthew: I was pretty screwed up. I was angry at my wife and kids. They just went about their business and I didn't fit in. I wasn't happy. I missed my unit and what we were doing over there. I didn't care about what we were having for dinner or who was having a baby. I used to spend every day solving problems and figuring out how to stay alive. I had important work to do. I was always in danger. Now I was dying from boredom.

The therapist continued to get details until satisfied there was enough information about what had occurred. He did not interrupt the Veteran's flow but was mindful of his agenda for the session, which was to review the PHQ-9 that Matthew completed at the beginning of the session; to provide psychoeducation about depression; and to give the Veteran the sick role.

The therapist found an opening to say:

Therapist: Matthew, I'm beginning to get a picture of how difficult it was for you to transition from what you were doing in Afghanistan to your life back here. It sounds like it was not easy for you and that it affected your wife and children. It also sounds like you felt different after deployment. I want to learn more about this as we proceed but we just have a little more time today, and I have a few more tasks that I need to do with you before we finish. So please bear with me. I want to look over your depression questionnaire with you. Your score, which I just totaled, is a 32. That puts you in the severe range of depression. Does that surprise you?

Matthew: Not really.

Therapist: Specifically, you get the highest scores for feelings of sadness, irritability, guilt, self-blame, lack of interest in things, and no real enjoyment in things that used to make you happy. You also feel pretty hopeless about the future. No wonder you've been feeling bad. I'd also like to ask you to rate your mood on a scale from 1 to 10. One is the best you've ever felt, and 10 is the most depressed. What number would you give your mood this week?

Matthew: I'd say an eight. I feel pretty low.

Therapist: From the information that you gave me, and from the forms that you completed, it's clear that you have depression. That's the bad news. The good news is that depression is very treatable and you've just started a therapy that we use at VA to help Veterans who have depression. I want to say that it looks like your depression began sometime around your second deployment to Afghanistan. Before that you describe yourself as feeling good about your life, but not after your second return to Afghanistan. I think we need to understand more about what was happening with you at home and in Afghanistan. Next week I want to get more details. We'll also keep tracking your symptoms and mood every week. I would expect that your mood will improve and your symptoms decrease as we understand what happened to you and help you build skills that you can use to feel better in your current life.

Note that the therapist gave the Veteran a diagnosis of depression and also a number associated with its severity. This information is often very helpful and is a simple and quick way of monitoring symptoms and mood change throughout the course of treatment. He then provided hope and gave the sick role.

Therapeutic Tip: The sick role and veterans

The sick role as described in the *Comprehensive Guide to Interpersonal Psychotherapy* (Weissman et al, 2000) does not suit many Veterans, especially those who pride themselves in coping with challenges and in not being "weak." Veterans may find it difficult to accept the message that because of an illness they can be temporarily excused from normal activities. It may be helpful to acknowledge that in the military the ethos is "to complete the mission," but that the Veteran might consider going a little easier on himself until he is feeling better.

Therapist: Depression is common and it's treatable. Do you know how many Veterans have depression?

Matthew: No matter how many have it, it doesn't sit well with me. I've always been tough. I'm not weak.

Therapist: Depression doesn't mean that you're weak. It's common and common in Veterans. About 14% of Veterans have depression. That means that if we had 100 Veterans in this room, 14 of them would be feeling just like you. As I said that's the bad news. The good news is that depression is treatable. People get better from depression. There are lots of treatments. There is medication and there are talk therapies.

Matthew: No medication for me.

Therapist: Why is that?

Matthew: I'm not crazy. You're all alike here. You just think that I'm sick and that if you give me a pill you can just forget about me. Well I don't want any drugs.

Therapist: I hear you. We have other ways of helping at VA. We use several types of talk therapies that work to help people feel better. One therapy is called Interpersonal Psychotherapy or IPT. It was developed in the 1970's to treat people who have depression. And it's been studied a lot. It works. Most people feel at least somewhat better by the end of treatment. I think it might be a good therapy for you because there seem to be things going on in your life that are connected to your depression. Some of those changes occurred during your second deployment. I think if we dig deeper in your life, then and now, we may be able to understand what triggered your depression. And we won't stop there. We'll then figure out what you can do now to make your life happier.

The therapist instilled hope, provided a description of the sick role, and motivated the Veteran to begin treatment.

Therapist: This is a therapy that can work with or without medication. Again, I can't guarantee that this therapy will work but I am hopeful. Would you like to try it?

Matthew: Reluctantly.

Therapist: That sounds good enough for now. One thing I'd like to say – and I know you'll hear me say this many times – is that it's hard to be hopeful and enthusiastic about the future when you're in the midst of depression. Hopelessness and lack of enthusiasm are symptoms of depression. Let's get started and see how you feel over the weeks. One thing we notice is that for many people with depression it's difficult to do things that were routine in the past. Have you noticed that?

Matthew: Yes, everywhere.

Therapist: Give me a few examples.

Matthew: I'm not taking care of my house. The grass is overgrown. I don't call my kids. I get to work late, when I actually go.

Therapist: That's just what I'm talking about. Other people with depression describe just those same problems. If you hadn't been in the military, I might be saying to you that it's temporarily OK that you can't do these tasks. But I've learned that this doesn't sit well with Veterans. You're accustomed to taking on responsibilities and completing them. But I'd like to suggest that you at least go a little easy on yourself for a little while. As your depression begins to lift, I expect that you will get back to doing all the things that you have always done, at the level that you've always done them. But right now this may not be possible. So if you can lessen your expectations just a little bit, I would recommend that. What do you think?

Matthew: I don't know.

Therapist: I appreciate your honesty. I'd at least like you to consider being a little more understanding of yourself, and the expectations that you and others have of you, as you work toward improving your depression.

The therapist explained the basics of IPT and told the Veteran what to expect in the next session.

Session 2: In this session, the therapist completed the second PHQ-9, mood rating, and the Interpersonal Inventory.

Therapeutic Tip: Symptom and mood ratings

In IPT the symptom and mood ratings are integral to the treatment. Use the ratings to help the Veteran monitor changes throughout the course of treatment. Changes in symptoms and mood provide an excellent jumping off point for focusing on what happened during the week that affected mood.

Therapist: Hello, Matthew. It's good to see you. I'm glad to see that you were able to complete the PHQ before we started. I'm interested if there has been any change in your symptoms since last week. It looks like your score is exactly the same. I'm not surprised. We just started our work. But as I told you last week, I hope and expect that your symptoms will go down as we work on the problems that are contributing to your depression. I also want to check on your mood. On a scale from 1 to 10, where would you rate your mood, remembering that 10 the most depressed?

Matthew: Seven. Tough week.

Therapist: OK. I want to hear about your week. Let's spend about 10 minutes talking about what happened this week that contributed to making you feel so depressed. Then, if you recall from last week, I need to get a little more information from you about the important people in your life. But for now, please tell me why you felt so bad this week.

In this second session it was important that there was time to conduct the Interpersonal Inventory. Therefore, the therapist only spent a brief amount of time reviewing the events from Matthew's week that affected his depression. Then the therapist turned the conversation to the Interpersonal Inventory.

Therapist: Matthew, you mentioned that things weren't good this week with your ex-wife. I think this would be a good time to start talking about the important people in your life. I want to devote today's session, and part of next week's session, to talking about these people. These are people who may be alive or dead and with whom you may have a good, bad, or mixed relationship. Who would you like to start with?

Matthew: Not really sure. No one comes to mind. Nobody is very important to me except for my kids.

Therapist: You have two children, right?

Matthew: Yes.

Therapist: Let's talk about each one of them. Who should we start with?

Matthew: I guess we'll start at the top. That's my big girl. I used to spend a lot of time with her. She called me the best daddy in the world. I'll bet she doesn't say that about me now.

Therapist: Why's that?

The therapist asked for details to find out when Matthew's relationship changed with this daughter and what changed in it. He did the same when conducting the Interpersonal Inventory for each child.

The therapist had the Veteran review his current relationship with his ex-wife to see if this was the source of his depression. There did not seem to be a connection.

After discussing his children and ex-wife, Matthew could not think of anyone else who was important to him. The therapist asked about his parents. Matthew described having a good relationship with his parents who live in Texas. He had contact with them approximately once per month. Conversations with them were "pleasant enough," but not very satisfying. The therapist began to get a picture of an isolated Veteran. During history gathering, Matthew told the therapist that he was not socializing, isolation was part of what led to his divorce, and he felt that no one understood him anymore. This information was leading the therapist to consider Interpersonal Deficits as the trigger for Matthew's depression. He needed to determine whether Matthew had significant Interpersonal Deficits as part of a lifetime pattern, or if this condition was triggered as a result of his combat history. To determine this, the therapist explored the extent and quality of Matthew's pre-military relationships.

Therapist: Matthew, I'm interested in hearing about your friends. Who are the friends who are important to you?

Matthew: Like I told you before, I don't really see anybody, not anymore.

Therapist: I'm trying to understand how long you've felt this way. I understand that right now you're not seeing people, not socializing much at all, but was there ever a time when you spent time with friends?

Matthew: Not for years now.

Even though Matthew said that he didn't see people, the therapist kept on pressing to see what social contacts he actually had.

Therapist: I just want to be clear, other than family, who do you see or talk with during the week.

Matthew: Nobody. I just can't be bothered. My old friends just talk about football, baseball, and money problems.

Therapist: Which friends are you talking about now? I want to go through each one individually. Tell me the name of one of the friends you're talking about. Then I'd like you to tell me about your relationship with him.

Matthew: Well, there's Fred. He's my next-door neighbor. We used to have beers together at night.

Therapist: Not anymore? When did you last spend time with Fred? Is Fred one of the people you feel that you don't have anything in common with?

Next the therapist explored the relationships the Veteran had prior to enlistment.

Therapist: Let's go back to the time before you enlisted. Tell me about your friends from that time.

Matthew: That's a long time ago. That takes me back to my high school days. I had three best friends.

Therapist: I'd like to hear about those friends. Let's start with the one that you felt closest to.

Matthew: That would be Ben. I grew up with him. We did everything together. We played ball, video games; we even double dated.

Therapist: So you spent a lot of time together?

Matthew: Yeah, of course. People used to joke that we were brothers because we spent so much time together. And we had a lot of fun.

Therapist: Would you have changed anything about your relationship with Ben?

Matthew: No way.

Therapist: What happened when you went into the Army? Did you stay in contact?

Matthew: For a while but then we just stopped. He got busy and I didn't think he was interested in what was up with me.

Therapist: I'm interested in knowing when that change happened. And, of course, I'd like to know why you think it happened.

Matthew: Like everything else, things were different after my second deployment. I just couldn't stand talking with anyone except people in my unit. Ben would call me up and text me about stupid stuff. Who cares who was in the World Series? He didn't have any idea what I was handling.

Therapist: So is that when you felt more distant and began avoiding him?

Matthew: (Matthew nods.)

Therapist: Is there anything else that you think I should know about your relationship with Ben before we move on to talk about your other friends?

Matthew: Only that I wish we still hung-out together.

Therapist: Have you made any attempts to contact him recently?

Matthew: No.

Therapist: Perhaps we'll concentrate on this during our weeks together. I just want to learn a little more about your friendships before we determine a focus of treatment. I want to find out about your other two high school friends and then I want to learn about a few of your friends in your unit.

The therapist obtained details of Matthew's high school friends, friends in his unit, and whether he had any romantic interests since discharge. He found that Matthew had satisfying friendships early in his life and also while he was in the military. His current lack of friends, along with his isolation from his family, seemed to be related to his combat experience. Prior to his second tour in Afghanistan, the Veteran had active, satisfying relationships with family and friends. Matthew did not exhibit significant symptoms of posttraumatic stress disorder.

Therapist: Matthew, we're almost out of time for today. Let's stop here. I've learned a lot about what factors are likely contributing to your depression. We can talk about this next week when we meet and we can come up with a plan for our remaining 14 sessions. Does that sound good to you?

Matthew: I'd like that. I'd like to know what you think. It's a mystery to me.

Session 3: The therapist began the session by reviewing the PHQ-9 and mood check. The purpose of this session was to provide the Veteran with the Interpersonal Formulation and to begin the Intermediate Sessions.

Therapist: Matthew, now that you've finished telling me about your life and talking about the important people in your life, I think I have an understanding of what's been going on with you. First of all, you have depression. Your symptoms are: (listed Matthew's symptoms). Your depression began after you went on your second tour to Afghanistan. Do you agree with that?

Matthew: I think you're right.

Therapist: Let me explain to you how I understand what's contributing to your depression. Your depression began right around the time of your second tour in Afghanistan. You said that before that tour you had a good marriage and were close to your wife and children. You also kept contact with your high school friends. You enjoyed spending time with people. You felt close to them too. But once you were deployed for the second time, things happened while in combat that made you feel that no one except people in your unit would understand. Because you felt this way, you began to stay away from people. You weren't interested in what they had to say and that they did not "get you." As you spent more time alone, your depression increased. Once you left the military you didn't have the camaraderie of the men who understood you. You didn't keep up contact with them. That also contributed to your depression. Now you aren't even seeing your kids on a regular basis.

Matthew: What can I do about all that?

Therapist: A lot. Over the next weeks I'd like understand how you feel when you're with people. Then I'd like to help you experiment with how to get re-involved with at least some of your friends. Let's spend the remainder of today talking about your past week. I'd like to hear about the people you encountered.

The therapist learned from Matthew how he spent his week and with whom he interacted. He used the remainder of the session to learn more about Mathew's patterns of interaction. At the end of the session he told the Veteran that they would continue this discussion next week, and that they would see how he could begin to get connected with people. He was especially mindful of the need to help Matthew get re-involved with his children.

The Intermediate Sessions

Session 4: The therapist checked on Matthew's depression symptoms and mood. He used the information from the symptom and mood ratings as an entree into the week's events. He kept the focus of the session on understanding what interfered with Matthew feeling connected to others.

Therapist: Your mood and symptoms are the same as last week. Again, we're just at the beginning of our work, so I hope you are not discouraged. It took you awhile to get depressed, and it's going to take a bit of time for your depression to begin to get better. I want to spend the next few sessions understanding how you spend your week and who you spend your time with. Tell me about your week.

Matthew: Not much.

Therapist: I'd like you to elaborate.

Matthew: Not much to elaborate. I didn't do much, didn't answer the phone, and didn't check emails.

Therapeutic Tip: What to do when the Veteran does not have much to talk about

When working with a Veteran who has Interpersonal Deficits, the therapist often encounters a situation that feels like "pulling teeth." The therapist has difficulty getting the Veteran to describe how and with whom. It is important to see this as further confirmation of the problem area of Interpersonal Deficits. The Veteran likely doesn't have much to discuss in session since he has not had an interpersonally active week. In IPT this is generally not thought of as resistance. The therapist's role is to help the Veteran understand that his lack of interactions is, in part, what is contributing to his depression. Aim for interpersonal gains that are small. The Veteran who has Interpersonal Deficits is not going to become a highly social person overnight and probably never will. Small gains may be enough to help the Veteran lessen his depression symptoms.

Therapist: As I've told you over the last few weeks, the work that we do in this office is based on what happens or doesn't happen to you when you are out of this office. You said that not much happened this week and that you didn't have much to do with anyone. I'd really like to know the specifics of your week. So I'd like to learn about what you did and about any people that you spent time with or talked with this week.

Matthew: (shrugs)

Therapist: Let's see, did you talk with your kids this week?

Matthew: No, they were busy this week.

Therapist: How do you know this?

Matthew: Got an email from their mother. But it didn't matter. I wasn't really up for getting together.

Therapist: You've also said that you miss your kids. I'm going to encourage you to see your kids, even though you don't quite feel up to it. I actually believe that this will begin to improve your mood. Before your deployments you had such a good time with them.

Matthew: Could be. I don't know. Sorry.

Therapist: No need to be sorry to me. I'm just trying to help us get an understanding of the connection between your depression and your isolation. You said that you don't feel comfortable around people because they don't get you. That is, they didn't experience what you did in combat, so you don't know what to talk about. Everything seems like small talk and a waste of time. Is that right?

Matthew: Yeah. That hasn't changed.

Therapist: The problem with that is that you are so isolated. You're not even seeing your kids. That concerns me. You're missing out on their growing up.

Matthew: I know but what should I do?

The therapist was careful to not to give advice that may have moved the session along, but would not have helped Matthew come up with his own plan.

Therapist: It's not for me to say, but I can help you come up with some plans that you might try. Okay?

Matthew: If you think so.

Therapist: I do. So, let's take a look at what you might do to spend some time with your kids. I know they are older than when you left for your second deployment, but what did you do with them then? That's when you all had fun together, right?

Matthew: I used to take them to a park near the lake. The baby was too young to do that but my older one liked it. We'd pack sandwiches and eat ice cream.

Therapist: Could you imagine doing that now?

Matthew: I'm pretty much a downer these days. I don't even know if I have the energy.

Therapist: I know, it's so hard when you're depressed to get up the energy to do what just might make you feel better. But I think it would help you if you could.

The therapist made the link between anti-depressant activity and improvement in mood. He did this many times throughout the session and in subsequent sessions.

Matthew: I don't know if their mother will let them go. She's pretty angry with me these days. She might not let me take them.

Therapist: You might be right but why don't we practice here how you might approach her.

The therapist began a modified Role Play with Matthew. Before beginning the practice, he began by having the Veteran consider what he wanted to get across, plus his timing, tone, and word choice.

Matthew: I know what she'll say. She'll say, "No."

Therapist: She might but let's try to see what you can say to her to get what you want. So let's start with when is the best time to talk with your ex-wife.

Matthew: No time.

Therapist: Well, let's take it from the other side. When's the worst time?

Matthew: That's easy. It's the morning. She's a real pain in the morning.

Therapist: So I'm guessing that would be the worst time to talk with her.

Matthew: I'd say so.

Therapist: I know you said she was difficult all the time but when would be a time that would be better than the morning?

Matthew: I guess the weekend. She's not busy getting to work and getting the kids to school.

Therapist: Now that you have determined the “when” in talking with her, let’s concentrate on what you want to communicate. Don’t worry right now about how you’ll say it, just what you want to get across.

Matthew: I want her to loosen up a little so that I can take my kids out with me.

Therapist: That seems clear enough. So now let’s focus on how to say it.

Matthew: I’m just gonna say that I want to get my kids and that she doesn’t get to control when I see them.

Therapist: You were clear but I’m guessing that if you say to your ex-wife what you just said, you wouldn’t get what you want.

Matthew: (laughing) I know. But she just makes me so mad. They are my kids.

Therapist: Do you know the expression, “Win the battle but lose the war?” I’m afraid that might happen if you approach her like this. How about a little less confrontational? It’s Saturday morning, you call her, and what do you say first?

Matthew: Probably should ask her how she is.

Therapist: Okay, go ahead. Let me hear you say that.

Matthew: This is embarrassing. I feel funny saying this to you.

Therapist: I know. I’m just here to act as a sort of coach. I’m listening for what might work. I don’t know your wife, but I know about what often works and what doesn’t. So I’d like you to keep trying.

Matthew: I guess I’ll say, “hello.” Then I’ll ask how she’s doing, and then I’ll ask to have the kids.

The therapist redirected Matthew to express what he would say rather than describing what he would say.

Therapist: Matthew, instead of telling me what you’d say, why don’t you say it to me as if I were your ex-wife?

Matthew: Okay. “Hey, it’s me. What’s up?”

Therapist: How would she reply?

Matthew: I think she’d be skeptical of my friendliness. She’d probably ask me what was going on.

Therapist: How would she say that?

Matthew: “What’s up with you? Why are you calling on a Saturday morning?”

Therapist: And your reply? Say it to me like I’m your ex-wife.

Matthew: “Just wanted to check-in to see if I could take the girls.”

Therapist: Let me stop you here to ask you how did that feel to you?

Matthew: Yeah, okay.

Therapist: To me it sounded clear, and you didn’t sound angry. How might she reply? Again, say to me what she would say.

The therapist continued with the modified Role Play until he and Matthew were satisfied that he sufficiently practiced. He got Matthew's agreement to try having a conversation with his ex-wife sometime before the next session. However, before ending the session the therapist built in the possibility that Matthew would not be successful in getting what he wanted from his ex-wife or that he would not ask her.

Therapist: It's almost the end of the session and it sounds like you have prepared yourself well for your conversation with your ex-wife. I just want to say that it is possible that you won't be successful or that you won't get a chance to speak with her. I just want to say that no matter what happens, please come back next week and we'll talk about this.

Matthew: Got it.

Sessions 5 - 8: During these sessions the therapist and Matthew continued to monitor his depression symptoms and mood, and to link these to his activity and connectedness to others. They focused on increasing his contact with his children, and looking for opportunities where Matthew could get involved with others. This was very slow going, which is not unusual for Veterans with Interpersonal Deficits. The therapist kept in mind that Matthew had said he felt like an outsider with most people because of his combat experiences, and that no one understood him. During these Intermediate Sessions the therapist also pointed out times when Matthew avoided others because he felt like an outsider. He also tried to get the Veteran to reconnect with men from his combat unit since Matthew expressed that he was more comfortable with them. When Matthew was successful in reaching out to others, the therapist talked with him about these efforts during the next week's session.

Session 8: In this session the therapist reminded Matthew that he was halfway through the treatment. He used this opportunity to further encourage the Veteran to reconnect with his military friends. This was something that Matthew had avoided during the first half of treatment. The therapist used the fact that only eight sessions remained to motivate him to take some risks in this area while also acknowledging how difficult socializing was for him. After checking on symptoms and mood, the therapist started session eight with the following dialogue:

Therapist: I want to remind you that this is our eighth session. We're halfway through our planned therapy. I know it's sometimes been difficult for you to follow through on things that we've worked on during our sessions. I'd like you to get as many opportunities to see your kids and to reconnect with some of your old friends - both military and non-military - while we still have time to talk about those experiences here. We only have eight more sessions. I'd like to see if you can...

Matthew: (Interrupting) I know. I have good intentions when I leave the office, but once I get home, I just have so much trouble. I really don't know what to do.

Therapist: First of all I want to tell you how much I respect your efforts. I understand how difficult it is to get reconnected. Your experiences while deployed make it so difficult for you to get back to your own life. I get that. I also know that if you keep at it, things may improve. That is, you will be able to get back to feeling more comfortable with people who have not had the military experiences that you've had. Since you have been having difficulty spending time with old friends, maybe it would be easier to start your socializing with Veterans who share some of your military experience. Maybe we could brainstorm about where you could meet other Veterans.

Matthew: Like what?

Therapist: I'd like us to put our heads together to come up with some possibilities for linking up with other Veterans.

Matthew: I don't know.

Therapist: I could come up with ideas but they would be my ideas and they might not be what you want. How do other Veterans get together?

Matthew: I guess here at this VA.

Therapist: You're right. There are lots of opportunities here to spend time with other Veterans.

Matthew: I don't want to be in any groups.

Therapist: Why not?

Matthew: I don't want to whine or to listen to other Veterans while they whine.

Therapist: Is that what you think happens in Veterans' groups?

Matthew: Yeah, just a bunch of guys complaining about their lives.

Therapist: That's not it. There are all sorts of groups including activity groups. And a lot of Veterans like the feeling of being understood by others in the group. After all, you've gone through similar circumstances. I have a pamphlet with some of the groups that we have here at the hospital. I'd like you to look over it this week and see what may interest you. If you can find something that might be of interest, I could help you sign up.

The therapist continued to encourage Matthew to find opportunities where he might make contact with other Veterans, and to maintain more regular contact with his children.

Session 9: In Session 9, the therapist picked up on the Work-at-Home from Session 8, which was for Matthew to read through pamphlets on VA groups that the therapist had given him the week before. In subsequent sessions, Matthew and the therapist continued discussing opportunities to socialize more with other Veterans. The therapist focused on helping Matthew explore what he still had in common with his non-military friends and how he might connect with them. Throughout these sessions the therapist also encouraged Matthew to continue seeing his children.

Therapist: Did you have a chance to look at the pamphlets this week about VA activity groups?

Matthew: I did, but I really don't want to go to any and I don't see how this would help me. Anyhow, I travel so much for work I won't have time to go.

Therapist: Let's talk about that. My big concern is that you're still depressed. You came here in part because after returning from deployment you were feeling lonely and disconnected from people. And you've had trouble finding opportunities to meet people. You don't feel like you have much in common with your old non-military friends. One place we know where you could meet people who've gone through similar experiences is at VA. That's why I'm encouraging you to just try. To improve depression you really need some connections with people.

Matthew: I know, you're right. I'm just lazy.

Therapist: It's not laziness. People who have depression find it very hard getting motivated to do anything. Given how depressed you've been, I'm impressed that you generally go to work.

Matthew: Nobody ever said that to me.

Therapist: So, let's think about one thing you can do at the VA in the coming week. Did you bring the pamphlets with you?

Matthew: I forgot them.

Therapist: I've got extra copies here.

Note: The therapist doesn't blame the patient for his lack of effort but rather frames it as a symptom of depression. However, the therapist keeps Matthew focused on how to find opportunities to socialize with other Veterans in the coming week.

Termination

Session 15: In Session 15 the therapist reviewed Matthew's depression symptoms and mood, what had brought him to treatment, his progress in treatment, the work he did that contributed to the reduction in his depression, and his feelings about termination.

Therapist: Hello, Matthew. Thanks for completing your second-to-last PHQ. I got out the PHQ that you completed in our first session. Do you remember what score you had then?

Matthew: Honestly I don't. I know I felt pretty bad.

Therapist: You had a 22. What do you think your score is today?

Matthew: It's lower today but I don't know the exact score. I know I've been feeling a little better. I don't feel better every day but overall I feel better.

Therapist: Today you got a 9. You're still depressed but you're right, your symptoms have decreased. Your mood rating has also improved too. I'd like to say that there isn't any magic to why your mood is better. You've worked very hard. Let's spend some time today talking about what brought you here and what changes you've made during your time here.

Session 16: In Session 16 the therapist encouraged the Veteran to keep the momentum going by seeing his children, and socializing with old and new friends. During this session the therapist talked with Matthew about his depression warning signs, future situations that might trigger another depression, and future treatment options.

Case Commentary

Matthew's experiences during deployment made him feel isolated and misunderstood by his family and friends. Typical social interactions seemed almost meaningless to him. He was irritable around anyone who had not had similar experiences. Through careful history taking and a thorough Interpersonal Inventory, the therapist ascertained that prior to his second deployment Matthew had more than adequate interpersonal skills and satisfying relationships with his then wife. He also had many friends with whom he spent enjoyable time. Therefore, the therapist did not need to build the Veteran's interpersonal skills. Instead he needed to help Matthew reclaim them. The therapist helped the Veteran to reconnect with a few former friends. He encouraged Matthew to see what they might still have in common. The therapist also helped the Veteran to spend time with others who may have had similar military experiences, including some men from his former unit. Throughout all phases of treatment the therapist emphasized how important it was for Matthew to see his children on a regular basis. By the end of treatment Matthew's depression had not resolved but some of his symptoms had decreased and his subjective mood rating had improved. Since Matthew had made some but not as much progress as he and his therapist had hoped during the 16 sessions, they decided to have him come in for monthly maintenance sessions. During the maintenance sessions the therapist would continue helping Matthew to find ways to increase his social involvement with other Veterans and with friends from his past.

Veterans with deficits often take longer than four months to make interpersonal changes substantive enough to sharply reduce symptoms of depression. Nonetheless, meaningful progress can be made within four months. Successful treatment of Veterans with IPT generally requires a combination of the establishment of small, reachable interpersonal gains combined with a hopeful, supportive therapeutic stance on the part of the therapist. For Veterans with Interpersonal Deficits who have not made sufficient progress, the 16-week IPT treatment may be extended for a limited period of time. During this extension, the Veteran continues working intensively on the problem area(s) that contributes to his depression. Monthly maintenance sessions may then follow. Alternately, if sufficient progress has been made after the acute treatment, time-limited monthly maintenance sessions may immediately follow to reinforce gains that have been achieved.

Problem Area: Interpersonal Deficits – Case Vignette: Will

Case Summary

Will is a 70-year-old, African-American, Vietnam Veteran with four grown children. His beloved wife of 40 years died one year ago after a prolonged illness. During the time of his wife's illness, Will provided considerable hands-on care and lost contact with friends. He is very disappointed that his oldest son avoided seeing his mother during her illness. Currently he has little contact with his oldest son and family and Will has limited contact with his other children who live out of town. He is depressed and socially isolated. Will wants contact with others but has avoided doing so. Friends have called him but he has not responded. Will was diagnosed with major depressive disorder, single episode, by his primary care physician who referred him to mental health. His depressive symptoms included anhedonia, sleep disturbance, decreased appetite with associated weight loss, irritability, discouragement, and difficulties with functioning. Like some older adults, he did not report feelings of depression but rather severe anhedonia.

Initial Sessions

Session 1: The therapist used the first session to take a complete mental health history since Will had never sought mental health services before. He reported feelings of grief following his wife's death that developed into a major depressive episode. He reported a solid history of occupation functioning and generally satisfying relationships with his wife and children. Throughout their marriage, his wife organized all social and family occasions. He was comfortable with this since he saw her role as mother and homemaker and his role as breadwinner. The therapist conducted the PHQ-9 with Will on which he scored 31 which is characterized as severe depression.

Will: I still don't know why I'm here.

Therapist: Your doctor was concerned about you. She first noticed changes in your sleep, appetite, and weight. She then asked you several questions – what we call a “depression screen” – which suggested that you might be depressed. Your doctor knew that your wife died a year ago and thought it would be helpful to talk with someone about these changes in your life and your mood.

Will: I'm not a talker. I took care of my wife when she was sick, she died, and now I'm alone. What's done is done.

Therapist: It sounds like you were dedicated to caring for your wife and I'm sure that her passing has affected you in so many ways. I know that for many people caring for a spouse can be stressful and losing a spouse is a very big change. Your doctor, who has known you for many years, felt strongly that it would be helpful for you to come and talk with me.

Therapeutic Tip: A referred Veteran does not feel he needs mental health services

Sometimes Veterans are referred to mental health care providers but are not clear why they have been referred, don't want to come, don't believe they are depressed, or don't believe mental health services will be useful. Motivational enhancement may be especially useful in helping the Veteran understand the impact of depression on his life and what he might gain by taking part in treatment. Even for those Veterans who have been engaged in motivational enhancement and who start IPT, reluctance to begin psychotherapy may remain. The Veteran's questions and concerns can often be addressed using psychoeducation within IPT.

Will: I like my doctor and that's the only reason I came. I don't think I'm depressed

Therapist: I appreciate your willingness to give this a try. Let's first talk about this questionnaire that you filled out. According to this questionnaire you scored a 31 which qualifies you for a diagnosis of depression. Let's talk about what that means especially since you don't think of yourself as depressed. According to this you feel sad all the time and can't snap out of it. Did I get that right?

Will: Yes.

Therapist: Nothing gives you satisfaction any more, you don't seem interested in being with people, and you find it hard to concentrate on things.

Will: It's not really true that I do not want to see people. I do want to see them but my wife always arranged things.

Therapist: Thanks for clarifying that and I think we'll be talking more about that. These and other things you circled on the questionnaire are symptoms of what we call depression, which has made it very difficult for you to do the things you need to do every day. There are many reasons that people become depressed and one of them is coming to terms with the death of an important person.

At this point the therapist was mindful of not prejudging what the IPT problem area would be although it appeared tied to the death of his wife. The therapist continued the session with further discussion of Will's symptoms and his reluctance to engage in psychotherapy. The therapist delayed discussion of treatments for depression, the functional impairment associated with depression, and the sick role until Session 2.

Session 2: Midway through Session 2 the therapist began the Interpersonal Inventory. After introducing the Interpersonal Inventory, Will said that he would first like to talk about his relationship with his wife.

Therapist: So tell me about your relationship with your wife.

Will: We got married right before I went to Vietnam. Going to Vietnam was hard. I didn't know if I'd ever come back. Lots of stuff was happening there and it was dangerous and really, really hot. Is that what you mean?

Therapist: Not exactly. I was interested in getting a better idea of your relationship with your wife – the ups and down, how you handled differences between, and what you would have liked to have been different.

Will described a generally good relationship with his wife with roles that were clearly defined. She cared for the children, the home, and initiated and maintained their social connections. He worked at a job he liked and was a good provider. He concluded his discussion about his wife by talking about how things began to change as his wife became progressively ill. This challenged him to take on responsibilities that were his wife's domain including cooking, cleaning, and shopping. He felt he did a pretty good job at these tasks but was not very good at keeping up connections with their children and their friends.

Therapist: I think I have a good beginning understanding of your relationship with your wife, including the time when she was dying. Is there anything else you think I should know about your relationship with your wife before we move on to talking about somebody else?

Will: No, it's really hard to manage things without her. I didn't realize she did so much.

Therapist: Who do you want to talk about next?

Will: Well, I guess I should talk about my son, Will. We call him Junior. I'm mad at him.

Therapist: Tell me more.

Will: He wasn't around when his mother was sick. He never called and he rarely came around even though he's not that far away.

Therapist: How did you get along before your wife became ill?

Will: He and his family would come over for Sunday dinner and holidays. My wife would cook. I don't know. She always arranged everything. After my wife got sick it just seemed like they never came around.

Therapist: Why do you think that was?

Will: I don't know.

Therapist: Looking back on your overall relationship with your son, what were some things about your relationship with your son you liked?

Will: We'd watch sports together while the women were making lunch.

The therapist continued talking with Will about his relationship with his son Junior. It appeared that prior to his wife's illness, Will was generally satisfied with this relationship but that his wife initiated all contact with his son and his family. In discussion about his relationship with his other children, the same pattern emerged. However, he did not express disappointment with the frequency of visits to his wife by his other children since they lived out of state. At this point the therapist was interested in whether Will had relationships outside of his immediate family. When he didn't spontaneously mention any the therapist decided she would ask about that in Session 3 when she completed the Inventory.

Session 3: The therapist began Session 3 by reviewing his PHQ-9 and mood rating. She then moved to completion of the Interpersonal Inventory.

Therapist: You've talked about your family but you haven't said anything about friends. Let's spend some time on that.

Will: I had some friends at work but I never saw them outside of work.

Therapist: Did you have any friends out of work?

Will: My wife handled all of that.

Therapist: When did she stop handling it?

Will: When she got sick.

Therapist: And then what happened?

Will: We mainly saw other couples. They still call sometimes but I'm not good at getting back to them. She was always the one who made the arrangements. Anyhow, we always saw them as a couple.

Therapist: Tell me about one couple you and your wife would see.

Will: Connie and Bob.

Therapist: Tell me about your relationship with Bob.

Will: I don't know, we always saw them together. My wife would make lunch and invite them over; and then his wife would make lunch and we'd go over there.

Therapist: What would you and Bob do when you were visiting?

Will: We'd eat dinner and then go watch whatever game was on television.

Therapist: What else?

Will: Talk about the work we used to do, things like that.

Therapist: Just to be clear. Your wife arranged these gatherings with Connie and Bob. Was that true with other couples too?

Will: Yeah, she was a natural about that.

Therapist: And what has happened with Connie and Bob since your wife died?

Will: Connie sometimes calls to see how I'm doing.

Therapist: And Bob?

Will: Never, he's just like me. He leaves it up to Connie.

The therapist finished the Inventory with Will. As she prepared to present the Interpersonal Formulation to Will, she considered two factors that may have contributed to the onset of his depression. The first was the death of his wife. Based on what the therapist learned from Will during history-taking and the Inventory, it did not appear that his depression developed from difficulties in the grief process. His feelings of grief were abating, he was not preoccupied with thoughts of his wife, he spoke of his wife in a way that seemed to acknowledge both positive and negative aspects of their relationship and – most importantly – the Veteran did not feel his symptoms were connected with his wife's death. The second was the social isolation he began to experience during his wife's illness and most profoundly since she had died. The Inventory underscored that he had almost exclusively relied on his wife to initiate and sustain relationships with family and friends. Now without her, he lacked the requisite interpersonal skills to make the social connections that he wanted.

Therapist: At this point, I'd like to talk to you about how I understand what has been contributing to your depression. First of all, let me restate that you do have depression. I know at first the label "depression" didn't make sense to you.

Will: Yeah, I wasn't going to kill myself or anything like that.

Therapist: No, you didn't have suicidal thoughts but many people who are depressed don't have suicidal thoughts. As you may recall, the symptoms that you do have are sadness, not interested or enjoying things, problems concentrating, weight loss, and problems with sleep. As we've discussed, those symptoms go along with a diagnosis of depression. Does this make more sense at this point?

Will: A little.

Therapist: At first I thought your depression might be connected to problems in coming to terms with your wife's death. But after talking with you, I realize the depression is connected to your lack of contact with family and friends. You're lonely. Your wife was the person who always reached out and connected you with family and friends. And now that she's gone, you've told me you don't know how to do that. Make sense?

Will: Yeah, but I'm just not good at that.

Therapist: This is just where we could start – helping you to get better at keeping in touch with people.

Will: You can't teach an old dog new tricks.

Therapist: I don't agree with you on that. I'm hopeful you'll make progress in learning the skills that will help you better keep in touch with people. As that happens, I would expect your depression to improve.

The therapist finished the session with a discussion of the treatment contract including expected attendance, arrangements for missed appointments, and a reminder to Will of the number of remaining sessions.

Intermediate Sessions

Sessions 4 - 7: During these sessions the therapist talked in detail with Will about how he spent his week and who he saw. A clear pattern emerged; friends reached out to Will but he was unresponsive. In attempting to clarify that, he said he "didn't know what to say" and it became even clearer that he had relied on his wife to handle social interactions. To obtain a clearer idea of

past relationship successes, she asked about his social functioning during his working years. It appeared that when he was in a structured social setting, Will felt more capable of and comfortable with interacting with others (e.g., he could talk about work and sports with his co-workers). Throughout these sessions, the therapist linked Will's depression to his social isolation.

Here is a dialogue from Session 7 in which the therapist helped Will develop some interpersonal skills he needed to respond to a dinner party invitation at the home of his friends Connie and Bob.

Therapist: A week ago, you had mentioned being ready to see friends. How's that going?

Will: Well, I don't know. Our friends, Connie and Bob, called and left a message on the answering machine about three days ago asking me to come over for dinner. Then they left another message and I didn't call them back. I don't know what to say.

Therapist: Is this the sort of thing your wife used to take care of?

Will: She took care of everything. They want me to come over for dinner. We never went over to their place for dinner. It was always too late for us. So we went for lunch. Bob and I would watch the game and my wife and Connie would talk. We'd eat and that was it.

Therapist: Will, let me ask you something. Do you want to go over to Connie and Bob's?

Will: I like them but I don't know... It gets even worse. They said there would be other people there.

Therapist: Before we get to that let me clarify something. You've been saying that you feel pretty lonely. So let's not worry about whose going to be at dinner, but would you like to see Connie and Bob?

Will: Yeah, I would like to but this is not the way we used to do it.

Therapist: Right, this is a change.

Will: It is.

Therapist: Maybe we could work here on how to get you prepared for that. But I just want to be clear. You do want to see them, right?

Will: Yeah.

Therapist: And you'd prefer it to be in the afternoon like in the old days?

Will: Yeah

Therapist: And if you felt more prepared would you be willing to experiment with going there?

Will: I guess so, but I don't know how to prepare.

Therapist: I think the first thing is the response to the phone call.

Will: I know. I haven't called them back. They've called me twice.

Therapist: And you know, it clearly tells me they want you there.

Will: They do.

Therapist: What would you say on the phone call?

Will: I don't know. "OK, I'm coming." (with an exasperated tone)

Therapist: Like that?

Will: Maybe not like that.

Therapist: One of the things that people do when they get invitations is that they say something about how pleased they would be to come over. There is some sort of expression of gratitude for being invited. Can you think of a way you might say that?

Will: Well... "thanks for inviting me. I'll come over."

Therapist: That sounds good to me. When you and your wife used to go over for those lunchtime get-togethers, did you bring something?

Will: I didn't, my wife did. She knew how to cook. I don't know how to cook. I'm eating take-out food now.

Therapist: So she was the person who took care of that part. Do you know how I knew how to ask that?

Will: No.

Therapist: Because generally when people get together the person coming over will say, "Is there something I can bring?" Or they will make a suggestion about something they could bring. I didn't know your wife. I just generally know that's what people do. So is there something easy that you could bring?

Will: I could bring dessert. It would be easy to just pick something up.

Therapist: That's a good idea. So maybe you could ask Connie, when you return the phone call, if you could bring desert. Alright?

Will: Yes.

Therapist: Sounds good. Do you think you could make that phone call?

Will: It's been three days since they last called. If I don't call now they probably won't call again. I'll call tonight.

Therapist: That sounds good. Again, I hope you can do that. Next week when we meet, we can talk about it. If by chance you didn't do it, we could talk about what got in the way. If you did it, we can talk about how it went. It sounds like you might be anxious but you can handle it.

Will: Yeah, just got to make the call.

Session 8: In this session the therapist followed up on Will's Work-at-Home to see how successful he was in accomplishing his task. The therapist continued working with the Veteran to build his interpersonal skills. The therapist knew from earlier sessions that it was difficult for Will to generate options. Unlike many patients, she found that what worked for him was to offer a suggestion and then have him weigh the pros and cons of that. This is an excerpt from the middle of the session.

Therapist: Will, I'd also like to follow up on the conversation that you had with Connie this week. You made the call, but now you're faced with your anxiety about going to dinner.

Will: Right, it's tomorrow night.

Therapist: Well good, because we have a chance to prepare a little bit. Did you learn anything from Connie about the dinner?

Will: Yeah. There will be two more couples, who I know, but my wife and I never got together with them.

Therapist: So there will be seven people?

Will: Yes, I might be the third wheel there.

Therapist: So that might be another time you miss your wife, right? Is that why you think you'll feel like a third wheel?

Will: That and I just don't know what to say.

Therapist: Well, let's talk about that.

Will: When we would get together with people, my wife was the talker. I'm not a talker. I don't know what to say. I just like to go and watch a game with somebody and let them talk.

Therapist: And this is definitely that kind of situation where there won't be a game on, right?

Will: No.

Therapist: You'll be sitting around a table for dinner?

Will: Yes. I don't know what to talk about.

The therapist helped the Veteran to prepare for some possible conversations that he might have at the dinner party. She also let the Will know that he was not alone in feeling anxious at such a gathering.

Therapist: Will, let's come up with some ideas. What you are saying makes sense. I don't know if you know this, but a lot of people get anxious before they go to a get together. Did you know that?

Will: No. I just assumed I was the only one.

Therapist: Well, I understand that you feel that way. But I'm here to say to you that you are not alone. And you know, one of the things that could be very helpful would be to have a couple of topics in mind that you could talk about. You might not use these topics if things go smoothly but you'll know that you always have them in your back pocket. Have you ever heard this expression, "people just talk about the weather"?

Will: Yeah.

Therapist: I actually think that's not a bad idea to have the weather in mind especially if there has been some big weather event – like that hurricane two weeks ago. So, do you think you could prepare to have something in mind?

Will: I can talk about the weather. But you know what? One of those guys is a Vet.

Therapist: So, I would guess that you have a lot to talk about with him. Do you have anything in common with him from your military days?

Will: Yeah, but I don't want to talk about the war.

Therapist: I see. So it's not a topic you want to get into. I'm just thinking about some other easy topics. When you hang out with Bob, what do you mainly talk about?

Will: Sports.

Therapist: Well, isn't that something you could talk about with the others?

Will: I don't think the wives want to talk about sports.

Therapist: I don't know about that but do you think the others might?

Will: Yeah we can talk about sports.

Therapist: Again, I'm just thinking about topics that you could put in your back pocket. In case you don't know what to talk about you can pull those out. You really follow sports?

Will: Yes, I do.

Therapist: So that would be an easy topic for you. You know the teams, who's winning, who's losing. Does that make you nervous to talk about?

Will: No, I know about that.

Therapist: I'm wondering about another topic. Do the people there have adult children?

Will: Yeah.

Therapist: Is that a topic that would be easy to talk about?

Will: The women always want to talk about their children. I don't want to talk about my children. I'm mad at them.

Therapist: That's right. So that wouldn't work for you.

Will: I don't care if they talk about their children.

Therapist: If they do start talking about their children, are there any questions that you might have in mind to ask?

Will: Yeah. Sure. "How are your kids?"

Therapist: That's a good general topic, I think. What about any follow up after that?

Will: I can't think of anything.

Therapist: Some people love to talk about their grandchildren. Do any of those people who will be at the party have grandchildren?

Will: I could ask them about their grandchildren. I could even talk about my grandchildren. I'm not mad at them.

Therapist: So now you have a few topics to talk about at the get-together.

Sessions 9 - 14: In session nine the therapist reviewed the visit at the home of Connie and Bob. Will said that things went better than expected. The therapist noted that his mood had improved and the therapist made a link between that improved mood and the satisfying visit with Connie, Bob, and friends. In subsequent sessions, they built on that success to slowly increase the number of social contacts concurrent with further development of his social skills. Will arranged to see Bob for coffee. He invited a former work colleague to go to a sporting event. And he made efforts to respond more quickly to phone messages. Notably, he contacted his oldest son who asked if he wanted to see the grandchildren at the son's home. Will enjoyed the visit but still felt resentful about his son's perceived lack of involvement during Will's wife's illness.

Termination

Session 15: Prior to Session 15, the therapist printed out a graph of all of Will's PHQ-9 and mood ratings scores over the course of treatment. She used the graph as a jumping off point in Session 15 to discuss improvement in his symptoms and mood.

His PHQ-9 score declined from 31 to 20. His subjective mood rating improved from 8 to 4. They discussed the meaning of changes in scores. The therapist noted that while he still was experiencing depressive symptoms he had demonstrated significant improvement. The therapist encouraged Will to discuss the issues that brought him into treatment, what skills he had learned, and his feelings about termination.

Session 16: The therapist began the session with further discussion of Will's feelings about ending therapy. He said that he was relieved that he didn't have to make the hour's drive to the VA clinic for weekly sessions but that he found the sessions more helpful than he originally thought they would be. He remarked, "I actually learned something." The therapist asked what he had, in fact, learned. Will said that he learned that he actually was depressed, that his wife had always made connections for him with family and friends, and now that she was gone he needed to make some effort himself to reach out to people. Will said that he found it really helpful when the therapist practiced what he would say to other people. The therapist emphasized that he was now increasingly figuring that out by himself. She pointed out some examples of what he had done. The therapist then asked Will to identify "warning signs" that he was becoming depressed again. "I stop responding to phone messages. I know that's it." The therapist emphasized that he needed to be on alert for that. In exploring future issues that might trigger depression, Will said that he was still mad at his son. The therapist felt that this was an important issue for which Will had begun to make some progress. The possibility of monthly maintenance treatment was proposed to Will, to address concerns about his relationship with his son and also to continue to strengthen his connection with others.

Case Commentary

Sometimes the death of a parent, or partner/spouse, or even a divorce, reveals that the Veteran had relied on the "invisible" hand of that individual to initiate and sustain connections. After death or divorce, Interpersonal Deficits are more fully evident in a Veteran who becomes increasingly socially isolated despite his desire for contact. Loneliness may lead to depression that then makes it even less likely the Veteran will make efforts to engage others. In the case of death of a parent or spouse/partner, the therapist might prematurely judge that the depression is tied to the death when, in fact, the depression driver is underlying Interpersonal Deficits. A carefully conducted history and Interpersonal Inventory will be especially helpful in determining whether Grief vs. Interpersonal Deficits will be the focus of IPT.

Will had functioned well in his life. He achieved occupational success and had a good relationship with his wife and children. His wife's illness and death revealed that she played a critical role in facilitating relationships with their children and friends. After her death, he was unresponsive to others' efforts to engage him. In part, his lack of responsiveness reflected grieving but also Will's lack of ability to navigate social interactions. He became increasingly isolated, lonely, and then depressed. Once depressed, it became even more difficult for him to reach out to others including his children and friends. The first hurdle for the therapist was to motivate and educate Will about treatment. The focus of treatment was on Interpersonal Deficits. In the Intermediate Sessions they worked together to build his interpersonal skills so as to reduce his social isolation. By the end of treatment, Will had made substantive progress although his PHQ-9 indicated he still had notable symptoms of depression. Toward the end of treatment, he had just begun to address ongoing disappointment and anger with his eldest son. The therapist suggested that he engage in monthly maintenance IPT to improve his relationship with his son, continue development of interpersonal skills, and further reduce his depressive symptoms.

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Glossary

Bi-directional link: Therapeutic efforts to help the Veteran understand the reciprocal relationship between interpersonally relevant events and depressive symptoms/mood.

Communication Analysis: An IPT technique used to help the Veteran understand what is conveyed in interpersonal communications and impact of communications on others and self, in service of improving Veteran’s ability to improve interpersonal behavior.

Decision Analysis: An IPT technique to help the Veteran think through a course of action to deal with an interpersonally relevant problem; elements of Decision Analysis include identify a current problem, review options to deal with the problem, think through advantages and disadvantages of different options, and make a choice of preferred option.

Grief: One of the four IPT problem areas that reflects difficulties coming to terms with the death of another person such as death of a spouse/partner, child, friend, or fellow service member; clinically referred to as “complicated bereavement.”

Initial Sessions: The first phase of IPT (sessions 1 – 3) that includes history taking, psychoeducation about depression, assignment of the sick role, the Interpersonal Inventory, Interpersonal Formulation, and treatment contract.

Intermediate Sessions: The second phase of IPT (sessions 4 – 14), during which the clinician implements strategies and relevant IPT techniques to accomplish goals associated with the problem area(s) identified for the Veteran.

Interpersonal Deficits: One of the four IPT problem areas that reflect a Veteran’s difficulties in initiating or sustaining relationships.

Interpersonal Formulation: A summary to the Veteran about the likely link between interpersonally relevant life events and current depression, establishment of the problem area(s) and treatment goals, and discussion of the plan for treatment.

Interpersonal Inventory: A broad review of current/past important relationships, whether positive or negative, in which the clinician assesses differences in expectations between the Veteran and others, and any desired changes in those relationships.

Interpersonal Role Disputes: One of the four IPT problem areas that reflects conflicts with another person, examples of which include longstanding disputes with spouse/partner, onset or exacerbation of conflict after return deployment, conflict with employers, and conflict with VA and military.

Interpersonal Skills Building: An IPT technique used to improve the Veteran’s ability to communicate with others, elements of which include finding an optimal time for discussion, using “I” statement, focusing on a specific issue, clarifying expectations, and exploring options for initiating an important conversation.

Psychoeducation: The provision of information about depression including its characterization as a medical illness, adverse impact on functioning, usual treatments, and likely favorable outcome when treated.

Maintenance IPT: Less frequent (usually monthly) IPT that builds on the principles and skills learned during the course of “acute” weekly IPT.

Motivational enhancement: Non-directive techniques based on the principles and strategies of Motivational Interviewing that are designed to promote the Veteran’s intrinsic motivation to change and recognize the value of engaging in treatment. Motivational enhancement typically involves the use of open-ended questions to help the Veteran recognize the need for and potential benefit of IPT.

Role Play: An IPT technique in which a Veteran enacts a recent or planned conversation with another person to help understand his own behavior and feelings as well as those of the other person; efforts are in service of interpersonal problem resolution.

Role Transitions: One of the four IPT problem areas that reflects a major life change for the Veteran such as return home from active duty, resumption of parenting role after deployment, physical or mental injury, and assumption of the caregiving role in later life.

Sick role: A concept derived from sociology that describes societal norms that accept temporary reprieve of responsibilities when an individual is contending with a medical illness.

Stage of dispute: A characterization of the interpersonal dynamics of a current dispute including renegotiation (ongoing, heated conflict in which both parties are emotionally engaged), impasse (emotional disengagement in which one or both parties are resigned to unsatisfactory relationship), and dissolution (consideration by one or both parties that relationship cannot be improved and should likely end).

Suicide safety plan: Clinical efforts to lower imminent risk of suicidal behavior that includes a prioritized, written list of coping strategies and resources that can be used before or during a suicidal crisis.

Symptom monitoring: Weekly efforts to assess the status of the Veteran's depression-related symptoms including use of the PHQ-9 and patient reported mood.

Termination: The third and final phase of IPT (sessions 15-16) during which the clinician engages the Veteran in a discussion of feelings related to ending therapy, changes in depression, and in identified problem area(s) over the course of therapy, warning signs of depression and possible future triggers, and possible need for further treatment including maintenance IPT.

Treatment plan: Identification of the problem area(s) that will be the focus of treatment, goals of treatment, structure of format of IPT, and expectations about Veteran's involvement in psychotherapy.

Work-at-Home: In between session efforts by the Veteran to actively address issues associated with the IPT problem area(s).

