JYU DISSERTATIONS 197

Jarmo Kontunen

# Therapeutic Change in Interpersonal Counselling (IPC) for Depression

## A Mixed Methods Study of Primary Health Care Patients

UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF EDUCATION AND PSYCHOLOGY

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## A Mixed Methods Study of Primary Health Care Patients

EEsitetään Jyväskylän yliopiston kasvatustieteiden ja psykologian tiedekunnan suostumuksella
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in building Ruusupuisto, lecture hall D104 Helena, on March 6th 2020 at 12 o´clock noon.

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# ABSTRACT

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The aim of this research was to optimize the use of effective treatment for patients with depressive disorders in primary health care. The dissertation examines whether brief treatment, Interpersonal Counselling (IPC), is appropriate for treating depression, and which are the factors that may influence a positive response to this counselling. This thesis consists of three studies based on the same patient sample which was viewed on three levels: In Study I, 40 patients with a diagnosis of major depressive disorder (mild or moderate) were randomized into two groups, 20 of them receiving IPC (7 sessions) and 20 a comparable treatment modality, Interpersonal Psychotherapy (IPT) (16 sessions). Statistical analysis showed that IPC delivered by mental health nurses in primary health care was comparable to IPT in secondary care. Approximately 60% of the patients had recovered by the time of the 12 months follow-up in both groups. Study II considered five IPC patients who had recovered and five who remained unchanged. Qualitative content analysis and applied conversation analysis (CA) of the case formulation process and its content in the initial phase of IPC suggested three core conditions for recovery from depression: joint construction of the problems by the patient and counsellor, the ability to restrict the scope to one problem area and the availability of social support from close relationships outside the treatment. In Study III the analysis of a recovered case indicated how IPC's interpersonal formulation approach and the focus within an IPC framework were able to guide the patient away from her self-accusation talk towards discussing her problematic relationship with her spouse. Overall, the results presented here have important clinical and organizational implications and support the conclusion that a significant proportion of major depressive disorder patients can be treated with brief treatment in primary care. Training front-line health care workers in psychotherapeutic skills could close the gap between mental health needs and access to care.

*Keywords:* depression, interpersonal counselling, IPC, interpersonal therapy, primary health care, case formulation, multiple case study, content analysis, conversation analysis, theory-building case study, Clinical Outcome in Routine Evaluation – Outcome Measure, CORE-OM

# TIIVISTELMÄ (FINNISH ABSTRACT)

Kontunen, Jarmo
Interpersonaalisen ohjannan (IPC) aikaansaama terapeuttinen muutos masennuksen hoidossa: Monimenetelmällinen tutkimus perusterveydenhuollon potilailla
Jyväskylä: Jyväskylän yliopisto, 2020, 95 s.
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Tämän tutkimuksen tarkoituksena oli tehostaa masennukseen hoitoa perusterveydenhuollossa. Väitöskirjassa tutkittiin, voiko lyhyt interpersonaalinen ohjanta (IPC) sopia masennuksen hoitokeinoksi ja mitkä tekijät vaikuttavat positiiviseen tulokseen tässä ohjannassa. Väitöskirjan tutkimusaineisto ja sen kolme osatutkimusta perustuivat yhteen potilasotokseen, jota tarkasteltiin kolmessa tasossa: Ensimmäisessä osatutkimuksessa 40 masennusdiagnoosin (lievän tai keskivaikean) saanutta potilasta satunnaistettiin kahteen ryhmään, joista 20 sai IPC:n mukaisen hoidon (7 käyntiä) ja 20 vertailuhoitona interpersonaalisen psykoterapian (IPT) mukaisen hoidon (16 käyntiä). Tilastollinen analyysi osoitti, että mielenterveyden hoitoon perehtyneiden sairaanhoitajien toteuttama IPC perusterveydenhuollossa oli verrattavissa tuloksiltaan IPT:aan erikoissairaanhoidossa. Noin 60 % potilaista oli toipunut 12 kuukauden seurannassa molemmissa ryhmissä. Toisessa osatutkimuksessa tutkittiin tarkemmin viittä toipunutta ja viittä ei-toipunutta IPC:n mukaisen hoidon saanutta potilasta. Laadullinen sisällön analyysi ja sovellettu keskusteluanalyysi hoidon alkuvaiheen tapausjäsennyksistä viittasivat siihen, että masennuksesta toipumista edisti kolme keskeistä tekijää: potilaan ja hoitajan yhdessä rakentunut ongelman määrittely, kyky rajata ongelma-alue yhteen ongelma-alueeseen ja potilaan mahdollisuus saada sosiaalista tukea läheisiltään. Kolmannessa osatutkimuksessa näkyi, kuinka IPC:n mukainen tapausjäsennys ja pitäytyminen IPC:n mukaisessa toimintatavassa ohjasi potilasta pois itsesyytöksistä ja auttoi häntä puhumaan ongelmallisesta suhteestaan puolisonsa kanssa. Kokonaisuudessaan tässä esitetyillä tuloksilla on merkittäviä kliinisiä ja organisatorisia seuraamuksia ja ne tukevat päätelmää, että merkittävä osa masennuspotilaista voidaan hoitaa lyhythoidoilla perusterveydenhuollossa. Hoidon etulinjassa toimivien terveydenhuollon työntekijöiden kouluttaminen psykoterapeuttisten taitojen käyttöön voisi täyttää hoidon tarpeen ja hoidon saatavuuden välistä kuilua.

*Avainsanat:* masennus, interpersonaalinen ohjanta, IPC, interpersonaalinen terapia, IPT, perusterveydenhuolto, tapausjäsennys, monitapaustutkimus, sisällön analyysi, keskusteluanalyysi, teoriaa kehittävä tapaustutkimus

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I feel particularly honoured to have Docent Matti Huttunen, and Docent Olavi Lindfors, as the official reviewers of this thesis. I am also indebted to the Department of Psychology for the opportunities it has given me for learning psychotherapy research and I would personally like to thank the present head, Professor Juha Holma, and Senior Lecturer Aarno Laitila, and Professor Emeritus Jarl Wahlström whose fellowship and professional careers have inspired me to continue my scientific endeavours.

The current work began in 2010 in the Itä-Savo Hospital District where the contribution of its chief physician, Timo Liukkonen, was invaluable for the production of this thesis. My interest in studying interpersonal psychotherapy began in 1996 in the South-Savo Hospital District, where the influence of its medical director, Pekka Ruohonen, and Professor Hannu Koponen was pivotal in the early years of my career as a psychologist.

I would like to say how genuinely privileged I feel to be as a co-author with talented research collaborators, such as Professor Markku Timonen, qualitative health care researcher Elina Weiste, and statistician Joona Muotka who have given me unfaltering support throughout this project. My warmest thanks go to psychologist Maarit Jokivirta who conducted the follow-up interviews with the counsellors, and to Malcolm Hicks for checking the English language of the entire contents of this thesis and its contributory papers. I would also like to acknowledge two leading experts in the field of psychiatry and interpersonal psychotherapy, Professor John Markowitz and Professor Myrna Weissman of Columbia University, New York, who have put time and effort into giving me their valuable comments on the manuscripts of the papers. Grateful thanks go to Associate Professor Klaus Ranta, Professor Mauri Marttunen, adolescent psychiatrist Tarja Koskinen, group psychotherapist Riitta Pelkonen, and psychologists Pauliina Parhiala and Viivi Kaivolainen for involving me in research into adolescent psychiatry and school health care.

I am deeply grateful to the patients who generously shared their therapeutic process with us, and to the nurses Marja Kunttu, Minna Laasonen, Maini Laukkanen, Eija Mutikainen, Sirpa Pakarinen-Ahonen, Eija Pekonen, Kaarina Pulkkinen, Pia Räihä, Ulla Seppänen and Merja Tissari, psychologists Anne Niittykoski and Taina Tiihonen and psychotherapists Anne Törmikoski and Anneli Viinikainen who made this study possible by recording their sessions for us. Their therapeutic discussions have touched me, and I have learnt a lot from them.

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Mikkeli, December 2019

Jarmo Kontunen

## LIST OF ORIGINAL PUBLICATIONS

I Kontunen, J., Timonen, M., Muotka, J., & Liukkonen, T. (2016). Is interpersonal counselling (IPC) sufficient treatment for depression in primary care patients? A pilot study comparing IPC and interpersonal psychotherapy (IPT). *Journal of Affective Disorders, 189*, 89 – 93. DOI: 10.1016/j.jad.2015.09.032.

II Kontunen, J., Weiste, E, Liukkonen, T., Timonen, M., & Aaltonen, J. (2019). Predicting response to interpersonal counselling (IPC) from case formulation: A qualitative comparison between recovered and unchanged depressive cases. *Counselling Psychology Quarterly*. Published online: 20 Mar 2019. DOI: 10.1080/09515070.2019.1588101.

III Kontunen, J., Liukkonen, T., & Aaltonen, J. (2019). Mechanisms of change in interpersonal counselling (IPC) for depression: A theory-building case study. Submitted manuscript.

Taking into account advice from the co-authors, the author of the present thesis wrote the original research plan, planned the interventions and conducted all parts of the qualitative and quantitative analyses as a principal investigator, and wrote the reports of the three publications.

## FIGURES



## TABLES

## LIST OF ABBREVIATIONS

Diagnostic evaluation:

| | |
|---|---|
| DSM-IV | Diagnostic and Statistical Manual of Mental Disorders, 4th edition |
| M.I.N.I. | Mini International Neuropsychiatric Interview |

Outcome measures:

| | |
|---|---|
| BDI | Beck's Depression Inventory-21 |
| CORE-OM | Clinical Outcome in Routine Evaluation – Outcome Measure |
| GHQ-12 | General Health Questionnaire |
| MÅDRS | Montgomery–Åsberg Depression Rating Scale |

Transcription symbols:

| | |
|---|---|
| [ ] | Overlapping talk |
| (0.0) | Pause: silence measured in seconds and tenths of a second |
| .hh | An in-breath / hh An out-breath |
| (h) | Laughter particles |
| ((word)) | Transcriber's comments |

# CONTENTS

# 1 INTRODUCTION

"The field of psychiatry is the field of interpersonal relations, under any and all circumstances in which these relations exist – a personality can never be isolated from the complex of interpersonal relations in which the person lives and has his being."(Sullivan, Conceptions of Modern Psychiatry, 1953)

The treatment methods to be studied here are Interpersonal Psychotherapy (IPT) and Interpersonal Counselling (IPC). The founders of IPT, Gerald Klerman and Myrna Weissman, acknowledged the importance of Sullivan and his interpersonal school in their development of the time-limited and structured IPT concept (Klerman, Weissman, Rounsaville, & Chevron, 1984). Sullivan's thinking as such was based on the role of social forces in the formation of mental illness, as confirmed by discussions with the cultural anthropologist Edward Sapir and the philosopher, sociologist and social psychologist George Herbert Mead (Evans, 2006). Sullivan (1953) viewed psychiatry as the detailed study of the communication processes which go on among people. He focused on direct and verifiable interactional behaviour rather than the intrapsychic aspects and stated explicitly in his writings that the goal of psychotherapy is the facilitation of interpersonal learning. It is interesting with respect to the history of psychotherapy that Sullivan proposed a brief psychotherapeutic approach in some situations as early as 1927 (Evans, 2006). Sandor Ferenczi and Otto Rank also started to develop a more active and time-limited form of psychotherapy in the 1920s, during an era when the psychoanalytic ideal was encouraging longer and longer analyses. It was not until the 1960s and 1970s, however, that Davanloo, Sifneos, Malan, Luborsky, Mann, Strupp and Klerman disseminated a set of brief psychodynamic psychotherapies for clinical use (see also, Demos & Prout, 1993).

The initial roots of this research came in practice from the medical meetings held by Professor Hannu Koponen at Moisio Psychiatric Hospital, Mikkeli, Finland, in 1996. The topic of one meeting was interpersonal psychotherapy (IPT) and those present were amazed at the power of this outwardly simple approach to the treatment of depression. I had previously been trained as a psychodynamic psychotherapist and I personally felt that IPT would be a plausible treatment

method for use at an outpatient clinic. We therefore introduced IPT in outpatient care by training 7 therapists to use its manual (Klerman et al., 1984) in eight bimonthly seminars and eight peer supervision meetings at which cases were discussed (Löyttynen, Koponen, Kontunen, Lehtonen, & Marttunen, 2008). This research project was a success in that 59 out of the 66 patients who received this therapy completed the 6-month follow-up period and the therapists were satisfied with the method and intended to use it in their clinical work in the future. Six months after the baseline, 72% of the patients were approaching the remission thresholds on the Montgomery–Åsberg Depression Rating Scale (MÅDRS) (Montgomery & Åsberg, 1979). After these self-motivated IPT experiences, we attended IPT didactic seminars given by John Markowitz, M.D., in Turku, Finland, who also provided training in the supervision and teaching of IPT for the members of our IPT association in Finland.

When I was teaching and supervising IPT in the East-Savo Hospital District in Savonlinna, Finland, Marja-Riitta Nilsson Kälviäinen, M.D. and Timo Liukkonen, M.D., Ph.D., raised the question of how this method could be adapted for use in a primary health care setting, which is where the majority of mild to moderate cases of depression first present themselves (Timonen & Liukkonen, 2008). Together with Professor Markku Timonen, they proposed a research project focused on brief psychological interventions that could easily be disseminated in a primary health care setting. This kind of research project appeared timely and addressed a real and urgent clinical need. We clearly needed more structured and time-limited forms of treatment to address the gaps between need and access, and between the existing treatment guidelines. These discussions also convinced me of the importance of performing psychotherapy in the front-line mental health services. I offered to provide primary care staff training in interpersonal counselling (IPC), which had been developed from interpersonal psychotherapy (IPT), and had been a promising, but as yet very little used intervention for the treatment of the acute phase of depression in primary health care (Weissman & Klerman, 1993). We started the research project in 2010, by recruiting participants from among those seeking treatment at primary health care units in the East-Savo Hospital District.

The aim of this research was to improve our understanding of ways to optimize effective treatment for patients presenting with depressive disorders in primary health care settings. This thesis was originally designed to answer three practical questions:

1. Is a short form of interpersonal counselling (IPC) appropriate treatment for depression in primary care patients?
2. Which moderating factors associate with recovery?
3. What might be the change mechanisms (mediators) that account for symptom change in response to IPC?

## 1.1 Current evidence for inconsistent treatment of depression

Early interventions for depressive symptoms can alleviate human suffering and reduce the cost of depression to society, but unfortunately such interventions are still poorly disseminated in society (Mihalopoulos & Chatterton, 2015). This chapter will discuss the discrepancies between the prevalence of depression, recommended depression guidelines and the unmet need for efficacious psychotherapies in primary care.

### 1.1.1 Depression as the leading cause of disability worldwide

According to the World Health Organization (2017), depression has become the leading cause of ill health and disability worldwide in recent years in terms of the number of disability-affected life years (DALY), and it has also become more common in Finland, the prevalence of those with significant depressive symptoms having grown from 9 to 13 percent among females and from 6 to 9 percent among males between 2011 and 2017. Within the year 2017 alone, 8 percent of women and 6 percent of men had been diagnosed with or treated for depression by a physician (Finnish Institute for Health and Welfare (THL) (2018). Research has shown that depression causes an even greater deterioration in health status than major chronic diseases such as arthritis, asthma, diabetes or coronary disease (Moussavi et al., 2007). According to recent Finnish reports, 3,500 new disability pensions due to depression were granted in 2018, the highest incidence of depression-related pensions being among middle-aged professional women (Finnish Centre for Pensions, 2019), while the total number of disability pensions for depression was approximately 36,000 and the total costs over 600 million euros (Finnish Centre for Pensions, 2018). Depression is also associated with significant excess mortality (Gilman et al., 2017) and markedly elevated suicide mortality (Cho, Na, Cho, Im, & Kang, 2016).

The explanations given for the increase in depression are somewhat contradictory. It is possible that stress factors associated with modernity may contribute to this rise (Sarris, O'Neil, Coulson, Schweitzer, & Berk, 2014) in that the modern accent on quarterly economic figures may consume so much energy that even mild depression can cause disability; i.e. our urban life subjects us to such constant streams of information that our "biological clock" may not be able to follow the naturally determined circadian rhythm. This has been pointed out as a critical modifier of mood-related behaviour and a source of affective disorders such as depression (McClung, 2011). Sleep disturbances are frequent symptoms of depression, and long-term poor sleep increases the risk of disability retirement due to depressive disorders (Paunio et al., 2015). Urban loneliness is also a growing problem in industrialized countries (Cacioppo & Cacioppo, 2018). The increase in the proportion of single-occupant households may detract from community participation, and individuals may perceive themselves to be socially isolated, even when living close to other people.

### 1.1.2 Depression guidelines and psychotherapy

The depression guidelines followed in Finland (Finnish Current Care Guidelines: Depression, 2020) recommend the use of brief periods of psychotherapy with antidepressants as the initial treatment of choice for patients with mild to moderate major depressive disorder. The majority of depressive patients should be treated in primary care, where the development of psychiatric consultation services and the use of nurses as case managers have been recommended. Early identification and treatment of depression in primary health care can alleviate human suffering and also reduce the cost of depression to society. Although the cost-effectiveness of depression treatment modalities is difficult to demonstrate, there are indications that this cost-effectiveness may be improved by tailoring psychotherapies to the needs of individual patients and by employing trained nurses to provide them rather than trained psychotherapists working in the secondary care sector (Bosmans et al., 2008).

Guidelines for the treatment of depression typically involve a stepped care treatment model. This is defined as a framework in which the provision of services is organized into a hierarchy of interventions from the least intensive to the most intensive, matching the individual's needs (NICE, 2009). When working with people with depression, building a relationship of trust and working in an open, engaging and non-judgemental manner should form the basis, and this will ensure a satisfactory therapeutic alliance. Recognition, assessment and initial management are needed as the first steps, after which the choice of treatment should be based on the subtypes of depression and the patient's personal characteristics. Medication should not be provided as the only intervention but as part of a more complex intervention. According to the guidelines, psychosocial interventions should be based on a structured and time-limited treatment manual. An intervention should contain outcome measures and ensure that the person with depression is involved in reviewing the efficacy of the treatment. When using a manual, practitioners should also receive regular high-quality supervision.

Notwithstanding that the depression guidelines highlight more sophisticated treatments, mental health services are far from objective in actual fact. The most common intervention for depression is the prescribing of antidepressant medication alone, as was found by Vuorilehto, Melartin, Riihimäki and Isometsä (2016) in their Vantaa primary care depression study. One-half of the patients were offered some type of psychosocial treatment, but the adherence to these interventions was poor. Limited monitoring of the treatment and the lack of systematic follow-up by doctors were also common shortcomings with regard to the continuity of treatment. The guidelines have been criticized as being simplistic in their conception of depression and in their provision of "one-size-fits-all" recommendations. These recommendations restrict themselves to randomized controlled trials and override patient preferences and naturalistic trials of treatment modalities, which could represent better forms of treatment in the real world (McQueen, 2009).

### 1.1.3 The unmet need for psychotherapy in primary health care

The dissemination of psychotherapies is still underutilized and the training of community therapists in psychosocial treatment skills is still in its infancy (Herschell, Kolko, Baumann, & Davis, 2010). An editorial in the leading science journal Nature has noted that studies aimed at enhancing forms of psychological treatment are grossly under-supported and these treatments lack the economic power that could make them easily obtainable (Therapy deficit, 2012). There is a limited availability of psychotherapeutic expertise and a lack of resources, especially in primary health care, where more than 80% of all patients with depression are looked after (NICE, 2004; Timonen & Liukkonen, 2008). Also, most psychotherapies employed in primary care settings, even short-term ones, can be perceived as too lengthy and labour-intensive (Nieuwsma et al., 2012). Many individuals in western countries experience an unmet need for treatment for depression (Mojtabai, 2009; McManus et al., 2009). This especially concerns the large number of patients who would prefer psychosocial treatments to antidepressants (Chilvers et al., 2001; Churchill et al., 2000; Dwight-Johnson, Sherbourne, Liao, & Wells 2000; McHugh, Whitton, Peckham, Welge, & Otto, 2013; van Schaik et al., 2004). Since obtaining one's preferred form of treatment appears to result in a better response (Lin et al., 2005), it is obvious that a greater variety of psychosocial treatment modalities is required for use in primary health care.

### 1.1.4 Effectiveness of psychotherapy in primary health care

The unmet need for psychotherapeutic treatment of depression is regrettable, because there is a lot of evidence supporting the efficacy of psychotherapeutic treatments both in primary health care and in secondary care. A recent meta-analysis of psychotherapies (Cuijpers et al., 2014) examined the absolute numbers of patients who no longer met the criteria for major depression and found that 62% of the patients who had been in some kind of psychotherapy no longer met the criteria for major depression, as opposed to 43% of the controls (care-as-usual, on the waiting list or receiving a placebo). When the care-as-usual group was considered separately, 48% of these patients no longer met the criteria for depression. The difference between the psychotherapy group and the control groups in the proportion of depression cases after treatment was significant ($p<0.002$). The BDI scores dropped by 13.42 points from the baseline score of 25.70 in the psychotherapy group and by 4.56 points from the baseline score of 24.63 in the control group. The efficiency of the various forms of psychotherapy may not be any lower in primary health care, provided that general practitioners refer patients for psychological treatment (Cuijpers, van Straten, van Schaik, & Andersson, 2009). Overall remission rates for active interventions may range between 50% and 67% compared with 32% for placebo patients and 35% for usual care conditions (Dawson et al., 2004).

The NICE guideline (2011) recommends Cognitive Behavioural Therapy (CBT) for depression on the grounds of the number of studies supporting it, but

comparisons indicate that CBT is no more or less effective than other therapies for adult depression (Cuijpers et al., 2013). Comparing psychotherapeutic interventions for patients with depression in a set of 198 randomized controlled trials, Barth et al. (2013) found evidence that seven interventions (interpersonal therapy, behavioural activation, cognitive-behavioural therapy, problem-solving therapy, social skills training, psychodynamic therapy and supportive counselling) were all more beneficial than being on a waiting list by margins that ranged from moderate to large (range d = -0.56 to d = -1.23).

## 1.2 Implementing guidelines for the psychological treatment of depression

Given that the focus of this thesis is on how best to optimize our primary care resources to help people with depression, this chapter first outlines practice-based studies which have been carried out in routine service settings. It then considers how much therapy would be needed in primary health care, before introducing interpersonal psychotherapy (IPT) as a form of treatment for depression that is adequately supported by research and serves as a basis for a more streamlined version known as interpersonal counselling (IPC). Lastly, it is argued that this latter counselling model may be best applied in primary care and evidence is presented to justify this claim. These deliberations are linked to aspects such as cost-effectiveness and the development of decision support tools to guide the personalized selection of forms of depression treatment, i.e. deciding which patients receiving initial treatment have a high probability of remission in response to inexpensive evidence-based therapy (cf. Kessler, 2018).

### 1.2.1 Practice-based studies in routine service settings

One of the world's largest single programmes in this field, Access to Psychological Therapies (IAPT), aims at bridging the gaps between guidelines, research and practice by training psychological therapists in the use of empirically supported treatment modalities (Clark, 2018). IAPT is currently treating over 560,000 people a year, and experiences from the first year have already suggested that compliance with the IAPT clinical model was associated with enhanced rates of reliable recovery (Gyani, Shafran, Layard, & Clark, 2013). Using the reliable change criteria of Jacobson and Truax (1991), approximately 64% (as many as 19,395 patients) had either recovered or had significantly improved according to a combination of the PHQ-9 and GAD-7 measures at the post-treatment stage, 40% of whom had reliably recovered. The recovery rates as calculated from the complete cohort of 11,000 patients varied substantially between the therapies offered, the numbers of therapy sessions and the proportions of experienced staff, with the empirically supported therapies provided in a higher average number of sessions and with a larger proportion of experienced staff being a clear predictor of a higher reliable recovery rate.

Richards and Borglin (2011), who collected a sample of 7,859 patients from the IAPT data, found that the majority of the patients in this population were treated in less than six sessions and that the attrition rate was high (47%). For the 4,183 patients who received two or more treatment sessions for depression, 55.4% achieved reliable improvement or reliable and clinically significant change criteria, and of the 2,906 patients who completed the treatment, 60.9% met this criterion (47.3% had recovered and 13.6% had significantly improved). The pre-post effect size in this group completing the course of therapy was 1.24. The most recently available IAPT data, from 2017, show that approximately half of the patients had recovered and two out of three had achieved a reliable level of improvement by the end of the treatment (Clark, 2018).

Two other studies carried out in routine service settings used the Clinical Outcome in Routine Evaluation – Outcome Measure (CORE-OM; Barkham et al., 2001) as an assessment method. The investigation implemented in primary care in Sweden (Holmqvist, Ström, & Foldemo, 2014) indicated that 40% of the 376 patients receiving at least five therapy sessions recovered (using the reliable change criteria of Jacobson and Truax (1991)). There were significant differences, however, between the three major treatment orientations, directive (cognitive, behavioural or CBT), reflective (psychodynamic or relational therapies) and supportive therapies. The gains in CORE-OM scores and the pre-post effect sizes (Cohen's d) were 4.3 (0.98) for supportive therapies, 7.2 (1.67) for reflective therapies and 7.7 (2.03) for directive therapies. Thus directive therapies and reflective therapies had comparable outcomes, and better ones than the supportive therapies which were offered in fewer sessions to patients of higher ages. In another study using CORE-OM, Stiles, Barkham, Mellor-Clark and Connell (2008) compared the outcomes of 4,954 patients who received cognitive-behavioural therapy, person-centred therapy or psychodynamic therapy. A total of 58.3% of the patients met the criterion for reliable and clinically significant improvement (i.e. they recovered), with gain scores varying from 8.2 to 9.0 and effect sizes ranging from 1.29 to 1.43. The distributions of the gain scores were all similar.

In summary, short-term routine treatments appear to be effective. Of the patients who complete their psychotherapy, 40–60% had recovered. But what do we mean by treatment effectiveness? Barkham, Stiles, Connell and Mellor-Clark (2012), having compared different ways of calculating effectiveness, found high attrition rates to constitute a big problem in these studies of routine care, as the sample may consist of all the patients who have sought treatment, those listed as having received a particular treatment or those who have completed their treatment as agreed with their therapist. Recovery rates from one database may range widely depending on the sample, from 19% (full sample) to 58% (completer sample). Patients who complete their treatment may be more likely to show an improvement than patients who fail to complete it.

### 1.2.2 How much therapy is sufficient in primary health care?

Although more and more effort has been made recently to improve the adoption of evidence-based psychotherapy in primary care settings, up to 12–16 sessions can be perceived as being too lengthy and time-intensive, due to insufficient training and skills in coping with depression, heavy caseloads and limited time, especially in rural settings. Evidence-supported psychotherapeutic care administered by primary health care workers for patients with depression is nevertheless needed in order to reduce the gaps between the guidelines and their implementation (Ravitz et al., 2013). Thus, we have to consider how many sessions would be optimal in a primary care context.

The idea of applying the dose-effect model of change to psychotherapy has been under research for at least 30 years (cf. Howard, Kopta, Krause, & Orlinsky, 1986). Based on two systematic reviews and 15 randomized controlled trials of brief psychotherapy for depression (8 sessions or less), Nieuwsma et al. (2012) concluded that depression can be efficaciously treated with six to eight sessions of psychotherapy. Stulz, Lutz, Kopta, Minami and Saunders (2013), in their session-by-session assessment of outcomes in routine outpatient care, provided for a final sample of over 6,000 patients mainly allocated from college counselling centres who had been treated for at least three sessions, and observed that 42% had recovered at post-treatment according to the criterion of Jacobson and Truax (1991) and 20.6% had significantly improved in terms of the Global Mental Health (GMH) score and the Behavioural Health Measure (BHM). Overall, the proportion of patients who recovered or were significantly improved was 62.6% and the average pre-post effect size (d) was 1.26. These analyses revealed that faster rates of change were associated with shorter treatments, and the impact of each session then diminished as treatment length increased. Examined in detail, those who achieved clinically significant improvement or had recovered by the end of their therapy had attended 7 sessions in 43.2% of cases and 15–17 sessions in 54.6%. The highest proportion found in that study was 63.1%, for patients who had attended 18–20 sessions, whereas beyond this number of sessions the proportions were lower. There was no consistent relationship between the expected effect of treatment and the number of sessions, but the researchers point out that there is no pre-specified dose of therapy that could be recommended for all patients. The choice of treatment and the number of sessions should be based on the individual patient's actual degree of improvement.

Molenaar et al. (2011), who carried out a randomized controlled trial aimed at evaluating whether 16 sessions of psychotherapy will be more effective in relieving depression and improving social functioning than 8 sessions, randomized 103 patients, 90 of whom received the allocated intervention and 62 completed the psychotherapy. For most patients (81%) this was the first treatment episode. The method, manual-based short psychodynamic supportive psychotherapy, was used in both groups, in an 8 or 16-session version. This method focuses on the affective, behavioural, and cognitive aspects of relationships and was implemented by seven fully trained psychotherapists. All

the patients in the two groups were also treated with medication prescribed by a psychiatrist. When the 7th out of the 8 therapy sessions and the 13th of the 16 sessions were compared, no significant differences appeared in depressive symptoms and social functioning.

### 1.2.3 Interpersonal psychotherapy (IPT) as a research-supported treatment

IPT is a manual-based, time-limited (12–16 sessions) and semi-structured treatment for depression that targets key interpersonal issues that are often very important to people experiencing depression and are frequently identified as key features of the stories told by people who seek treatment in primary care. More specifically, IPT maintains that depression is associated with non-reciprocal role expectations, communication problems and unsatisfactory interpersonal relationships in the patient's primary social group. The goal of the therapy is to reduce symptoms of depression by bringing about major changes in the patient's close interpersonal relations and developing new strategies to deal with problems involving other significant people. The aim is that the patient should be able to communicate his or her needs and expectations to others clearly in the course of the therapy and should also understand his or her contribution to the existing communication problems. The focus in weekly face-to-face sessions between the patient and the therapist is on the here and now, and the therapist should make active use of such common therapeutic techniques as non-directive exploration, encouragement of affect, clarification, communication analysis, decision analysis and role-play (Weissman, Markowitz, & Klerman, 2000, 2007).

The structure of IPT entails three phases of treatment: initial, intermediate and termination phases. The initial phase, usually the first 3 sessions, includes diagnostic evaluation, discussion about the sick role of the patient, an interpersonal inventory, identification of a focal problem area and the establishment of a framework for the treatment. In IPT the patient is understood to have a diagnosable and to some extent understandable disorder. Even though the patient is suffering now, it is important for the therapist to instil hope and enhance an expectation of change so that the depression will respond to treatment. The case formulation, which marks the end of the initial phase of IPT, is a collaboratively constructed summary of earlier discussions about the symptoms and their relation to interpersonal events. In the intermediate phase (including 7–11 sessions) the therapist and the patient work on one of the four IPT problem areas: grief, role disputes, role transitions, or interpersonal deficits, adopting working strategies that are specific to the chosen area. Grief implies bereavement-related depression, which is often associated with withdrawal from current relationships. In this focus the reconstruction of the patient's relationship with the deceased is substantive. Interpersonal role disputes refer to depressive symptoms that result from a current overt or covert dispute with a significant other person, so that working with this problem area necessitates understanding how non-reciprocal expectations relate to the dispute. An interpersonal role transition is a major life change which is usually subjectively experienced as a loss. Reviewing negative and positive aspects of old and new roles is important

in this problem area. Interpersonal deficits refer to longstanding difficulties in establishing or maintaining close relationships, in which case exploring repetitive patterns in initiating or sustaining close relationships and encouraging observed successes step by step may turn the patient away from interpersonal sensitivity towards taking up a more courageous role in relationships (Hinrichsen & Clougherty, 2006; Weissman et al., 2000; Weissman et al., 2007; Weissman, Markowitz, & Klerman, 2018)

The original intent of the founders of IPT was not to develop a new form of psychotherapy but to describe what was believed to be reasonable and current practice with depressed patients. IPT was originally called a "high contact," as part of the first clinical efficacy study of the use of pharmacotherapy and psychotherapy for the treatment of depression (Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974). Himself a psychiatrist and the first leader of the IPT research group, Gerald Klerman saw depression as basically a biological illness, but he had also observed that the brain responds to its environment and he felt that the interpersonal context of the onset of a depressive episode might be a substantial consideration in terms of psychotherapy. He considered that medication should help the patient sleep and eat better, but it should not solve the patient's disputes with a spouse. That is where he assumed psychotherapy would have its effect (Markowitz & Weissman, 2012; Weissman, 2006). When this hypothesis was confirmed in two clinical trials, Klerman and Weissman began to describe the treatment more fully, renamed it as IPT and published a manual for clinicians (Klerman, Weissman, Rounsaville, & Chevron, 1984).

Although IPT was not initially developed as an active treatment for depression, it is currently one of the best researched among the evidence-based psychotherapies (Weissman, Markowitz, & Klerman, 2018). The most comprehensive meta-analysis of the effects of IPT is the one conducted by Cuijpers et al. (2011) whose conclusion was that there is no doubt that IPT treats depression efficaciously and that it deserves its place as one of the most convincingly empirically validated treatments for depression. IPT has also been tested on different age and target groups, in different treatment settings, with various diagnostic groups and in sundry cultural backgrounds (Markowitz & Weissman, 2012; Weissman et al., 2018).

Most of the IPT treatments that have been studied to date have been assessed in university hospitals under controlled conditions. It is quite poorly known whether IPT can be effectively delivered in broadly representative patient samples. Two studies have been carried out in Finland in "real life" settings. That of Karlsson, Säteri and Markowitz (2011) demonstrated that comorbidity was extremely high among depressed patients in public outpatient clinics: 73% of patients suffered from personality disorders, 76% from an anxiety disorder and 20% from alcohol dependence. In this population there were no differences in symptoms and social functioning between index group and the treatment–as-usual group at the end point of IPT, but the patients who had received IPT were significantly more satisfied with their treatment and more of them terminated their treatment at 16 sessions than in the control group, even though they were

offered an opportunity to continue. Saloheimo et al. (2016), describing the outcomes of three treatment modalities in public mental health settings, reported that the patients improved markedly in all three treatment cells and that the addition of IPT or group psychoeducation to treatment-as-usual (TAU) produced only a small further advantage.

Although most IPT assessments have been outcome studies, there have also been some case studies describing the process as it occurs within sessions (Crowe & Luty, 2005; Crowe et al., 2012; Dennis, 2012; Hall & Mufson, 2012; Markowitz et al., 2012; Rafaeli & Markowitz, 2011; Verdeli et al., 2008) and some examining factors that are correlated with changes in IPT. Markowitz, Bleiberg, Christos and Levitan (2006) found a correlation between symptomatic improvement and the resolution of interpersonal problem areas. When the four IPT problem areas were compared with the time to remission, patients in these categories were shown to be treated with equal success by trained IPT clinicians (Levenson et al., 2010), except that patients whose treatment focused on role disputes experienced a significantly longer time to remission than those whose treatment focused on grief or role transitions. In contrast to the initial hypotheses (Klerman et al., 1984), researchers found that the interpersonal deficits group did not have any more difficulties in treatment than those in the other groups, while another study with adolescents showed that the benefits of IPT over TAU were particularly strong for adolescents who reported high levels of conflict with their mothers and social dysfunction with friends (Gunlicks-Stoessel, Mufson, Jekal, & Turner, 2010).

IPT has been used in a shorter version for 8 to 10 sessions (Swartz et al., 2004; Swartz et al., 2008; Grote et al., 2009; Poleshuck et al., 2010; Arcelus, Whight, Brewin, & McGrain, 2012), and it seems that the term "therapy" has been used as a rule to refer to this shorter version of IPT, and even for use in 8-session groups as a simplified format for facilitators who may not have received any previous training in mental health (Bolton et al., 2003; Lewandowski et al., 2016). In this kind of therapy it is proper to use the concept of counselling, although in actual practice the definitions of psychotherapy and counselling overlap. The British Association of Counselling and Psychotherapy does not differentiate between the two, defining both as "umbrella terms that cover a range of talking therapies." When a treatment method is used by non-mental health workers, the concept of counselling is valid, because there are also some restrictions on practicing psychotherapy. In Finland, for example, the National Supervisory Authority for Welfare and Health (Valvira) grants, upon application, the right to use the protected occupational title "psychotherapist" to licensed professionals who have at least three years of psychotherapy training with theory courses, supervision and personal psychotherapy.

### 1.2.4 Interpersonal counselling (IPC) as a viable treatment choice in primary care

More research has been carried out in recent years on the use of IPT by non-mental health professionals (Bolton et al., 2003; Lewandowski et al., 2016; Ravitz et al., 2013; Ravitz et al., 2014). Deviating from the original idea that IPT therapists

should have already achieved proficiency in some form of psychotherapy (Klerman et al., 1984), registered nurses and rehabilitation practitioners or crisis response workers without psychotherapy training have been trained to perform IPT. In such cases, when a shorter version of IPT is used or the user is someone other than a psychotherapist, it is justified to use the term counselling.

With reference to earlier findings regarding the optimal number of sessions, interpersonal counselling (IPC) can be a viable first-line intervention for treating depression in primary health care. Weissman and her working group (1993, 2014; Weissman & Verdeli, updated IPC manual, 2013 —Dr. Weissman, personal communication with the author, February 19, 2016), have laid down the protocol for IPC in primary care, stressing that it is designed to fill the gap between screening patients for depression and triaging them to appropriate care. Basically, it consists of only three sessions that provide structure and content for primary care practitioners to evaluate, support and triage patients with depressive symptoms (Weissman & Verdeli, 2012; Weissman et al., 2014), but it has also been outlined in a 6-session version by Weissman and Klerman (1993) and Judd, Weissman, Davis, Hodgins, & Piterman (2004).

In its original form, interpersonal counselling (IPC) was developed as a simplified version of IPT that could be administered by non-mental health professionals so that they could treat patients with subsyndromal depression (Weissman & Klerman, 1993). Distinctly fewer efficacy studies have so far been conducted on IPC than on IPT, but it has been shown to have an effect on mild depression at the primary health care level or in hospital settings when assessed relative to a control group (Klerman et al., 1987; Mossey, Knott, Higgins, & Talerico, 1996; Neugebauer et al., 2007; Judd, Piterman, Cockram, McCall, & Weissman, 2001; Oranta Luutonen, Salokangas, Vahlberg, & Leino-Kilpi, 2010, 2011; Serretti et al., 2013).

In the largest IPC study to date, Menchetti et al. (2010, 2014) evaluated the efficacy of interpersonal counselling in primary care by comparing it with that of selective serotonin reuptake inhibitors (SSRIs) in a multicentre sample of 287 patients in Italy. The attrition proportion was very small and the whole analysis was carried out using an intention-to-treat approach. The proportion of patients in the IPC group who achieved remission at two months, 58.7%, was significantly higher than that in the SSRI group, 45.1%, and no severe side-effects were recorded in the course of the trial. IPC was outstandingly effective for patients in their first episode of depression to be treated in primary care.

Although most studies of IPC in primary care have assessed the outcomes of counselling for depression and psychological distress, there have been some that have considered moderators of the treatment outcome. Menchetti et al. (2014) identified predictors, such as mild depression, low functional impairment, the first depressive episode, absence of any comorbid anxiety disorder and being a smoker, all of which predicted a better outcome following IPC. In addition, having a mild comorbid physical illness or none at all and being unmarried proved to be predictors of a better outcome. Badger and her colleagues (2006) carried out interpersonal counselling by telephone with women suffering from

breast cancer and found that those with long-term marriages seemed to benefit more from IPC than those with more recent and/or less stable relationships. In another study with prostate cancer survivors the results suggested that IPC conducted by telephone provided a more favourable outcome than health education in men who had a higher level of education, higher urinary and sexual functions, social support from friends and a knowledge of cancer (Badger et al., 2013). In addition to these moderator studies, two IPC investigations have portrayed cases in a variety of circumstances (Badger, Segrin, Meek, Lopez, & Bonham, 2004; Ceballos, Andrade, Markowitz, & Verdeli, 2016).

## 1.3 The process of change in psychotherapy and counselling

Psychotherapy research has shifted more and more in the direction of process-outcome research, which is intuitively more appealing to clinicians but means that there has been a paucity of investigations into the processes that contribute to the outcome of IPC. This section first discusses change process research in psychotherapy in general before focusing on case formulation as a blueprint for change, and finally the processes which may be crucial for the outcome of IPC.

### 1.3.1 Explaining psychotherapy change processes

Change process research (CPR) was first proposed by Greenberg (1986) to form a bridge between outcome research and process research, pointing to the need for examining the change process as such. CPR research takes into account both the baselines and endpoints of the scales, and also the form of the functions taking place between these points. Most change process research to date has been quantitative, and it has been claimed that qualitative approaches (e.g. narrative, conversation analysis and discourse analysis) have so far been under-utilized in the context of mental health treatment (Elliott, 2010).

The examination of the mechanisms of change, where a "change mechanism" refers to "the basis for the effect, i.e., the processes or events that are responsible for the change; the reasons why change occurred or how change came about" (Kazdin, 2007, p. 3), can be dealt with statistically in terms of mediators and moderators. In general, these concepts describe two types of three-factor association. A mediator mediates the relationship between an independent and a dependent variable and explains how and why such effects occur, e.g. why a treatment has an effect on the outcome, while a moderator affects the direction and/or strength of the relation between an independent and a dependent variable and explains for whom or under what conditions the choice of treatment differentially affects the outcome, e.g. how best to match treatments to individual patient needs (Baron & Kenny, 1986; Kraemer, 2016). In other words, a moderator is a baseline value, while changes in outcome can be explained by changes in the mediator variable (Johansson & Høglend, 2007).

Despite an increasing interest in mechanisms of change in psychotherapy research, no definitive mechanisms of change for any type of psychotherapy have been satisfactorily demonstrated (Johansson & Høglend, 2007). Lemmens, Müller, Arntz and Huibers (2016) confirmed this fact recently by summarizing the results of 35 relevant empirical studies of depression that represented examples of mechanism research and identifying a total of 39 potential mediators in 12 separate treatment modalities. The results regarding the mediators were mixed, and the researchers concluded that psychotherapy might be too multi-dimensional and complex a phenomenon to be explicable in terms of relatively simple causal models of psychological change (Lemmens et al., 2016).

There are nevertheless several comprehensive descriptions and explanations for change processes in psychotherapy and counselling, among which, at perhaps the most pan-theoretical level, Wampold (2001, 2015) has outlined a "contextual model" explanation for the benefits of all psychotherapies, maintaining that psychotherapy is a culturally embedded healing practice. The contextual model includes the fact that there is a) a real personal and genuine relationship between the therapist and the patient, b) the creation of expectations through explanation of the disorder and its treatment, and c) the enactment of health-promoting measures. He suggests that these common factors collectively shape a theoretical model for change in psychotherapy (Wampold, 2001, 2012, 2015) and establishes a contextual model based on meta-analyses of empathy, expectations, cultural adaptation, therapist differences and alliances in psychotherapy. The effect sizes (and percentages of variability in the outcomes) were 0.63 (9.0%) for empathy, 0.24 (1.4%) for expectations, 0.32 (2.5%) for cultural adaptation, 0.55 (7.0%) for differences between therapists in naturalistic studies, and 0.57 (7.5%) for alliance creation (Wampold & Imel, 2015).

The fact that an alliance needs to be created between the therapist and the patient in the initial sessions implies a consensus and joint commitment to the therapeutic goals and the tasks involved in advancing these goals (Horvath & Bedi, 2002). Better outcomes are linked to the achievement of a goal consensus, i.e. agreement between the patient and the therapist on the therapeutic goals and the processes by which these goals are to be achieved (Tryon & Winograd, 2011). The effect size for goal consensus and collaboration, as determined in the meta-analysis, was 0.72, and its contribution to the variability in outcomes 11.5% (Wampold & Imel, 2015). One key element in reaching a goal consensus is case formulation in the initial sessions.

### 1.3.2 Case formulation and its importance for the outcome

"A psychotherapy case formulation is a hypothesis about the causes, precipitants and maintaining influences of a person's psychological, interpersonal, and behavioural problems" (Eells, 2007a, p. 4). Case formulation in psychotherapy or counselling provides an opportunity for a shared understanding of the patient's difficulties. It can also offer a way of tailoring treatment to the individual and his or her singular situation that diagnosis alone does not (Eells & Lombart, 2011; Macneil, Hasty, Conus, & Berk, 2012; Sturmey, 2009). Case formulation models

in psychotherapy and counselling share many common features, but each is also distinct from the others. Each therapy model has a conceptual framework that stems from its historical origins (Eells, 2007b). Cognitive-behavioural methods are based on learning principles and the observation of behaviour, while humanistic-existential methods are more heterogeneous, but derive from humanistic-phenomenological or family systems theories, for example. Psychoanalytically rooted methods are based on Freud's original drive reduction model, self-psychology or object-relational streams, while IPT, which also traces its origins to the psychoanalytic tradition, differs in its outlook and practise to the extent that it deserves to be considered apart (Markowitz, Svartberg & Swartz, 1998). IPT has a distinct emphasis on outcome, a more active stance on the part of the therapist and more practical goals (syndromal remission and prompting patients to make rapid changes to their interpersonal environments). The IPT rationale does not imply explaining intrapsychic conflicts, but rather its theoretical background is based on the relational theories of Harry S. Sullivan and John Bowlby. It is a pragmatic, research-proven approach that relies on psychosocial research findings connecting relationships with mental health, which informs IPT's specific focus on current interpersonal problems (Lipsitz & Markowitz, 2013).

Case formulation is primarily the treatment tool which defines a good enough focus for the patient and the therapist and marks the culmination of the initial phase of IPT. It summarizes current relationships and links the onset of the patient's mood disorder or distress to one of four focal interpersonal problem areas (Markowitz & Swartz, 2007). Evidence has accumulated to indicate that IPT therapists tend to agree when determining focal problem areas based on initial treatment sessions (Markowitz et al., 2000).

In accordance with the IPC manual (Weissman & Klerman, 1993; Weissman et al., 2000; Weissman & Verdeli, updated IPC manual, 2013—Dr. Weissman, personal communication with the author, February 19, 2016), counsellors should find out first what was going on in the patient's life at the time the symptoms began. Secondly, they should explore what may have triggered the symptoms or what seems to be maintaining them. Thirdly, they should construct an interpersonal inventory to get an overview as to who are the important people in the patient's life, which relationships would support them and which relationships might be most closely tied to the depressive symptoms. Based on all the information obtained in the initial phase, the formulation is explicitly presented to the patient. The counsellor can then suggest a relationship between the patient's symptoms of distress and current life stress, focusing on one IPT problem area (grief, interpersonal disputes, role transitions, or interpersonal sensitivity/loneliness). It is also possible for the counsellor to give the patient homework sheets comprising questions concerning life events in the IPT problem areas (Weissman 1995a, 1995b) at the end of the first IPC session and review the answers during the second session.

Although the key elements in IPC and IPT are the therapist's ability to perform case formulation and the correct choice of the interpersonal problem

area (Ravitz, McBride, & Maunder, 2011), there has been no previous systematic research into the interactional ingredients of IPT or IPC case formulations. Previous research into other forms of therapy has emphasized the collaborative nature of case formulation and its joint construction (Buttny, 1996), but it has also been shown that case formulation is a complex interactional activity (Antaki, Barnes, & Leudar, 2004; Davis, 1986), and it is this reality that may explain the limited amount of direct evidence linking case formulation with outcome. However, meta-analyses have consistently linked the efficacy of psychotherapy with the quality of the therapeutic alliance, regardless of the therapeutic approach that is adopted (Horvath, 2001; Horvath, DelRe, Flückiger, & Symonds, 2011). A strong alliance early in therapy is crucially important, as it has proved to be a consistent predictor of the final outcome (Horvath, 2001; Horvath & Bedi, 2002). An early alliance is especially crucial in time-limited, short-term interventions in which the clinician needs to rapidly develop a shared idea of the focus of the therapy and a treatment plan for the following sessions (Markowitz & Swartz, 2007; Rawson, 2005). This is the essence of the process of case formulation in the initial phase of therapy.

Case formulation, in which the clinician links the patient's symptoms with interpersonal life events, is the crux of IPC and determines the direction and mechanisms of the treatment that follows (Markowitz & Swartz, 2007). In the following middle and conclusion phases the therapist will use both common and specific strategies in relation to the four problem areas in order to activate the potential change mechanisms inherent in IPC.

### 1.3.3 Putative mechanisms of change in IPC

Although IPT and IPC have demonstrated efficacy for the treatment of depression, little is known about what these change mechanisms are. It has been argued that the improvement achieved by IPT, as also by CBT and other psychotherapies, is likely to be a consequence of non-specific effects common to all therapies (Wampold & Imel, 2015). Lipsitz and Markowitz (2013), however, have hypothesized specific interpersonal change mechanisms in detail in order to better distinguish IPT from other therapies. In their paper they clarify what the core elements and mediators of IPT are in the light of relational theory and research findings regarding stress, social support and illness. They postulate that IPT actively enhances social support, decreases interpersonal stress, facilitates emotional processing and improves interpersonal skills. As separate entities these change mechanisms are not unique to IPT, but IPT's uniqueness lies in activating all of these mechanisms within a coherent and plausible therapeutic frame, ensuring congruence between the therapeutic process and the explanations for the illness.

Lipsitz and Markowitz (2013) base their specific hypothesis of interpersonal change mechanisms on two primary theoretical foundations. The first of these is relational theory, developed by Adolph Meyer, Harry Stuck Sullivan and John Bowlby. Meyer viewed psychopathology as an individual's attempt to adapt to a changing environment (Klerman et al., 1984), while Sullivan went further and

described how humans change through the influence of others so that mutually improving the patient's current interpersonal situation by means of therapy may change his or her psychopathological experience (Frank & Levenson, 2011). Bowlby's attachment theory consolidated the relational theory with one of the principal theories in psychotherapy field. Attachment styles derive largely from early childhood experiences and are transposed into expectations about close relationships in adolescence and adulthood. Attachment theory promotes the conceptualization of the patient's interpersonal problems, an understanding of the patient's relationships and the planning of IPT interventions that are likely to be of benefit (Stuart & Robertson, 2012). The second theoretical foundation for IPT is social theory. Findings on correlations between social environment and the onset of mental disorders from the 1950s and 1960s highlighted the role of recent stressful experiences (Klerman et al., 1984), while social epidemiological research revealed how stressful life events, chronic stressful conditions and social support for mental health can be substantial background circumstances. An individual will often have encountered severe life changes before depression (e.g. the death of a loved one, divorce, unemployment or the diagnosis of a chronic medical illness). Patients are seen as victims of circumstances in these situations (Lipsitz & Markowitz, 2013), and IPC attempts to encourage them to view the situations in an interpersonal context, helping them to enhance their life situation with the support of intimate family members or friends. This "enhancing social support" is the first, and presumably the most important, change mechanism involved in IPC. Patients have an acute and justified need for support from others, and a counsellor should actively encourage patients to develop supportive relationships outside their therapy and help them to engage with and rely more on others.

"Decreasing interpersonal stress" is the second change mechanism in IPC. This target's key sources of interpersonal stress and seeks possibilities for changing stressful aspects of the interpersonal reality or the patient's relationship to that reality. The IPC medical model and the sick role of a patient may also ameliorate that stress, allowing the patient to temporarily set aside some activities which seem to be overwhelming. The third change mechanism is "facilitating emotional processing". This attempts to develop a capacity for emotional awareness and regulation, helping the patient to recognise the legitimacy and appropriateness of unbearable feelings and to understand their interpersonal meaning. The fourth change mechanism, "improving interpersonal skills", is essential for successful resolution of the patient's current crisis or predicament. Since patients will generally possess latent social skills, the use of communication analysis or role play in IPC will encourage them to put these skills into practice during the time between sessions.

## 1.4 Aims of the present research

The research presented here aims at improving our understanding of ways to optimize the use of effective treatment for patients who present with depressive disorders in primary health care settings. The effectiveness of treatment for depression has become a crucial issue, since depression has become a leading cause of disability worldwide, and the majority of depressive patients need to be treated in primary care. We have evidence for the efficacy of psychotherapy in clinical trials, but there is still a lack of knowledge concerning the dissemination of treatments supported by this research in primary care, and how mediating factors may be related to the outcome.

This thesis explores the subject at three levels: by comparing interpersonal counselling (IPC) with interpersonal psychotherapy (IPT) in a clinical trial, by examining the process of case formulation, which has been highlighted in a multiple case study as being central to the IPT approach, and by investigating the change processes involved in IPC in a theory-building case study. The principal questions to be answered are as follows:

1. Is interpersonal counselling (IPC) sufficient treatment for depression in primary care patients? (Study I)
2. How is the process of case formulation associated with the outcome of IPC? (Study II)
3. What are the putative mechanisms of change involved in IPC? (Study III)
4. In what ways do the qualitative case data add depth to the statistical outcome results? (Studies I, II and III)

# 2 METHODS

"How can we integrate the clinician's concern with what is best for a particular patient with the researcher's concern for scientific rigor and generalizability?" I have tried to answer this question put forward by George Silberschatz (2017) in the course of choosing the methods to be used in this work. In order to respond to this challenge and to add depth to the quantitative analysis, the research should involve a qualitative understanding of the outcome. Statistical measurement alone does not allow researchers to demonstrate the complicated process of psychotherapy or the complexity of the change that takes place in individuals. For this reason, Hill, Chui and Baumann (2013), for instance, recommend that research should combine quantitative and qualitative methods. The association between intervention and outcomes in RCT is like a black box which does not explain why things work or do not work (White, 2013). Without looking inside the black box, we may make statements about the outcomes of a complicated process of treatment without any understanding of that phenomenon. This may also convince us that efforts to disseminate evidence-based practices without studying the relationship concerned are incomplete and may be potentially misleading (Norcross & Wampold, 2011).

## 2.1 Study design

A process diagram illustrating the research is provided in Figure 1. This shows how the patients were selected and allocated to the subsamples and which sample level is concerned in each studies. In this process qualitative data collection was embedded within a randomized, controlled trial. Study I (Kontunen, Timonen, Muotka, & Liukkonen, 2016) can be seen as a component study, which identifies the active ingredients of psychotherapies, e.g. comparing the full therapy with a therapy in which one or more components have been left out (sometimes referred to as dismantling studies) or a component is added to an existing therapy (Wampold & Imel, 2015). Cuijpers, Cristea, Karyotaki, Reijnders

and Hollon (2019) have published a systematic review and meta-analysis of component studies of psychological treatments of adult depression. Out of 1885 full-text papers, they included 16 studies with sufficient data and a high standard for the treatments studied. One of these was our study (Kontunen et. al, 2016) in which IPC was perceived as a "slimmed down" version of IPT (Weissman et al., 2000), a treatment that would be considered logically viable, however. The strength of the evidence resulting from such component studies is high, because the difference between a therapy with a component and a therapy without that component can be directly attributed to the effects of that intervention, and no third variable is likely to be responsible for the change in outcome (Cuijpers et al., 2019). Study II (Kontunen, Weiste, Liukkonen, Timonen, & Aaltonen, 2019), represents a systematic case comparison that aims to bridge the gap in research practice by providing more clinically relevant information about findings from the first randomized clinical trial (Iwakabe & Gazzola, 2009). In turn, Study III (Kontunen, Liukkonen, & Aaltonen, 2019) is a theory-building case study that offers a way in which observations can be processed and the understanding they engender can be accumulated to improve counselling practice (Stiles, 2007).

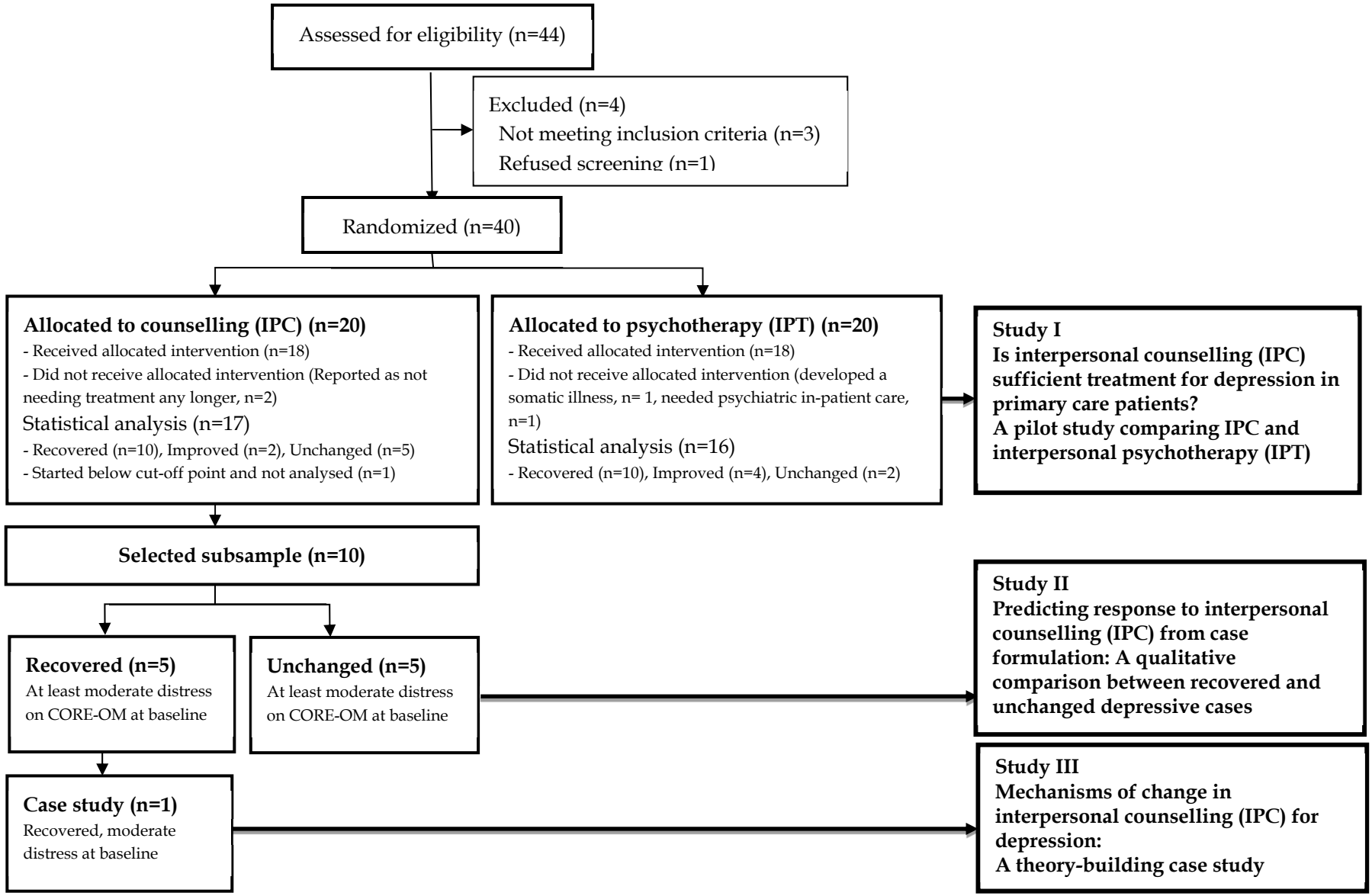


FIGURE 1 Attrition flow-chart from admission to the selected subsamples and the sample level for each study.

The initial study was a parallel-group, randomized clinical trial comparing interpersonal counselling (IPC) with interpersonal psychotherapy (IPT) in patients seeking treatment for depression in primary care units. The trial was conducted in the hospital district of East-Savo, Finland, and a 25-page research plan was produced consisting of an introduction and details of the methods (background, objectives, trial design, participants, interventions, outcome measures, sample size, allocation implementation and statistical methods). The plan also contained an exactly defined diagram of the therapist/patient instruments at each time point and of the follow-up, together with critical questions and caveats. Before recruitment began, a psychiatrist informed general practitioners and nurses in the municipal primary care units about the trial. Primary care personnel were also given an information sheet about the research to hand to their patients when referring them for a screening visit. At that visit the psychiatrist explained the purpose of the research and its procedures and evaluated the patients for eligibility after obtaining their written informed consent. The ethical committee of the East-Savo Hospital District approved the research on January 12, 2010, and the plan was subsequently approved by the supervisory group of the Department of Psychology, University of Jyväskylä, on January 30, 2010. Data collection then took place between March 2010 and April 2012.

The patients filled out forms with their demographic details and characteristics at the screening visit. Participants were required to have a diagnosis of major depression arrived at by the research psychiatrist using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) following the Mini International Neuropsychiatric Interview M.I.N.I protocol (Sheehan et al., 1998). The inclusion criterion for age was 18 years. The initial plan was to assess for eligibility only patients who were seeking treatment for their first depressive episode, but it quickly became apparent that almost all the patients had experienced earlier depressive episodes, so that it was essential to accept any untreated depressive episode. The exclusion criteria were acute suicidal risk, bipolar disorder, psychosis and psychotic or severe depression. Alcohol abuse was screened by means of the Alcohol Use Disorders Identification Test (Audit) (Babor, de la Fuente, Saunders, & Grant, 1992), a measure that contains 10 self-rated items summed into a single score ranging from 0 to 40, a score of over 7 being associated with harmful drinking. Depressive severity was evaluated with the 10-item, clinician-rated Montgomery–Åsberg Depression Rating Scale (MÅDRS) (Montgomery & Åsberg, 1979), which is often used to select patients for clinical trials (Williams & Kobak, 2008). The MÅDRS items are rated on a 0–6 severity scale, yielding a total score in the range of 0–60, the cut-off point for severe depression being 30. A research psychiatrist was trained to use MÅDRS by an expert in psychiatric diagnostics (Professor Hannu J. Koponen, MD, PhD, University of Helsinki, Faculty of Medicine, Institute of Clinical Medicine, Department of Psychiatry, Old Age Psychiatry).

As stated in Figure 1, 44 patients were referred to and screened by a psychiatrist, four of whom were excluded: three who failed to meet the inclusion criteria and one who refused screening. No patients refused to participate after having been informed about which treatment they had been allocated to. The 40 were randomized by the screening psychiatrist at the end of the screening visit, using a procedure in which 30 tickets for IPT and 30 for IPC were sealed in individual envelopes, shuffled and marked with consecutive numbers. The envelopes were then opened in numerical order for the recruited patients once their written consent had been received. Both the screening psychiatrist and the patient were blinded to the randomization until the envelope was opened. The original study design had allowed for a total of 60 patients to be randomized, but it was decided to terminate the study at the end of April 2012 due to forthcoming changes in personnel. It was possible to combine the patient's antidepressant medication with IPC/IPT if deemed clinically desirable, the decision to prescribe medication being the responsibility of the attending physician.

## 2.2 Participants

The participants were selected from the same population at three levels, as shown in Figure 1. For Study I, 40 patients were randomly assigned to 7 sessions of IPC carried out at primary care units, or 16 sessions of IPT carried out at a secondary care unit. For Study II, 10 patients from the IPC group (5 recovered and 5 unchanged) were selected for a multiple case study. One case from the Study II population was then selected to represent the counselling process experienced by a recovered patient in Study III.

### 2.2.1 Study I: The randomized clinical trial

With 40 patients fulfilling the selection criteria for inclusion in the clinical trial, 20 patients were assigned to the IPC group and 20 to the parallel IPT group. Eighteen patients in each group (90%) completed the treatment. One patient (male) attended only the first IPC session and another (female) attended 3 sessions, reporting that they did not need the treatment any longer, while one IPT patient dropped out during the third session because she needed psychiatric in-patient care and another (male) had a fall and developed a somatic illness, so that he was admitted to hospital after the 8th session of IPT.

As seen in Table 1, the IPC and IPT groups were comparable in terms of age, sex, educational level and marital status. Most of the patients were female and their average age at the start of treatment was 38 years. The educational level of most of the patients was intermediate (vocational training/school) and 70% were married or cohabiting. The Audit scores were low (M=4.63 in the IPC group and M=4.44 in the IPT group) and only 2 patients in each group showed an increasing or higher risk. Altogether 12 of the IPC patients were diagnosed as having recurrent depression, as compared with 10 of the IPT patients. Fourteen patients

(70%) in the IPT group (treatment in secondary care) received antidepressant medication, compared with nine (45%) in the IPC group (treatment in primary care). Selective serotonin reuptake inhibitors (SSRI) (escitalopram, sertraline or citalopram) constituted half of the medication in the IPT group, and half was noradrenergic or specific serotonergic antidepressants (NaSSA) (mirtazapine). Two thirds of the medication in the IPC group was SSRIs, while one third was tricyclic-related antidepressants (TCAs) and serotonin–norepinephrine reuptake inhibitors (SNRIs). No patients in this group received NaSSA.

TABLE 1 Demographic and clinical baseline data on the treatment and control groups (intention to treat).

| Variable | IPC (n=20)* | IPT (n=20)* | $\chi^2$ or *t* Value | *df* | *P* Value |
|---|---|---|---|---|---|
| Age, mean (SD) years | 38.6 (12.6) | 37.5 (13.0) | 0.27 | 38 | .84 |
| Sex | | | | | |
| Female | 13 (65%) | 16 (80%) | 0.29 | 1 | .48 |
| Male | 7 (35%) | 4 (20%) | | | |
| Marital status | | | | | |
| Married or cohabiting | 15 (75%) | 13 (65%) | 0.48 | 1 | .73 |
| Single or divorced | 5 (25%) | 7 (35%) | | | |
| Educational level | | | | | |
| Low | 1 ( 5%) | 2 (10%) | | | |
| Intermediate | 14 (70%) | 12 (60%) | 0.58 | 2 | .79 |
| High | 5 (25%) | 6 (30%) | | | |
| Job status | | | | | |
| Employed or studying | 14 (70%) | 11 (55%) | 0.96 | 1 | .51 |
| On sickness benefit or unemployed | 6 (30%) | 9 (45%) | | | |
| Alcohol use (Audit) | | | | | |
| Lower risk (0–7) | 17 (90%) | 16 (89%) | 0.00 | 1 | 1.00 |
| Increasing or higher risk (8+) | 2 (10%) | 2 (11%) | | | |
| Depression | | | | | |
| Current | 7 (37%) | 10 (50%) | 0.69 | 1 | .52 |
| Recurrent | 12 (63%) | 10 (50%) | | | |
| Antidepressant medication | | | | | |
| No medication | 11 (55%) | 6 (30%) | 2.56 | 1 | .20 |
| Medication | 9 (45%) | 14 (70%) | | | |
| CORE-OM, mean (SD) | 17.5 (4.1) | 16.6 (5.5) | 0.58 | 38 | .57 |
| Well-being scale | 22.5 (5.8) | 22.5 (7.2) | 0.00 | 38 | 1.00 |
| Symptoms scale | 22.5 (5.6) | 22.5 (7.6) | 0.02 | 38 | .99 |
| Functioning scale | 18.1 (5.7) | 15.5 (5.1) | 1.49 | 38 | .15 |
| Risk scale | 3.2 (3.9) | 3.3 (5.7) | 0.05 | 38 | .96 |
| BDI, mean (SD) | 22.5 (8.5) | 21.8 (8.0) | 0.26 | 36 | .80 |

* Data are expressed as numbers and percentages

*Note:* IPC=interpersonal counselling, IPT=interpersonal psychotherapy, Audit=Alcohol Use Disorders Identification Test (scale range 0–40), CORE-OM=Clinical Outcomes in Routine Evaluation (scale range 0–40), BDI=Beck Depression Inventory (scale range: 0–63).

Since the groups did not differ with respect to the patients' depressive symptoms or well-being, they can be regarded as having been comparable at the beginning of the treatment. Similarly, the outcome measures were closely correlated. The Pearson correlation coefficient between baseline CORE-OM and BDI was .70, and internal consistency (Cronbach's alpha) was 0.90 for CORE-OM and 0.82 for BDI.

### 2.2.2 Study II: A systematic multiple case comparison

Ten out of the 36 patients who completed the treatments, all from the IPC group, were selected to form the sample for multiple case comparison. They included all five patients meeting the criteria for unchanged cases and five of those who had recovered in terms of their CORE-OM scores using the criteria set out by Jacobson and Truax (1991) (Table 2). The selection of five out of the ten recovered cases represented an attempt to render the two groups comparable in terms of baseline psychological health in spite of differences in outcome at the end of the treatment. The CORE-OM score at baseline had to be moderate, not mild, because none of the unchanged patients had a mild baseline score and such a patient would have needed no auxiliary treatment for depression. This arrangement thus prevented any confounding treatment effect on the outcome. Using these criteria before any qualitative analysis, we found five patients who had recovered to serve as counterparts to the unchanged patients.

The recovered and unchanged groups were comparable in terms of sex (four females, one male) and educational level (four vocational qualifications, one master's degree). The average age of the ten cases at the start of treatment was 44 years (SD = 12.7; range 24–58), being 40 years in the recovered group and 47 years in the unchanged group. All five members of the recovered group and three of the unchanged group were married. Four members of the recovered group were employed or studying, and one was on sickness benefit, while three of those in the unchanged group were employed or studying and two were on sickness benefit. Three of the recovered patients were diagnosed as having recurrent depression, as compared with two of the unchanged patients. None of the patients had problems with alcohol consumption.

TABLE 2 Demographic and clinical data for the patients in the recovered group (n=5) and unchanged group (n=5).

| Cases (pseudonyms) | Age | Marital status | CORE-OM and BDI scores at the beginning of IPC | CORE-OM and BDI scores at follow-up |
|---|---|---|---|---|
| Recovered group | | | | |
| Paula | 54 | Married | Moderate distress (19)<br>Moderate depression (19) | Non-distressed (4)<br>Non-depressed (1) |
| Daniel | 33 | Married | Moderate distress (16)<br>Mild depression (16) | Non-distressed (9)<br>Non-depressed (7) |
| Carolyn | 54 | Married | Moderate distress (19)<br>Severe depression (30) | Non-distressed (7)<br>Non-depressed (7) |
| Joanna | 30 | Married | Moderate distress (17)<br>Mild depression (11) | Non-distressed (6)<br>Non-depressed (2) |
| Mary | 30 | Married | Moderate distress (20)<br>Severe depression (35) | Non-distressed (2)<br>Non-depressed (0) |
| Unchanged group | | | | |
| Ann | 58 | Married | Moderate distress (17)<br>Moderate depression (19) | Moderate distress (14)<br>Mild depression (17) |
| Dorothy | 51 | Married | Moderate distress (22)<br>Moderate depression (25) | Moderate distress (23)<br>Severe depression (40) |
| Helen | 48 | Married | Severe distress (26)<br>Severe depression (45) | Moderate distress (25)<br>Mild depression (15) |
| Lisa | 53 | Single | Moderate distress (17)<br>Moderate depression (19) | Moderate distress (16)<br>Mild depression (16) |
| Alex | 24 | Single | Moderate distress (16)<br>Moderate depression (19) | Moderate distress (13)<br>Mild depression (17) |

*Note:* CORE-OM = Clinical Outcomes in Routine Evaluation - Outcome Measure. Clinical cut-off: Non-distressed (healthy) < 13, Moderate = 13–25, Severe > 25 (Barkham et al., 2001). Scores are multiplied by 10, yielding a more convenient range of 0–40 (Leach et al., 2006). BDI = Beck Depression Inventory. Clinical cut-off: Non-depressed (healthy) < 10, Mild = 10–18, Moderate = 19–29, Severe >29.

The changes were significant in that there were no statistically significant differences in the pre-treatment scores between the recovered and unchanged groups (CORE-OM: p=0.841; BDI: p=0.905), but the differences between the groups at the 12-month follow-up examination were significant (CORE-OM: p=0.008; BDI: p=0.016). No subsequent psychiatric or psychotherapeutic treatment had been needed by the recovered patients for one year after the last IPC follow-up session, whereas three of the unchanged patients were continuing treatment with the same counsellors, one was on a "coping with depression" course and the fifth patient had become motivated to continue in intensive psychotherapy.

### 2.2.3 Study III: Case study

The patient for this theory-building case study was selected from the recovered group of those who received IPC counselling as meeting the criteria of generalizability and triangulation (McLeod, 2012). Firstly, the patient's problems were required to have been in the most prevalent problem area in the original recovered group (Kontunen et al., 2016) and the patient's situation to have represented a real and urgent clinical need. According to recent reports, Finland is one of the fastest-ageing countries in Europe, and early retirement due to ill health is a serious problem among middle-aged professional women (Finnish Centre for Pensions, 2019). Secondly, all the outcome and process measures were required to be readily available, enabling triangulation across sources. Thirdly, the patient's counsellor was required to be representative of the mental health personnel at the basic level and not a specialized psychotherapist. The patient selected was aged 52 and was given the name of Kathy. Her counsellor was a woman around 60 years old who had had 20 years of in-patient experience and over five years of out-patient experience with depressed patients.

## 2.3 Treatments and therapists

Interpersonal counselling (IPC) was carried out in the five municipal primary care units belonging to the East-Savo Hospital District and the control interventions using interpersonal psychotherapy (IPT) at one psychiatric outpatient clinic in Savonlinna. Adherence to the treatment protocol in the IPC and IPT groups was ensured by means of session-by-session checklists, audiotaping all the treatment sessions and discussions of the treatment protocols in regular supervision groups.

### 2.3.1 Interpersonal counselling (IPC)

The recommended number of therapy sessions was set at 6+1, following the structure of IPC as interpreted by Judd et al. (2004) and according to the protocol of Menchetti et al. (2010, 2014). It was recommended that sessions should last 45

minutes, and the purposes of the visits were outlined session by session in a 30-page checklist, following the observations of Weissman & Klerman (1993) and Judd et al. (2004) on the structure of IPC.

The aim of the first session was to establish rapport, determine the presence of depression and introduce IPC. In the second session the counsellor explored the patient's current interpersonal and social situation and suggested a relationship between the patient's symptoms of distress and current life stress, focusing on one IPT problem area (grief, interpersonal disputes, role transitions, or interpersonal deficits). The last problem area is referred to in Finland as "interpersonal sensitivities" (following Stuart & Robertson 2003 and Morris, 2012), because these words represent more accurately conditions of loneliness and isolation, a common problem especially in the Finnish countryside. This framework has a more positive treatment connotation than deficiency. In the middle phase (sessions 3–5), the counsellor helped the patient deal more positively with the problem area that they had identified, while the last two sessions addressed termination of the IPC relationship by reviewing developments over the course of the treatment and assessing the patient's current state. During the treatment sessions the counsellors also had an opportunity to give their patients homework sheets for the intervening periods between the sessions in order to accelerate the process of change in each problem area (Weissman & Klerman, 1993; Weissman, 1995a, 1995b). It was similarly recommended that maintenance sessions should be conducted if the patient's problems required it, but only after a new contract had been negotiated.

Eight mental health nurses from primary health care units received 3 days of theoretical IPC training and a supervision period of 40 hours with at least one pilot case before the research material was collected. All the counsellors had at least 10 years of outpatient or inpatient experience of working with depressed patients. The present author served as an IPC trainer and supervisor. Supervision in a group format continued monthly throughout the data collection period.

### 2.3.2 Interpersonal psychotherapy (IPT)

Empirically validated interpersonal psychotherapy (IPT) was used for the high-intensity control group rather than resorting to treatment as usual (TAU). According to one meta-analysis (Mohr et al., 2014), the choice of the control may have a substantial impact on the outcome of a randomized trial for psychotherapy to treat depression. TAU has been the common treatment for the control group, but it is often very hard to specify. If one wants to assess the benefit of a therapy method, one should design the TAU group therapy so that it is similar in all other respects, e.g. in the frequency and length of the sessions, the clinical supervision of therapists and patients' equal opportunities to address major problems. This means that the control group in a well-organized study should contain both general and essential elements of treatment (see Baskin, Tierney, Minami, & Wampold, 2003; Wampold et al., 2011).

The control group treatment (IPT) was provided by two registered psychotherapists and two licensed psychologists, all of whom had been treating

depressed patients for over 15 years and had practiced IPT with more than five patients before this research began. Their training material in Finnish (Kontunen, Karlsson, & Larmo, 2007) was based on the Comprehensive Guide to IPT (Weissman et al., 2000) and additional literature on IPT (Hinrichsen & Clougherty 2006; Klerman et al., 1984; Mufson, Moreau, Dorta, & Weissman, 2004; Weissman et al., 2007).

## 2.4 Data collection

The outcome measures were assessed before the beginning and end of the intervention and repeated 6 and 12 months after the beginning, and qualitative process data were recorded during the IPC and IPT sessions. Post-therapy interviews with both patients and counsellors were carried out 6 months after the beginning of the intervention, and a retrospective review of the medical records of each patient was conducted one year after the end of the 12-month follow-up. An overview of all the data per assessment (and for each study separately) is given in Table 3.

TABLE 3 Overview of data collection per time point (weeks) targeted at the IPC or IPT patients.

| Data | 0 IPC IPT | 1-6 IPC IPT | 7 IPC | 7-15 IPT | 16 IPT | 26 IPC IPT | 52 IPC IPT | 104 IPC IPT |
|---|---|---|---|---|---|---|---|---|
| *Clinical outcomes data* | | | | | | | | |
| Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM) (Studies I, II, III) | X | | X | | X | X | X | |
| Brief version of the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-5) (Study III) | | X | | X | | | | |
| Beck Depression Inventory (BDI-21) (Studies I, II, III) | X | | X | | X | X | X | |
| General Health Questionnaire (GHQ-12) (Studies II, III) | X | | X | | X | X | X | |
| *Researcher-rated dataset* | | | | | | | | |
| Audio recordings made during sessions (Studies II, III) | | X | X | X | X | X | X | |
| Audio recordings of follow-up interviews (Study III) | | | | | | X | | |
| Retrospective review of the medical records: medication and auxiliary treatment data (Studies I, II, III) | | | | | | | | X |

### 2.4.1 Quantitative data

The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) (Barkham et al., 2001; Evans et al., 2002) is one of the most widely used outcome measures for psychological therapies worldwide and has currently been translated into over 25 languages. All translations are required to be performed by teams with comprehensive expertise who are native speakers of the target language, fluent in English or professional translators. As a member of the focus group, the author helped translate the Finnish version, which was in its "candidate for release" phase at the time of the research. By the end of the project the Finnish translation had been approved by the CORE System Trust (2015). The strength of the CORE-OM lies in its coverage of a broad scope of welfare and psychological health. Its 34 items are designed to assess levels of psychological distress and the outcomes of psychological therapies. The CORE items are scored on a 5-point scale from 0 to 4, ranging from "Not at all" to "Most or all the time," and relating to the previous week. Higher scores indicate greater distress. The items comprise four domains: 1) specific problems (depression, anxiety, physical problems, trauma), 2) functioning (general day-to-day functioning, close

relationships, social relationships), 3) subjective well-being (feelings about one's self and optimism about the future), and 4) risk (risk to one's self, risk to others).

The CORE-OM scoring systems have shown excellent psychometric properties, and validation of the CORE-OM instrument, for the Finnish population has demonstrated similar results to those found in the UK: the internal consistency (Cronbach's alpha) of the total score was excellent in both clinical ($\alpha = 0.94$) and non-clinical ($\alpha = 0.91$) samples (Honkalampi et al., 2017). The CORE-OM scores also exhibited good internal consistency in the original sample of the present study (N=36), as Cronbach's alpha varied from 0.90 at baseline to 0.96 at 12 months of follow-up.

The brief version of the CORE-OM (CORE-5), which was used as a weekly outcome measure for ongoing monitoring (Wright, Bewick, Barkham, House, & Hill, 2009), consists of five items measuring symptoms of anxiety and depression, general functioning and subjective well-being. This measure provided a way of linking important counselling and patients' life events to specific psychological changes.

The Beck Depression Inventory (BDI) scale (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), which is one of the most common self-reported measures of depression and has been looked on as the gold standard in depression outcome research, is a 21-item self-report instrument in which the items are scored on a four-point scale from 0 to 3 and summed to obtain a total score ranging from 0 to 63. The internal consistency of the BDI-21 was 0.89 in a large nationwide population-based sample in Finland (Elovainio et al., 2009). BDI scores also exhibited good internal consistency in the original sample examined here (N=36), as Cronbach's alpha varied from 0.82 to 0.93. The Pearson correlation coefficient between BDI and CORE-OM in the original sample was .70 at baseline and .82 at the 12-month follow-up.

Psychological distress in the original sample was measured by means of the General Health Questionnaire (GHQ-12) (Goldberg et al., 1997), the internal consistency (Cronbach's alpha) of which varied from 0.80 at baseline to 0.96 at 12 months of follow-up. The Pearson correlation coefficient between GHQ-12 and CORE-OM was .63 at baseline and .89 at the 12-month follow-up and that between GHQ-12 and BDI .71 at baseline and .82 at 12-month follow-up.

### 2.4.2 Qualitative data

The qualitative data were obtained from three sources: 1) The process involved in case formulation, as studied in Study II, was investigated using audio recordings of the initial two sessions for each of the 10 patients (N=20). As each session lasted 45 minutes, the data submitted to precise qualitative analysis involved approximately 15 hours of interaction (10 patients x 2 sessions x 45 minutes). In the case of Study III, 7 audio-recorded IPC sessions, 1 assessment session and 2 follow-up sessions were selected for rigorous qualitative analysis. As each session again lasted 45 minutes, the direct data examined involved approximately 8 hours. All the recorded material was also transcribed at the

standard language transcription level and selected extracts were transcribed meticulously at the discourse analysis level.

2) Audio recordings of follow-up interviews carried out by a third party but including the same questions for the patient and counsellor, were also used in Study III. Following the method established by Elliott (1999), the interviewer asked about the changes the patient had experienced in the course of counselling, the helpful and hindering aspects of the counselling itself, her experiences of alliance, the accuracy of the problem area, and how she felt about taking part in this research, in order to check possible problems related to the patient's treatment or the trial itself. These audio recordings were also transcribed at the standard language transcription level.

3) With the permission of the ethical committee and written informed consent from the patients, the auxiliary psychotherapeutic treatment provided for depression and the use of antidepressant medication at any phase in the treatment or afterwards were assessed one year after the end of the 12-month follow-up from the medical case records by the research psychiatrist who participated in Studies I, II, III.

## 2.5 Analyses

Change process researchers need to use all the available tools belonging to their qualitative and quantitative methods to analyse their data, within the same paper if necessary (Elliott, 2012). This means that nomothetic and idiographic approaches can be combined (Robinson, 2011). In addition, comparing data collected by different methods (triangulation) is an essential form of validation in psychotherapy and counselling research (Elliott & Timulak, 2005).

### 2.5.1 Quantitative analyses

The main statistical analysis used here (Studies I, II, III) to express the consequences of treatment for the patients was the analysis of reliable clinically significant change described by Jacobson and Truax (1991). The descriptive analysis of differences in demographics and clinical variables between the IPC and IPT patients was conducted using t tests for continuous data and $\chi^2$ analyses for categorial data (Study I), while the scales used in Study II were compared between the groups using the non-parametric Mann-Whitney Test. Significance was established at $p<0.05$. All these analyses were carried out with SPSS software, version 22.0 (IBM Corp., 2013). Analyses of the statistical significances of differences within and between groups and effect sizes (ES) were also used with the Mplus statistical program (version 7) in Study I (Muthén & Muthén 1998–2012).

The method of Jacobson and Truax (1991) is recommended for use in all psychotherapy outcome research whenever possible (Lambert & Ogles, 2009), as it examines clinically significant changes, i.e. ones that are unlikely to be due to

simple measurement unreliability. The method includes two steps for evaluating individual recovery: the first calculating a reliable change index (RCI) from a function of the remainder of the post-pre test, the initial standard deviation of the measure and its reliability, and the second calculating the cut-off C value to find a weighted midpoint between the means of a patient and a non-patient population. These two steps are used to classify individuals into one of four categories: 1) recovered (patient has passed the cut-off and the RCI in a positive direction), 2) improved (has passed the RCI in a positive direction but not the cut-off), 3) unchanged (has passed neither criterion), or deteriorated (has passed the RCI in a negative direction). Those patients whose baseline scores were under the cut-off C value were not divided into these classes. When calculating the RCI and cut-off, the results obtained by Connell et al. (2007) in a non-patient population were used for the CORE-OM. The non-patient values of Nuevo et al. (2009), Elovainio et al. (2009) and Aalto, Elovainio, Kivimäki, Uutela, & Pirkola (2012) were used for BDI.

Differences in changes between IPC and IPT were analysed by the statistician Joona Muotka using hierarchical linear modelling (HLM). This estimation uses a full information approach, with standard errors that are robust in the case of a non-normal distribution. The Wald test was used for assessing differences in change between groups and for testing change in the IPC group.

### 2.5.2 Procedures for analysing qualitative data

Before the statistical results of this investigation had been published (Study I), I had started to listen to the audiotapes and found that the multiple case study (Study II) and the case study (Study III) could address questions that fascinated me as a psychotherapist. My own experiences and those of the leading IPT researchers (Markowitz & Swartz, 2007; Ravitz et al., 2011) had highlighted the crucial role of case formulation in the IPT approach, but it was surprising to find that neither IPT or IPC case formulation had been studied before. In addition, given the vast amount of time and resources needed for any treatment investigation, it seemed economically efficient to focus the multiple case study on case formulation. These qualitative procedures were also realistic and feasible for me and my limited research resources.

The choice of cases for the multiple case study (Study II) was based on the analysis of reliable clinically significant change presented in Study I. Having selected the cases, I listened through the material several times and wrote detailed process notes to help me understand what had happened in the sessions. The recorded material was transcribed at the standard language transcription level (and selected extracts meticulously at the discourse analytical transcription level) subsequent to this immersion in the cases. At the first stage of analysis and as a preparatory stage for the subsequent analysis, I gathered and presented all the data obtained from the 10 patients in rich case record form (cf. Elliott, 2002), comprising basic facts about the patient (demographic information, diagnoses, problems on presentation), quantitative baseline scores on the CORE-OM subscales and initial remarks on the cases.

At the second stage of processing the data I conducted a content analysis of the patients' descriptions of their close relationships and the problem areas using the Atlas.ti 7.5.16 (1993–2017) software for coding and to help in obtaining a systematic analysis of the unstructured data. Atlas.ti is a workbench for the qualitative analysis of textual, graphical, audio, or video data. Directed content analysis (Hsieh & Shannon, 2005) proved to be a workable method for evaluating the patients' descriptions of their close relationships and the problem areas from the transcribed audiotapes. Directed content analysis is also referred to as deductive category assignment (Mayring, 2014), implying that the categories of close relationships used here were deduced from the theory and practices of IPC (Weissman et al., 2000). I coded the transcribed material into topic segments according to shifts in the content of the case formulation phases (discussing symptoms, evaluating interpersonal relationships and establishing an interpersonal problem area), and then coded the categories of the problem areas in accordance with the four problem areas recognised in IPC (Klerman et al., 1984; Weissman & Klerman, 1993; Weissman et al., 2000).

At the third stage of analysis, Elina Weiste, who at this point in the research was unaware of the outcomes of the cases, conducted the applied conversation analysis (CA) on the data concerning case formulation. CA is a qualitative micro-analytical approach to the study of human interaction at its finest level of detail. It highlights the fact that different kinds of social actions are organized into sequences (Sidnell & Stivers, 2013), so that each utterance gains its meaning in relation to the previous utterance and poses implications for subsequent utterances (Heritage, 2011). Following this idea, the analyst explored the process of case formulation as an interchangeable conversation in which the patient and the counsellor relate their conversational moves to the preceding context. The detailed conversation analysis transcripts display the words as they were said and indicate pauses within and between utterances and also overlapping speech (see Hepburn & Bolden, 2013, and the simplified transcription symbols provided here under Abbreviations).

The last stage of the data analysis was aimed at increasing the trustworthiness of the results. Here I compiled all the findings into compressed tables, figures and text extracts (see tables and figures in the Results section). The case formulation segments that had been analysed by means of conversation analysis were also discussed at two group meetings (data sessions) attended by trained CA researchers who were unaware of the outcomes. Data sessions are a standard means of quality assurance for CA data analysis. To validate the categories of the content and process of case formulation, I and Elina Weiste listened to the audiotapes while reading the transcripts once again. Finally, the selected examples and extracts and the outcome data were discussed several times with all the research team members who shared opinions, disagreements and feelings regarding the findings, thus reducing the biases inherent to a process in which just two persons were analysing the data. The research team was composed of a clinical psychologist and psychotherapist (the present author), a sociologist and occupational therapist (Elina Weiste), a physician specialized in

psychiatry and family therapy (Timo Liukkonen), a professor specialized in general practice and psychiatry (Markku Timonen) and a professor, psychoanalyst (IPA) and family therapist (Jukka Aaltonen). These discussions were inspired by the notion of consensual qualitative research (Hill et al., 2005).

The selection of a case for the theory-building case study (Study III) was also based on the analysis of reliable clinically significant change in Study I. Contrary to the procedure in Study II, I was now listening to all the sessions held with one patient to understand what happened in the process of IPC. After this immersion, I analysed the data using the qualitative software program Atlas.ti 7.5.16 (1993–2017), coding the material into topic segments according to content shifts in the verbal dialogue between the patient and the therapist (Angus, Levitt, & Hardtke, 1999; Angus, 2012). Applying the hypothesis of Lipsitz and Markowitz (2013) to the case, topic segments were next explored through the four interpersonal change mechanisms assumed in IPT. Since the theory-building case study was aimed at testing the theory, the hypothesis of Lipsitz and Markowitz (2013) was critically reviewed again in the light of this case (McLeod, 2012). To increase the trustworthiness of the findings, selected segments of the recordings were also investigated at one group meeting (data session) attended by trained conversation analysis (CA) researchers and one meeting attended by a clinical psychologist and a psychotherapist at an advanced level of competence. These people all were blinded to the outcome of the case.

### 2.5.3 The mixed methods analysis

Although the randomized clinical trial methodology has often been proclaimed as the gold standard in efficacy research, resolution of the gap between the researcher and the practitioner in psychotherapy research calls for the use of a mixed methods approach (Dattilio, Edwards, & Fishman, 2010).Thus the basic reason for using mixed methods emerged from the need for a more complete understanding of the outcome of IPC.

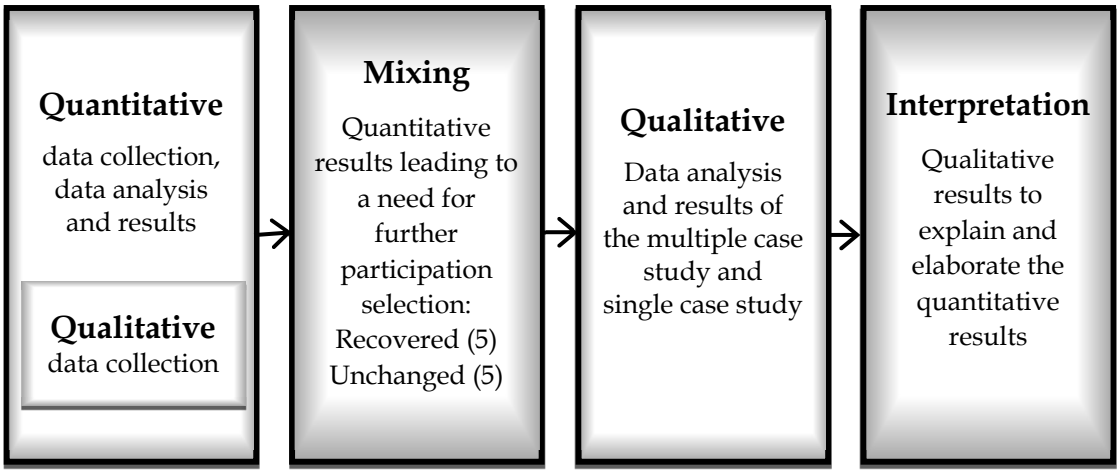


FIGURE 2 The embedded explanatory sequential design employed in this work (Figure based on Creswell & Plano Clark, 2018).

An illustration of the mixed method process is provided in Figure 2. Quantitative and qualitative data were collected in parallel, analysed separately, and then merged, after which a further data analysis was carried out using the SPSS statistical software, version 22.0 (IBM Corp., 2013) and the qualitative Atlas.ti 7.5.16 (1993–2017) software. This design and software allowed a link to be made between the process of counselling and standard measures of depression in an approach that could be called an embedded (at the data collection stage) and explanatory sequential (at the data analysis stage) design (Creswell & Plano Clark, 2018; Hanson Creswell, Plano Clark, Petska, & Creswell, 2005). This design proved useful for studying different groups within a single investigation, as the qualitative data collection could be invoked in order to explain the quantitative results. This integration of the data at the data interpretation stage is presented in the Results and Discussion sections below.

## 2.6 Ethical considerations

This work followed the World Medical Association (WMA; 1964) ethical principles for medical research involving human subjects (Declaration of Helsinki), and the protocol was approved by the ethical committee of the East-Savo Hospital District. The 25-page research plan also consisted of all the CONSORT topics regarding how the trial was designed and analysed (Consort group, 2010). Also, all items on the list of 18 Health Insurance Portability and Accountability Act (HIPAA, 2018-2019) Identifiers or mentioned in the Definition of Protected Health Information (PHI) were removed from the data. All the research data were carefully stored according to the standards laid down by the East-Savo Hospital District.

An indispensable aspect of research ethics is the principle that treatments should do no harm and that they should promote human welfare. At the screening visit psychiatrist Timo Liukkonen explained the purpose of the research and procedures involved (including the facts that all the treatment sessions would be audiotaped and that patients had the right to refuse to participate or to withdraw their consent at any time without reprisal). After ensuring that the potential patient had understood the information, the psychiatrist sought written informed consent. In addition, the follow-up interviews included questions about possible problems related to the patient's treatment or conducting the trial to ensure that the ethical principles had been observed. Both the therapies involved here had been empirically validated, and neither was known prior to this research to have any side effects. It may therefore be assumed that the patients in both groups received a better diagnostic assessment and a more circumspect and attentive therapeutic intervention than usual.

Since the multiple case study and the theory-building case study involved a higher degree of moral risk than the randomized clinical trial, some additional measures were needed (McLeod, 2012). While prospective informed consent had

been obtained from all the patients before the commencement of counselling, additional informed consent was obtained from the patient and the counsellor by the research psychiatrist and principal investigator for the purposes of the case study. Furthermore, the details of the cases were disguised, so that they were not identifiable. If it seemed that some detail about a patient might be identifiable, that detail was left out. Also, no comparable details were written on the paper unless they were central to the clinical discussion. The patients' names were in themselves pseudonyms. The maintenance of confidentiality through client disguise while using the case illustrations was a challenging task, and careful consideration was given to the complicated balance between changing enough characteristics to protect the client's privacy and altering the case to the extent that its validity was threatened (Sieck, 2012).

# 3 RESULTS

This section provides answers to the main questions addressed in this research by first summarizing the results presented in the original studies and then attempting to integrate these results by constructing a tentative conceptual model of the therapeutic change processes required for performing successful IPC in a primary health care context.

## 3.1 Study I: The outcome of IPC in primary care as compared with IPT in secondary care

Significant improvement in the outcome measures, CORE-OM and BDI, was observed across both groups, i.e. the IPC counselling in primary health care performed equally as well as the IPT in secondary care. As shown in Table 4, there were no statistically significant differences in the changes in clinical outcome measures between the treatment groups, as was confirmed using hierarchical linear modelling with Mplus (Muthén & Muthén 1998-2012).

TABLE 4 Parameter estimates for the IPC and IPT groups.

| Groups | Parameter | CORE-OM | BDI |
|---|---|---|---|
| **IPC** | Baseline | 17.515*** | 22.627*** |
| | End | -8.231*** | -13.172*** |
| | 6-MFU | -0.351 | -0.778 |
| | 12-MFU | 0.280 | 1.026 |
| **IPT** | Baseline | 16.635*** | 21.842*** |
| | End | -7.148*** | -10.097*** |
| | 6-MFU | -0.672 | -1.876 |
| | 12-MFU | -0.790 | -0.656 |
| **Group differences** | Baseline | -0.880 | -0.785 |
| | End | 0. 929 | 3.069 |
| | 6-MFU | -0.185 | -1.090 |
| | 12-MFU | -1.130 | -1.675 |

*Note:* ***P<0.001. The IPC and IPT parameter estimates at baseline are outset scores, and the other IPC and IPT parameter estimates are changes with time. The group difference parameter estimates at baseline are differences in outset scores between the IPT and IPC groups, and the other group difference parameter estimates are group differences in changes. IPC is the reference group. The p-values of the group differences are all greater than 0.1. IPC=interpersonal counselling, IPT=interpersonal psychotherapy, MFU=month of follow-up.

The within-group effect sizes from baseline to 12 months of follow-up for CORE-OM were Cohen's d =1.516 (95% Confidence Intervals 0.788, 2.244) in the IPC group and d =1.575 (95% CI 0.866, 2.285) in the IPT group. Similar patterns were noted for the four subscales of CORE-OM: d =1.569 (95% CI 0.728, 2.410) for well-being in the IPC group and d =1.604 (95% CI 0.752, 2.456) in the IPT group, d =1.592 (95% CI 0.880, 2.305) for problems/symptoms in the IPC group and d =1.621 (95% CI 0.820, 2.421) in the IPT group, while the effect size for functioning was not so significant, but still large, (d =1.112 (95% CI 0.522, 1.703) for IPC and d =1.299 (95% CI 0.744, 1.855) for IPT. Fourteen patients experienced a risk to themselves that exceeded the cut-off point (3.1) at the baseline and 5 patients after 12 months of follow-up. Within-group effect sizes on this scale were d =0.601 (95% CI 0.028, 1.174) in the IPC group and d =0.578 (95% CI 0.253, 0.902) in the IPT group. The corresponding scores and effect sizes for BDI were d=1.414 (95% CI 0.584, 2.244) and d=1.398 (95% CI 0.627, 2.168) respectively.

The third set of statistics used to express the consequences of treatment for the patients, those applying to clinical significance (Jacobson & Truax, 1991), showed that 59% (10/17) of the IPC group patients had recovered, 12% (2/17) had significantly improved and 29% (5/17) remained unchanged, while in the IPT group 62.5% (10/16) had recovered, 25% (4/16) had significantly improved and 12.5% (2/16) remained unchanged. A detailed comparison of the patients'

outcomes in terms of the differences between the pre-therapy and post-therapy (12-month follow-up) CORE-OM scores are shown in the scatter plot in Figure 3.

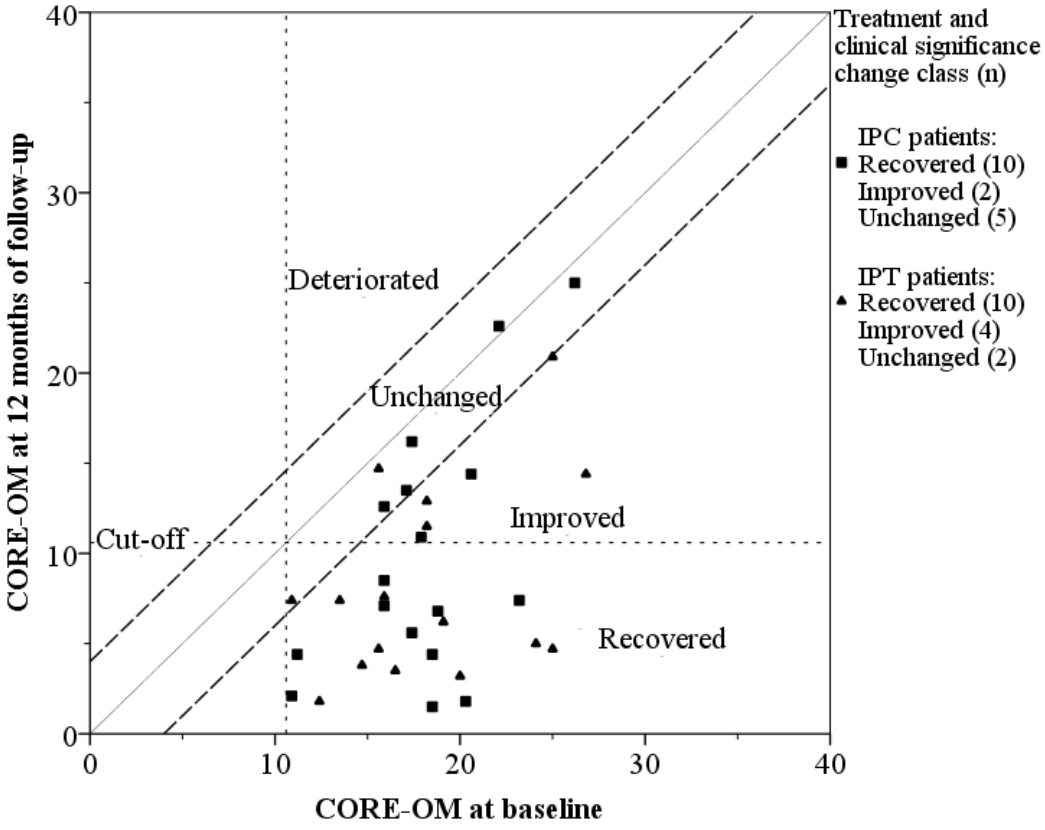


FIGURE 3 Scatter plot comparison between pre-therapy and post-therapy (12month follow-up) CORE-OM scores.

*Note*: Those scores below the lower interrupted linear equation line and below the horizontal cut-off line on the plot reflect those individuals who demonstrated recovered and scores below interrupted linear equation line but above the cut-off line reflect the individuals who demonstrated improved. The scores between interrupted linear equation lines on the plot reflect those individuals who demonstrated unchanged. Clinical significance (see Jacobson and Truax (1991)). CORE-OM Clinical Outcomes in Routine Evaluation.

No significant differences were found between the groups ($\chi^2$1.924, df 2 p=0.382), and approximately the same results were obtained with criteria defined based on the absence of depressive symptoms or the presence of minimal depressive symptoms (score < 10) and a 50% reduction from the baseline: i.e. the remission rates were 61% (11/18) on BDI in both the IPC and IPT groups.

## 3.2 Study II: Predicting response from the case formulation

A summary of the findings regarding case formulation for the patients in the recovered group (n=5) and unchanged group (n=5) is given in Table 5. The conversation analysis (CA) yielded two main types of interaction in connection with identifying the problem area and constructing the case formulation: joint and unilateral construction.

In all the recovered cases the interaction was characterized by joint negotiation between the counsellor and the patient, i.e. the case formulation had been constructed collaboratively. The counsellors had explored various ideas and deliberated over them together with the patients and presented their conclusions as tentative suggestions that were open to joint exploration. They were also responsive to the patients' emotional expressions and in the end the patients manifestly agreed on the problem area. In addition, it proved possible in the recovered group to jointly limit the patient's problem to one area, generally role disputes in social relationships.

TABLE 5 Main findings regarding case formulation for the patients in the recovered group (n=5) and unchanged group (n=5).

| | | Steps in case formulation | |
|---|---|---|---|
| Cases (pseudonyms) | Evaluating interpersonal relationships | Establishing an interpersonal problem area | Making the interpersonal formulation |
| Recovered group | | | |
| Paula female, 54 years, married | Adequate perceived support from spouse | Role disputes with a co-worker and a boss at the workplace | Joint construction: strong responsiveness – strong agreement |
| Daniel male, 33 years, married | Adequate evoked support from spouse | Role disputes in family business | Joint construction: strong responsiveness – strong agreement |
| Carolyn female, 54 years, married | Adequate evoked support from spouse | Role disputes with spouse | Joint construction: strong responsiveness – strong agreement |
| Joanna female, 30 years, married | Adequate evoked support from spouse | Role transition upon childbirth | Joint construction: strong responsiveness – strong agreement |
| Mary female, 30 years, married | Adequate perceived support from spouse | Role disputes at work and role transition due to husband's unemployment | Joint construction: strong responsiveness – strong agreement |
| Unchanged group | | | |
| Ann female, 58 years, married | Inadequate perceived support from spouse | Role transition - illness and cancer surgery, leaving work and role disputes with daughter | Joint construction: strong responsiveness – strong agreement |
| Dorothy female, 51 years, married | Inadequate perceived support from spouse and friends | Role transition – illness and threat of death and interpersonal deficit/isolation | Joint construction: strong responsiveness – strong agreement |
| Helen female, 48 years, married | Inadequate perceived support from spouse | Complicated grief – death of mother and role transition – daughter leaving home | Unilateral construction: weak responsiveness – partial agreement |
| Lisa female, 53 years, single | Inadequate perceived support from relatives | Complicated grief – death of mother and role disputes with sisters | Unilateral construction: weak responsiveness – partial agreement |
| Alex male, 24 years, single | Difficulties in accepting support from any close relation | No commitment to work on any suggested problem area, isolation and suicidal thoughts later in the session | Unilateral construction: weak responsiveness– partial agreement |

The interaction in the unchanged cases typically reflected difficulties between the patient and the counsellor: unilateral construction of the problem area, weak agreement and difficulties in responsiveness. The counsellors asked the patients to name the problem area or goal of the therapy, but did not investigate these collaboratively or develop them any further. They used the counselling manual strictly and inflexibly, bypassing the patient's responses, and had difficulties in reacting to the patients' emotional expressions. They also ended up with more than one problem area (complicated grief and role transition or role disputes), or else failed to define a manifest problem area during the initial two sessions.

Simultaneously with the findings of differences in the process of case formulation, there were differences in the patients' backgrounds. All the patients who recovered mentioned that they were able to discuss things with their spouses and felt they had social support available outside the treatment. In contrast, the unchanged patients had had less social support available and maintained that their husbands couldn't understand their problems, or else they had distant relationships with everyone.

None of the recovered patients had been prescribed antidepressant medication at any phase of treatment or follow-up, and only 7 sessions of counselling included in the present study had been needed. Three of the unchanged patients continued treatment with the same counsellors, one continued treatment in group counselling, and the remaining one became motivated to continue in intensive psychotherapy.

## 3.3 Study III: Mechanisms of change in IPC

The analysis of the case of Kathy suggests that interpersonal change mechanisms derived from the theoretical construction of Lipsitz and Markowitz (2013) might explain how the interpersonal formulation in IPC and the maintenance of the focus within an IPT framework leads to symptom change. Without the counsellor's effort in actively encouraging the patient to develop supportive relationships outside the counselling itself and maintaining the chosen focus on role dispute, the patient could have been left to repeat her self-accusation stance. The IPC protocol clearly guided the patient to work on her problematic relationship with her spouse, and the counsellor was even very prescriptive in keeping to the IPC principles. As could be expected in theory, the patient's change was not linear: distress increased during the initial sessions as the role dispute had reached an impasse before the problem began to resolve itself. As Table 6 shows, out of the four interpersonal change mechanisms it was 'facilitating emotional processing' that was mostly noticeably activated in the initial sessions. 'Decreasing interpersonal stress' and 'enhancing social support' were considerable in the middle phase, and 'improving interpersonal skills' came to prominence in the final sessions.

TABLE 6 Interpersonal change mechanisms throughout the phases of counselling.

| IPT change mechanisms* | Phase in which the change mechanism mostly occurred | Examples of the change mechanism |
|---|---|---|
| Facilitating emotional processing | Initial | IPC 1: The counsellor helps Kathy to give legitimacy to her feelings:<br>"That you kind of have the right to live like you feel. That it's terrible to live contrary to what you feel. If it is so bad to be in some relationship or anywhere else". |
| Decreasing interpersonal stress | Middle | IPC 3: The counsellor guides Kathy to see reciprocal expectation in marriage, instead of blaming herself for all the difficulties:<br>"Are you now absolutely sure that it is your fault?" |
| Enhancing social support | Middle | IPC 4: The counsellor encourages Kathy to extend her candour in friendship to candour with her spouse:<br>"With the other side, right. Yes. Like many say, a man makes a much better friend, as it were." |
| Improving interpersonal skills | Termination | IPC 7: The counsellor validates Kathy's adverse predisposition to interpret others' feelings and her perception of the importance of direct communication:<br>"Yes, in a way you guess the feelings of others like that…And you don't know those feelings until they tell you." |

* According to Lipsitz and Markowitz (2013)

The theoretical construct of Lipsitz and Markowitz (2013) aims to explain the specific processes entailed in IPT, but there are also many alternative descriptions and explanations at different points in Kathy's case. In addition to construction in the sense of Lipsitz and Markowitz (2013), the zone of proximal development (ZPD) (Leiman & Stiles, 2001; Vygotsky, 1978), moments of meeting (Stern et al., 1998) and appropriate responsiveness (Stiles, 2009) can be seen to be reflected in the success of counselling. These alliance-related facets are presented and exemplified in Table 7.

As all the extracts in Table 7 show, Kathy and her counsellor may have had discrepant experiences of personal safety, intimacy and attachment. Although they had a common cultural background, their ways of dealing with problems were mutually opposed. Kathy was very cautious about telling anyone about her problems, whereas the counsellor was bold about fostering discussions of close relationships and making her own more immediate type of self-disclosure

prominent in the sessions. These opposites in the behaviour of Kathy and her counsellor helped them to complement each other.

TABLE 7 Putative alliance-related change mechanisms.

| Alliance-related facets | Examples of change mechanisms | |
|---|---|---|
| The zone of proximal development (ZPD) | IPC 3: The counsellor pushed Kathy ahead quite hard, inviting her to adopt a new perspective and try a new behavioural tactic immediately in the initial sessions. Kathy tolerated this and was able to make use of counselling: | |
| | Counsellor: | Yes, that's it. So it would be necessary to get him to discuss things first. |
| | Kathy: | Well, I'll try then. Yes, I will try to cheer myself up. We have to wait and see what will come out of it… |
| | Counsellor: | Whatever it might be, because things can't get any worse. |
| | Kathy: | Can't they? |
| | Counsellor: | No, no. Things can't be any worse. This anxiety of yours is so severe. |
| Moments of meeting | IPC 3: The following dialogue was unexpected. Both parties contributed something unique and authentic as individuals in response to a "now moment." and the interaction was transformed to a new level of activation and joy after Kathy's fixed emotional circle: | |
| | Kathy: | Well he is not the kind of person who would really excite me, but I wouldn't, I wouldn't go and try out who excites me and who doesn't. Where do you find these people, whether this one or that one excites you? |
| | Counsellor: | Just try, hee hee |
| | Kathy: | Try, and see who would agree to it. Hee, hee. |
| | Counsellor: | Line up all the unattached men in town, hee hee? |
| | Kathy: | Mm |
| | Counsellor: | Just joking, hee hee. |

Table 7
Continued

| | | |
|---|---|---|
| Appropriate and complementary responsiveness | IPC 7: Appropriate responsiveness means that the therapist or counsellor does the right things at the right time. The counsellor did not accept Kathy's pessimistic self-accusation as such but actively provided support in accordance with the IPC model, thus complementing Kathy's hesitation: | |
| | Kathy: | Well yes, I tried, at first I did, but I could see that it was not going to work. That I had to do something. It would be going back to the same thing, if... Like when we talked here, and you said precisely that, … that say it, say it out aloud, that I should dare to say it in spite of everything, what my own feelings were like. And then somehow, I should show responsibility for the other person. And somehow hand him the cards, tell him that these are the conditions. And that I can't do anything else. That I have made this observation and come to this point of view. |
| | Counsellor: | And what about those feelings of your own. |
| | Kathy: | Yes, my own feelings. |
| | Counsellor: | And emotions, yes. |
| | Kathy: | Yes, and then give,... let the other take responsibility for his feelings. Because I do have the tendency to jump to conclusions really quickly, that as you feel this way, and so on. |
| | Counsellor: | Yes, in a way you guess the feelings of others like that. |
| | Kathy: | Yes I do. |
| | Counsellor: | Or you think you know them. |
| | Kathy: | I think I know, although I don't necessarily know at all. |
| | Counsellor: | And you can't know until they tell you. |
| | Kathy: | Quite right, you can't know. Now that I think about it, when I came here the first time, and all that. I really am in much better shape now. |

## 3.4 Integration: from general efficacy to idiographic process-outcome effectiveness

The above emerged as an example of the successful use of IPC in primary health care by virtue of the interplay between the counsellor and the patient in the joint construction of the problem area and the counsellor's appropriate practice of

adhering to the IPC manual and its protocol and showing complementary responsiveness. A tentative conceptual model involving mediating and moderating factors is presented in Figure 4. This qualitative case study extended our findings with regard to the efficacy of IPC by exploring putative mediators (facilitating emotional processing, decreasing interpersonal stress, improving interpersonal skills and enhancing social support) in relation to the hypothesized interpersonal change mechanisms (Lipsitz & Markowitz, 2013). In addition, it revealed the importance of alliance-related mediating factors: joint construction of the interpersonal problem area, leading to strong agreement on the part of the patient and appropriate complementary responsiveness from the counsellor, which was associated with the concepts of a zone of proximal development and moments of meeting. Two factors (adequate evoked support from a close relationship and the ability to limit the problems to one area) could be looked on as moderators and used to identify patients who are likely to benefit from IPC.

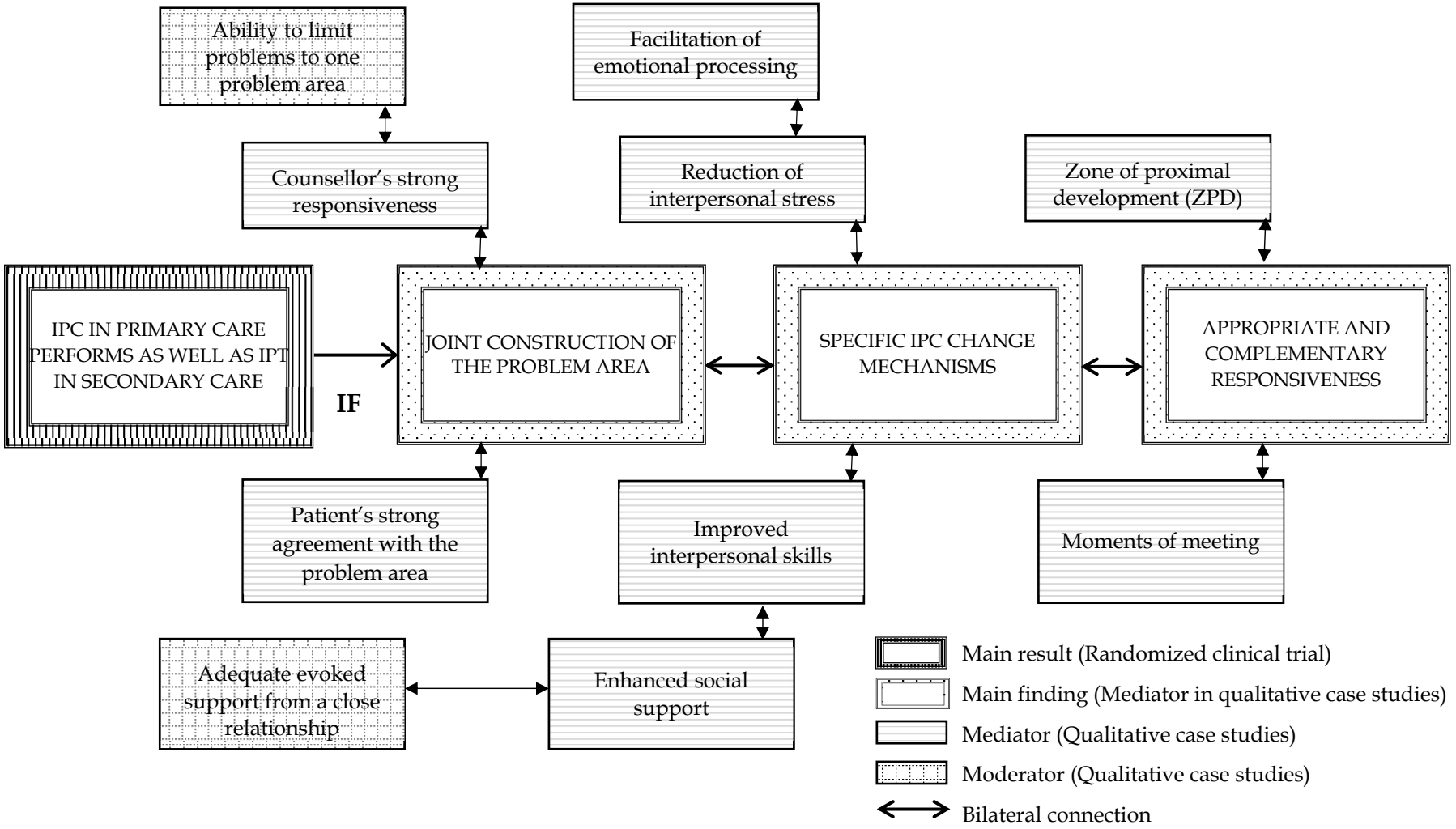


FIGURE 4 Tentative conceptual model of therapeutic change processes involved in successful interpersonal counselling (IPC) in primary health care.

# 4 DISCUSSION

The purpose of this research was to optimize the use of effective treatment for patients with depressive disorders who present in primary health care settings. The questions to be answered were whether IPC is sufficient treatment for depression in primary care patients, how the process of case formulation is associated with the outcome of IPC, and what the putative mechanisms of change involved in IPC are. This chapter will provide a general discussion of the results and findings reported above, followed by methodological considerations, implications for future research and implications for clinical work and training.

## 4.1 Overview of the results

The main result stated in Study I was that both interpersonal counselling (IPC) in primary health care and interpersonal therapy (IPT) in secondary care are helpful for previously untreated primary care patients with mild to moderate major depression. Both groups improved significantly over time, with large effect sizes, so that ca. 60% of the patients in both the IPC and IPT groups recovered and reached remission. In Study II, the interaction in the case formulations for the recovered group was generally characterized by the construction of one problem area jointly by the counsellor and the patient and the counsellor's responsiveness to the patient's expressions of emotion. With the unchanged patients the interaction reflected more difficulties between the patient and the counsellor, i.e. unilateral construction of the problem areas, weak agreement and difficulties in responsiveness. Social support was available for each patient who recovered, whereas the unchanged patients lacked social support other than through the treatment. The findings of Study III suggested that the theoretical construct of Lipsitz and Markowitz (2013) implying four interpersonal change mechanisms might explain how the interpersonal formulation involved in IPC and the maintenance of the focus within an IPC framework can lead to symptom change. Thus 'facilitating emotional processing' may be said to have dominated

the counselling process in the initial sessions, 'decreasing interpersonal stress' and 'enhancing social support' were substantial in the middle phase, and 'improving interpersonal skills' was mobilized in the final sessions to resolve the patient's problem. The theory could not be satisfactory, however, without the dimension of a therapeutic relationship, i.e. 'appropriate and complementary responsiveness' on the part of the therapist. In summary, performing successful IPC in primary health care was confirmed as eminently possible under the following conditions: 1) joint construction of the case formulation by the patient and counsellor, 2) appropriate use by the counsellor of the IPC manual and its protocol, and 3) complementary responsiveness on the part of the counsellor.

## 4.2 Discussion of the results

This section discusses the above results and findings in relation to previous quantitative and qualitative research.

### 4.2.1 Research into the effectiveness of treatment for depression

The statistical results presented here validated the conclusion reached by Nieuwsma et al. (2012) that major depressive disorder (MDD) or depressive symptomatology can be efficaciously treated with 6-8 sessions. The work that is most immediately comparable with Study I is that of Menchetti et al. (2014), in which the proportion of depressed primary care patients who achieved remission on the Hamilton Rating Scale for Depression (HRSD, 21-item) after two months of IPC was 59%. The present remission rate is also comparable with that reported by Cuijpers et al. (2014) in their meta-analysis of all psychotherapies for depression, namely that 62% of the patients who received any kind of psychotherapy no longer met the criteria for major depression. Comparing the results with those of practice-based studies carried out in routine service settings is more complicated, however, because recovery rates depend on how the sample is chosen (Barkham, Stiles, Connell, & Mellor-Clark, 2012). It is still clear, however, that the outcome results presented here exceed those of the selected completers' group in practice-based studies, as 58–64% of the patients reported to have completed psychotherapeutic treatments recovered or improved and 40–58% of these had recovered (Richards & Borglin 2011, Gyani et al., 2013, Holmqvist et al., 2014). By contrast, a total of 71% of the present IPC patients recovered or improved, including 59% who recovered in terms of the criteria of Jacobson and Truax (1991). Even taking into account the mild to moderate severity of MDD in these cases, it is promising that the remission rates for IPC seem to be comparable with those of psychotherapies for depression.

The good results achieved here could only partially be attributed to the IPC approach, as these mental health nurses trained in IPC already had a great deal of experience in treating depressive patients. In my experience a structured

method of this kind requires the nurses, doctors, psychologists or other health workers to possess at least the basic skills required for this purpose.

The similarities between the treatment outcomes achieved with IPC, IPT and other psychotherapies can also be viewed through the concept of the equivalence paradox (also called the "Dodo Bird Verdict" by Rosenzweig, who, in 1936, first invoked the dodo's words in Alice's Adventures in Wonderland, "Everybody has won and all must have prizes," to illustrate his observation of the equivalent success of diverse psychotherapies). This argument still seems to hold good in the analysis of psychotherapies in general (Wampold & Imel, 2015) and in primary health care (Stiles, Barkham, Mellor-Clark, & Connell, 2008). The equal results reported in Study I can also be seen as reflecting a component effect (Cuijpers et al., 2019) in that the 16 sessions of full therapy comprising IPT did not lead to an outcome that differed from that of the briefer 7 sessions of IPC counselling. A corresponding result was obtained by Molenaar et al. (2011) when comparing 8 and 16 sessions of psychodynamic supportive psychotherapy.

Although randomized trials have gained in importance in recent years and more training has been called for in evidence-based treatments (cf. Weissman et al., 2006; Sburlati, Lyneham, Mufson, & Schniering, 2012), the relationship between evidence-based research and clinical practice is problematic. It is interesting to note that if the control group in a trial receives a different form of active treatment, the differences between the two groups will be smaller or may even disappear entirely (Baskin et al., 2003), as was found here. For this reason it is justified to complement the quantitative results with qualitative analysis.

### 4.2.2 Mediators and moderators in case formulation

The analysis of IPC case formulation presented here provided a working alliance perspective as a mediating factor for the outcome. The counsellors reformulated the patients' problems as a discourse consistent with the IPC perspective during the initial counselling sessions, and this helped to direct the counselling process in the recovered cases towards a favourable symptomatic outcome. If, on the other hand, no emotional bond or shared idea of the goals of the counselling could be formed during the initial sessions, this indicated that the patient would not benefit from the intervention (Horvath & Bedi, 2002). These findings are in line with those of Buttny (1996) and contribute to previous research by linking joint identification of the problem area with a positive outcome for the overall therapeutic process. At a general level this process refers to the philosophy of a language game, as put forward by Wittgenstein (1953), i.e. case formulation can be seen as a language-game in which a counsellor reformulates the patient's utterances for the purposes of therapeutic work.

Yet another interactional practice that seems to be linked to joint construction of the case formulation as a mediating factor is shared decision-making (SDM), which has been recommended at a mental health policy level but has remained limited in terms of implementation (Slade, 2017). SDM denotes generally a choice between treatment models, but it can also imply shared decisions within a treatment model. The concept of SDM has been formulated in

reaction to the paternalistic model in medicine (i.e. the assumption that physicians make the decisions). The customary alternative, an informed choice model (i.e. that the patients make the decisions after obtaining information from the clinicians) represents the opposite approach, but still implies a one-way exchange of information and may leave the patient alone with the decision (Charles, Gafni, & Whelan, 1999). By contrast, SDM offers the patient an active role and a share of the responsibility, while the clinician has an opportunity to participate in the decision-making process, but not to dominate it (Charles, Gafni, & Whelan, 1997). Such shared decision-making was clearly present here in the recovered cases, whereas there were various difficulties with regard to decision-making in the suggested problem areas in the unchanged cases.

A patient might still benefit from IPC even though no consensus can be reached regarding the case formulation, as the present findings indicated that IPC can assist the counsellors in exploring interpersonal stress situations and in giving the patients preparatory strategies for managing these, while at the same time providing tools for selecting patients with severe depression for other, more appropriate treatment (Weissman & Verdeli, 2012). In one of the unchanged cases, for instance, the counsellor and patient could not agree on an IPC problem area that could be explicitly labelled in the case formulation, and consequently the patient's depressive symptoms did not change significantly. In fact, the post-test revealed even more distress in the patient's close relationships. One can assume that a patient's increased distress in close relationships could serve as a starting point for work on the interpersonal level once the belief that life is meaningless has been rejected. The case in point here evidently became more aware of his depression, judging from the fact that he was motivated to continue in an intensive course of 200 hours of rehabilitative psychotherapy in the private sector lasting three years on the strength of reimbursement from the Social Insurance Institution. This reimbursement is normal in Finland, where it is the most commonly used procedure for obtaining psychotherapy.

From a counsellor's perspective, the data point to different ways of using the manual. In the light of the audiotapes listened to and the transcriptions obtained, the counsellors followed the IPC manual faithfully, but also adapted it as required. The structuring of the treatment into phases and intervening tasks seemed natural, and the protocol seemed to help the counsellors to focus on the goal and logic of the treatment. But there was also an evident risk that the therapeutic alliance might be overshadowed when the counsellor reformulated the patient's complaints with excessive emphasis on finding a problem area. The counsellors in the unchanged group typically adhered to the manual in a strict manner, which could weaken the alliance with the patient. They tended to interrupt the patient's speech and return to reviewing the questionnaire form, bypassing the patient's accounts of emotional experiences. Some studies have suggested that high levels of adherence to specific technical procedures may weaken this alliance, thereby interfering with therapeutic change (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Henry, Butler, Schacht, & Binder, 1993). It has also been assumed that therapists who carry out therapy by the book attend

more to their manuals than to their patients (Duncan & Miller, 2005). Following the manual in a rigid "cookbook" fashion involves a risk that counsellors will fail to pay enough attention to nuances in the therapeutic relationship and the patient's rhythm (Weissman et al., 2000, p. 378).

In addition to factors in case formulation that mediate the outcome, two factors were found here which may just as well be moderators as mediators. Firstly, social support was available for each recovered patient, whereas the unchanged patients lacked social support. This observation is consistent with previous research into IPC (Badger et al., 2006; Badger et al., 2013) and the overall evidence for the role of spousal support during the recovery phase (Gariépy, Honkaniemi, & Quesnel-Vallée, 2016; Salakari et al., 2017). The fact that all the present unchanged patients had had less social support available from their spouses or friends may lead us to conclude that patients whose basic psychosocial structure is in order are more likely to benefit from short-term therapy (Joutsenniemi, Laaksonen, Knekt, Haaramo, & Lindfors, 2012) and may also be more ready and suitable for psychotherapy (cf. Laaksonen, Knekt, & Lindfors, 2013).

Secondly, the fact that concentrating on one problem area in case formulation, generally role disputes in social relationships, was associated with a better outcome, suggests that if the problems are multifarious and associated with role transition after a serious loss of health or complicated grief, the benefit of short-term counselling will probably be poorer. These observations support earlier findings that suffering from a concurrent physical illness may limit the benefit of IPC (Holmes et al., 2007; Menchetti et. al, 2014). Complicated grief (combined with role disputes or role transition) was also associated with a poorer outcome, which is in line with the findings of Markowitz et al. (2006) in dysthymic patients. All these findings may be related to the heterogeneity of depression argued for by Rantala, Luoto, Krams and Karlsson (2018). The present unchanged patients seemed to be experiencing a quite different form of depression from those who recovered. Out of the 12 classified subtypes of depression, hierarchy conflict was typically associated with the depression observed in the recovered group. On the other hand, loneliness, traumatic role transition after a serious loss of health and grief as underlying reasons for depression predicted a poorer outcome.

### 4.2.3 Mechanisms of change and the therapeutic alliance

The qualitative theory-building case study reported here supported the hypothesis of four interpersonal change mechanisms (enhancing social support, decreasing interpersonal stress, facilitating emotional processing and improving interpersonal skills that are inherent in IPC as proposed by Lipsitz and Markowitz (2013), but it also adds significant alliance-related contributions that go beyond their work. This wider perspective was obtained by examining therapeutic interaction session by session at its most detailed level. No data on this therapeutic interaction was accessible from the Lipsitz and Markowitz (2013) review. The zone of proximal development (ZPD) (Vygotsky, 1978; Leiman &

Stiles, 2001), moments of meeting (Stern et al., 1998) and appropriate responsiveness (Stiles, 2009) could all be observed in the successful counselling process.

On the other hand, the present findings regarding the qualitative IPC process can also be evaluated from other perspectives. Firstly, the criteria of Wampold's (2001, 2015) pan-theoretical "contextual model" were met in the sense that the patient formed an initial bond with her counsellor and regarded that counsellor as trustworthy and existing in a real and equal relationship. She settled down to the counselling process, agreed on the goals and purposes of counselling and the counsellor was able to induce her to perform healthy actions by improving her interpersonal relations. The counsellor worked in a mutually accepted role with the patient to provide a comprehensible and sufficiently logical explanation for the patient's problems and a proposal for their treatment. Thus the IPC case formulation was not too far removed from the patient's own understanding of the situation. The impact of IPC may to a considerable degree reflect the extent to which its principles combine an explanation of depression as a treatable illness with certain crucial factors required for productive psychotherapy: a view of treatment that the patient finds justifiable and acceptable, congruence between the therapeutic process and the causal explanations for depression, and active participation by the patient in the treatment. These principles form an understandable and mutually shared basis for joint action by the patient and counsellor.

Secondly, the patient's readiness for change (Norcross, Krebs, & Prochaska, 2011; Prochaska & DiClemente, 1983) can be seen to be reflected in the success of counselling. The patient was aware of her self-accusation and quite soon came to associate it with the difficulties in her marriage and attempted to discuss the situation with her spouse. At this point she represented a subject who is at the stage of initial contemplation, so that she could quickly reach the stages of preparation and action during the treatment.

Thirdly, the assimilation model (Stiles et al., 1990) can explain how matching therapist interventions with client potentials can contribute to successful development in counselling. This model describes psychotherapeutic change as an 8-stage Assimilation of Problematic Experiences Sequence (APES) in which the patient's problematic experiences are assimilated into the self, allowing the person to integrate previously painful, avoided or distorted experiences via meaning bridges. Building meaning bridges is a process of coming to terms with problematic voices, which in turn reduces distress (Stiles, 2011). The patient's initial stage could be rated as APES 2, which means that she suffered acute psychological pain and was aware of a problematic experience, but could not formulate the problem clearly. Over the course of counselling she gained new understanding of herself and was applying this understanding productively in her relation to her spouse and friends. This change could be rated as APES stage 5: Her affective tone was positive and optimistic, and she became used to working on the problem. She was relatively satisfied at this stage.

Whether a formerly problematic experience can become a resource in new situations (e.g. APES 6 and 7) remains to be seen in the future.

Fourthly, if the innovative moments coding system (IMCS) of Gonçalves, Ribeiro, Mendes, Matos and Santos (2011) had been used to analyse the association between events and the treatment outcome the idea of reconceptualization would undoubtedly have emerged. Reconceptualization, which seems to be a distinctive feature of a successful psychotherapy process (Gonçalves & Ribeiro, 2012; Fernández-Navarro et al., 2018), was observed e.g. when the patient remarked on the contrast between her past problematic position and her more adjusted current one. She also integrated this change process into her improved well-being.

## 4.3 Methodological considerations

The research was carried out in a naturalistic clinical setting, thus assessing effectiveness rather than efficacy. A mixed method design was preferred for in order to achieve a comprehensive story for each individual patient, although it was extremely labour-intensive and time-consuming. On the other hand, this highlighted the diversity of interactional factors lying behind the statistical outcomes and explained the therapeutic interaction at its finest level of detail. Thus the findings serve to increase our understanding of the therapeutic relationship that explains why patients recovered or remained unchanged, at least as much as did the treatment method (Norcross & Wampold, 2011).

### 4.3.1 Strengths of the research

One strength of this research lay in its mixed methods design, including both quantitative and qualitative data sources. Also, the attrition rate was small. Adherence to the treatment protocol was ensured by means of session-by-session checklists, audiotaping all the treatment sessions, discussing the protocols in regular supervision groups and interviewing the patients and the therapists about their experiences of the therapy and counselling process.

The randomization was blinded, so that the screening psychiatrist did not know the treatment to which the patient had been assigned before conducting the structured diagnostic interview, thereby ensuring accurate classification of the patients' diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association 1994), as defined in the concept of a Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al., 1998). The treatments were well-defined and assessed with psychometrically robust outcome measures. Three groups of statistics (statistical significance of the within-group and between-group differences, effect sizes (ES), and clinical significance) were used to express the consequences of psychotherapy and counselling for the patients.

The sources used for the qualitative analysis were audio recordings of the sessions and the patients' post-therapy interviews. Interactional features of the sessions from the audio recordings were analysed by means of applied conversation analysis (CA) and content analysis. Quantitative and qualitative data were collected in parallel, analysed separately and then merged. The data analyses were carried out with both statistical and qualitative software, leading to an embedded and explanatory sequential design (Creswell & Plano Clark, 2018; Hanson et al., 2005) that allowed the process of counselling to be linked to standard measures of depression. The various evaluations and judgments formed a clinically relevant and coherent whole.

The statements made by the patients and counsellors in the extracts and their textual interpretations by the researcher were brought forward as part of the overall findings, and in this way the qualitative analyses added to and enriched the understanding that had been developed in the quantitative analyses. The author had the advantage of over 30 years' clinical experience as a psychologist and psychotherapist, in addition to which entering this research was a matter of extreme professional interest. One significant shift that took place in the course of this work concerned my views regarding the power of short-term counselling. At the outset I was greatly concerned about the possibilities for treating depression with so few sessions, partly on account of my background as a psychoanalytic psychotherapist, but I can now see the value and role of short-term counselling and appreciate how this kind of intervention can be helpful without sacrificing the depth of psychotherapeutic work, provided that the counsellor's therapeutic stance is a humanistic one. For my part, I tried throughout as a researcher to be honest, respectful and encouraging towards the counsellors and therapists responsible for the treatments.

### 4.3.2 Limitations of the research

Although the choice of a mixed method design was the main strength of this work, the research also entailed a number of limitations that have to be taken into account. Firstly, the original design included a total of 60 patients to be randomized, but we had to terminate the recruitment at the end of April 2012. Our impression was that although we had informed general practitioners repeatedly about the research, they ended up treating most patients (possibly more obvious or non-compliant psychotherapy cases?) at their offices and only some (possibly more problematic or psychotherapy-oriented cases?) were passed on to the research group directly or through the nurses. The problem may be the same as that described by Judd et al. (2001): "A large number of general practitioners initially agreed to participate in the study, but only a small number participated. The main reasons for non-participation were lack of time and poor remuneration for involvement in the study." Also, our impression was that not all patients suffering from depression contact the public health services. Thus, the statistical power of the sample size was quite low and limited our possibilities for detecting significant differences between two sets of conditions at each time point.

Secondly, the considered decision to use a high-intensity comparator, the empirically validated method known as interpersonal psychotherapy (IPT), as a control group for IPC instead of a waiting list control group, TAU or simple psychoeducation, for instance, may leave the reader wondering what would have happened if an alternative control group had been used. In the absence of the inclusion of such a control group one cannot speculate on these comparisons, but it must be accepted that all comparison results are highly problematic to interpret because of multiple methodological biases. The blinding used in drug trials is not possible in psychotherapy trials, and in the case of waiting list controls patients know they are waiting for therapy and do not expect any improvement. This means that there can be a "nocebo" effect for psychotherapy patients, just as there is a placebo effect for patients receiving a medication placebo (Benedetti, Frisaldi, & Piedimonte, 2019).

Thirdly, the allocation of patients was implemented not only for two treatments but for two settings: IPC was used in municipal primary care units and IPT in one outpatient psychiatric clinic. These settings in themselves could potentially have deviant effects on the outcome, although the IPC patients could have been sent for psychiatric consultation when needed. Basically, the IPC patients were treated in primary care by general practitioners and the IPT patients in secondary care by psychiatrists, and the differential setting in which the interventions were offered, primary versus secondary care, was likely to have had an effect on their medication. Antidepressant medication was not controlled, which may have obscured some of the real differences between IPC and IPT. Medication was allowed because the Finnish Depression Treatment Guidelines (Finnish Current Care Guidelines: Depression, 2020) encourage pharmacotherapy in cases of mild to severe depression. The decision to prescribe medication was the responsibility of the treating physician.

Fourthly, the investigator's personal involvement in the research may have influenced the outcomes. The author himself trained and supervised the therapists and conducted the post-therapy interviews with the patients together with the research psychiatrist, and it is therefore possible that the researcher's allegiance may have influenced the outcomes in favour of both treatments. Allegiance on the part of researchers and therapists has been shown to influence outcomes in favour of the preferred treatment. A recent overview of reviews (Munder, Brütsch, Leonhart, Gerger, & Barth, 2013) indicated that the mean researcher allegiance in psychotherapy outcome research was r=.262, corresponding to a moderate effect size. Under ideal conditions, research with a "crossed therapist" design, implying that the same therapist would provide both treatments, would solve this problem (cf. Munder et al., 2013; Falkenström, Markowitz, Jonker, Philips, & Holmqvist, 2013).

Fifthly, the investigator may have shown some bias in the data analysis which could constitute a source of error, although diligent efforts were made to analyse the data in as objective a manner as possible. For example, it was impossible to calculate inter-rater reliabilities for the qualitative categories in the case study, since I was in the first instance the only person identifying the

categories. The method of consensual qualitative research (CQR) (Hill et al., 2005) would presumably have been appropriate here, but we had to settle for two group meetings of independent experts (trained in conversation analysis (CA) and psychotherapy). Neither the number of categories of change mechanism nor their occurrence in the initial, middle or final phases of therapy was predefined, although there were powerful conceptual commitments to finding that the theoretical assumptions of Lipsitz and Markowitz highlight only some aspects in the data (Hsieh & Shannon, 2005). Other stories are possible.

In spite of the above limitations, I believe that this research measures up to the trustworthiness required of a mixed method study. The reader is able to grasp the integrity of the data, rely on the primary researcher's evidence for an appropriate balance between the meaning of each case and its interpretation and finally agree that the applications of the findings are important (Williams & Morrow, 2009).

## 4.4 Future research

This work has added to and enriched our understanding of factors inherent in the content and process of counselling that affect the achievement of a satisfactory outcome, but it has also brought to light a number of implications for future research. It is to be hoped that future comparisons between IPC and IPT will have a larger sample size and establish better control over confounding variables, and also that research into depression interventions will pay equal attention to qualitative assessment of the change mechanisms that facilitate improvements alongside the improvements in depression symptoms conventionally noted in clinical trials.

Longer-term follow-up studies are required to determine whether the benefit of IPC continues and is maintained over time, because it has been found that the therapies discussed here do not constitute sufficient treatment in over half of all depression patients, as seen in the 5-year follow-up data based on the Helsinki Psychotherapy Study (HPS), for example (Knekt et al., 2011). It has also been found that medication is preferred for those patients who need auxiliary treatment after psychosocial interventions, possibly reflecting the superior availability of medication or dissatisfaction with the psychotherapy received, or simply a lack of interest in time-consuming or expensive therapies (Knekt et al., 2016).

Based on the preliminary findings in this thesis, the primacy of counselling or medication among the population of patients seeking treatment for depression for the first time might be a fruitful area for future research. There were substantial differences in antidepressant medication use between the groups studied here (IPT=70%; IPC=45%), and it was also found that, regardless of the severity of the baseline symptoms, the patients who were not prescribed antidepressant medication had fewer depressive symptoms in CORE-OM at follow-up, while 90% of the patients who received no concurrent antidepressant

medication during IPC had no need for auxiliary treatment for depression during the one-year follow-up. In this respect, the good results achieved with IPC do not seem to have been due to medication, as those without medication had better recovery rates. Afterwards, when I presented the results to the counsellors for review, they commented that most patients without prescribed medication could very well have had medication but had refused. It is possible that the more seriously ill patients may somehow have been prescribed medication during the symptom assessments and had accepted it in the first place, and that this vulnerability had shown up after a year. Another explanation, however, could be that medication impaired the outcome in this population of patients seeking treatment for depression for the first time, a situation possibly confirmed by the observations of Serretti et al. (2013) and Menchetti et al. (2014), since the proportion of remission for primary care patients in their first depressive episode was significantly higher in the IPC group than in the SSRI group, suggesting that IPC is a useful alternative to antidepressants. Peeters et al. (2013) also found lower BDI scores in patients receiving cognitive therapy alone than in patients who received cognitive therapy and pharmacotherapy. There has been some debate as to whether pharmacotherapy or psychotherapy should be used primarily, and the common finding has been that when psychotherapy and antidepressants are employed concurrently they have greater effectiveness than either modality alone (Wolf & Hopko, 2008, Cuijpers, van Straten, Warmerdam, & Andersson, 2009). The outcome of pharmacotherapy, psychotherapy and their combination would appear to depend on the severity of depression. A meta-analysis has suggested that for sub-clinically, mildly or moderately depressed patients antidepressants may not be any better than a placebo, but conversely, for patients with very severe depression pharmacotherapy is markedly superior to a placebo (Fournier et al., 2010). This current hypothesis is still under debate, however (Kirsch et al., 2008; Horder, Matthews, & Waldmann, 2011).

The differences in treatment cultures might be an important research topic in its own right. Medication is reported to have been prescribed more often in a special care unit, and although the small sample size enabled only tentative conclusions to be reached, secondary care may be oriented towards more complicated cases and thus patients may more often be prescribed medication or directed towards follow-up treatment. It was found that only 11% of the present IPC group (those in primary care) had continued in intensive psychotherapy, while 39% of the IPT group (those in secondary care) had done so (unpublished data).

Future research should certainly examine the feasibility and acceptability of IPC for different client groups presenting with depression symptoms (e.g. in school health and welfare services or in occupational health). The acceptability of IPC is reported here to have been high, and patients indicated in their follow-up assessment interviews that the structuring of their treatment into phases and intervening tasks seemed natural and that they had no problems with the treatment protocol. The counsellors also felt that the structure of the counselling,

with a manual and adequate monitoring, was useful and that the protocol helped them to focus on the goal and logic of the treatment (unpublished data).

As far as previous findings regarding the different types of depression (Rantala et al., 2018) are concerned, it was found here that the unchanged patients seemed to be experiencing a quite different form of depression from those who recovered. They had experienced irreversible life changes and a lack of prospects for the future, which may be referred to in a sense as 'giving up'. Ratcliffe (2018), who approached depression from the phenomenological philosophical tradition, emphasized how depression experiences involve profound changes in one's sense of possibility which are inseparable from the prospect of interpersonal relations. Future research should examine this phenomenon beyond the diagnostic criteria with respect to a favourable or unfavourable outcome in counselling and psychotherapy.

Future research will need to recognise more mediating factors, such as how successful outcomes could be created by mobilizing support from others. The present case study suggested that mobilizing support from others was a prerequisite for recovery from depression, since the counsellor's active and prescriptive stance and relevant questions about the patient's relationship with her spouse were able to turn the patient away from her attitude of self-accusation towards a discussion of her marital problem. This decisive turnaround paved the way for small but useful changes that made recovery more likely.

## 4.5 Clinical implications

This thesis has demonstrated that short-term counselling, including the joint construction of a problem area and appropriate and complementary responsiveness on the part of the counsellor, is helpful for people in primary care who are suffering from depression. This topic is of international interest, as the challenges posed by depression have become a major treatment problem throughout the world. Health care workers require effective interventions for use in their work. Since the testing of short-term IPC in a typical clinical setting in primary care is of great clinical importance, the results of this thesis carry a number of implications.

Firstly, the findings have important organizational implications. The research was carried out in a naturalistic clinical setting in which the patients were actually seeking treatment for the first time and were being treated by mental health nurses, who share the responsibility for the treatment of depression in Finnish primary care with general practitioners, although it is the physician who has the final juridical responsibility in each case. The findings increase our knowledge of Finnish primary health care opportunities in the field of depression care and are applicable in practice. In Finland the use of special mental health services (2/3 for both MDD and anxiety disorders) has been more prominent than primary care services have been in many other countries (Hämäläinen, Isometsä, Sihvo, Pirkola, & Kiviruusu, 2008), suggesting that

secondary care may deal with too many cases that could just as well be treated in primary care. IPC could be an effective method for using primary care to reduce the pressure on specialized psychiatric outpatient visits, as was found here.

Secondly, generalizing the findings to different organizational systems and counsellors' educational levels should be undertaken with careful consideration. The acceptance of psychotherapy or counselling manuals by the clinical community may meet with only mixed enthusiasm if clinicians feel that their patients' problems are too complex (cf. Carroll & Rounsaville, 2008). Clinicians may feel that manuals produce only a small almost value added in Scandinavia, where "Treatment as usual" appears to represent a treatment of comparable effectiveness (cf. Karlsson et al., 2011; Saloheimo et al., 2016). That is why the dissemination of IPC should be implemented properly. Manuals operationalize treatments and guide therapists in order to maintain a common thread, but they cannot work magic. To become good therapists or counsellors, trainees should learn the common factors involved in IPC (cf. Markowitz & Milrod, 2011). IPC carried out according to the manual can be a good additional tool for nurses treating depression, but actual psychotherapeutic work involves an interactive relationship between two individuals who are able to influence each other, and therefore, the changes it may produce are neither mechanistic nor unidirectional, so that the outcome is not directly determined by the method or the actions of the therapist (Leiman 2004, Krause & Lutz, 2009). Similarly, it is important that treatment providers should be able to work in an environment where doctors and nurses collaborate and supervision is available. In Finland there are mental health nurses who are specialized in treating depressive patients in primary care ("*depressiohoitajat*" in Finnish), and their labour input at the primary care level has been said to make them the most relevant occupational group in that sector (Sadeniemi et al., 2014). IPC could be best suited for them.

Thirdly, IPC may make a contribution to the choice of the optimal length of treatment for the patients. In this research IPC appeared to be safe in the hands of mental health nurses, with none of the patients reporting clinical deterioration. Contrary to my prior assumptions, most of the patients were of the opinion in the follow-up interviews that the short period of treatment consisting of 7 sessions had been sufficient for them. I also found that IPC had strengthened the patients' commitment to any further treatment where this proved necessary. Thus IPC might well serve as a means of evaluating, supporting and conducting triage for patients with depressive symptoms in primary care (Weissman & Verdeli, 2012; Weissman et al., 2014). Studies focusing on the choice of the optimal length of therapy have shown that tiered therapy graded from less intensive and less resource-intensive to more intense and longer-lasting would be cost-effective and that all that is needed is to select factors for predicting the outcomes of short vs. long-term therapy (cf. Knekt et al., 2016; Laaksonen et al., 2013; Maljanen et al., 2015).

Fourthly, this thesis specifies the details of the case formulation process used in IPC, providing tools for clinical work and training, and enabling the identification of further observable interactions that can be performed by

clinicians and are associated with successful therapy processes. The findings emphasize the importance of the joint construction of a problem area, a reflective attitude towards the problem and the counsellor's responsiveness to the patient's expressions of emotion. A formulation is a useful construct, open to revision and much more than a matter of selecting from one of four focal points, but it can still be presumed that many novice clinicians feel inadequately trained in case formulation, and, as has been observed previously, clinicians may not use it in day-to-day clinical practice (Ben-Aron & McCormick, 1980; Perry, Cooper, & Michels, 1987). Many existing case formulations for psychotherapy may be too complex and lengthy to be used by counsellors or novice psychotherapists. Although any case formulation in the treatment manual represents at best a simple guideline for a highly complex task, clearer, more specific and more detailed treatment manuals are needed to foster the utilization of case formulation and boost its feasibility (i.e. ease of application) (cf. Carroll & Rounsaville, 2008). Combining their findings on case formulation, levels of expertise and outcomes, Kuyken, Fothergill, Musa and Chadwick (2005) discussed the implications of these for training and suggested that novice therapists may achieve better outcomes by staying close to the protocols and manuals. Focusing training on case formulation has produced formulations that have been rated higher in overall quality and clinicians in the training group who have gone beyond summarizing descriptive information and are able to make inferences that include the mechanisms linked to symptoms and problems (Kendjelic & Eells, 2007). IPC case formulation of this kind could be feasible for use in primary care settings.

Finally, the findings reviewed in this thesis have implications for understanding the crucial role of social support. Humans have an innate tendency to seek attachments, and humans of all ages are happiest and most competent when they are confident that one or more trusted persons are available to help them in times of trouble (Bowlby, 1969). Mobilizing support from others through IPC may be a prerequisite for recovery from depression, and as such it cannot be overemphasized. Recovery from depression is a team effort, and it is supremely important to put the ideas into practice together with people who are present in one's own life (Law, 2013, 2016). As Victor Hugo states in his novel "Les Miserables" (1862), "The supreme happiness of life consists in the conviction that one is loved; loved for one's own sake—let us say rather, loved in spite of one's self."

# YHTEENVETO (SUMMARY)

## Interpersonaalisen ohjannan (IPC) aikaansaama terapeuttinen muutos masennuksen hoidossa: Monimenetelmällinen tutkimus perusterveydenhuollon potilailla

Tämän tutkimuksen tarkoituksena oli lisätä ymmärtämystä siitä, kuinka voimme auttaa psykoterapeuttisin keinoin niitä potilaita, jotka tulevat hoitoon masennuksen vuoksi perusterveydenhuoltoon. Vaikka käypä hoito -suositukset esittävät lievän ja keskivaikean masennuksen hoitamista perusterveydenhuollossa, ongelmana on ollut psykoterapeuttisen hoidon rajattu saatavuus. Tässä väitöskirjassa tutkittiin, kuinka tehokkaasti ja millä ehdoilla masennusta voidaan hoitaa lyhyellä 7 käyntikerran ohjaus- ja neuvontamenetelmällä. Tässä menetelmässä (Interpersonal Counselling, IPC) keskitytään ajankohtaisten ihmissuhdeongelmien ja elämänmuutosten aiheuttaman stressin käsittelyyn ja sitä kautta masennusoireiden helpottamiseen. Tutkimus koostui kolmesta artikkelista ja niiden kokoomateoksesta. Ensimmäinen artikkeli antoi tilastollisen kokonaiskuvan hoitomenetelmän vaikuttavuudesta. Toinen artikkeli toi esille, mitkä tekijät hoidon alussa vaikuttavat hoidon tulokseen. Kolmas artikkeli kuvasi hoitoprosessissa vaikuttavia mekanismeja.

Väitöskirjan tutkimusaineisto koostui ensi kertaa masennuksen vuoksi hoitoon hakeutuneista potilaista. Potilaat (N=40) satunnaistettiin joko lyhyen IPC:n tai 16 käyntiä sisältävän interpersonaalisen psykoterapian (IPT) mukaiseen terapiaan tutkijapsykiatrin strukturoidun diagnostisen haastattelun jälkeen. Tutkimuksessa potilaiden vointia ja oireita arvioitiin hoitojen alussa, lopussa sekä 6 kuukauden ja 12 kuukauden jälkiseurannassa. Tuloksellisuuden arviointiin käytettiin Clinical Outcome in Routine Evaluation (CORE-OM) ja Beck Depression Inventory (BDI) -arviointiasteikkoja. Potilaiden hoitoprosesseja seurattiin terapiaistuntojen ääninauhoituksin ja jälkihaastatteluin.

Tutkimuskokonaisuuden tilastollisen osan päätulos oli se, että psykiatristen sairaanhoitajien toteuttama lyhyt ohjaus- ja neuvontamenetelmä (IPC) perusterveydenhuollon depression hoidossa oli verrattavissa tuloksiltaan puolta pidempään lyhytpsykoterapiaan. Vuoden seurannassa 59 % IPC-hoidoissa olleista potilaista oli täysin toipunut ja 12 % merkittävästi parempivointisia. Tulos vahvisti sitä, että ensivaiheen masennuksen hoitoon kannattaa panostaa ja että mielenterveyteen perehtyneiden sairaanhoitajien toteuttama lyhytkin strukturoitu ohjaus ja neuvontamuotoinen hoito on usein riittävää.

Tutkimuksen toisessa vaiheessa verrattiin viiden täysin toipuneen ja viiden oirekuvaltaan muuttumattoman IPC:n mukaisessa hoidossa olleen potilaan alkuvaiheen tapausjäsennyksiä keskenään. Kvalitatiivisina analyysimenetelminä käytettiin sisällön analyysia ja keskusteluanalyysia. Masennuksesta täysin toipuneiden potilaiden ongelma-alueen määrittely toteutui hyvin luontevasti potilaan ja hoitajan välillä. Onnistuneiden hoitojen vuorovaikutuksessa korostui hoitajan kyky asettua potilaan emotionaaliseen kokemukseen ja kyky kutsua

potilasta vastavuoroiseen ongelmanmäärittelyyn. Ongelma-alueena oli yleisimmin ristiriitaiset odotukset työyhteisössä tai puolison kanssa. Hoidon onnistumista tuki se, että kaikilla toipuneilla potilailla oli olemassa tai löydettävissä sosiaalista tukea hoitosuhteen ulkopuolella. Niiden potilaiden ongelma-aluetta, jotka eivät olleet toipuneet, oli vaikea määritellä, eikä siitä syntynyt selkeää yhteisymmärrystä. Vaikka jatkohoitoa vaativissa tapauksissa ongelmaa pyrittiin määrittelemään hoito-ohjeiston mukaisesti, se jäi joko hyvin yksipuoliseksi tai ulkokohtaiseksi. Osalla ei-toipuneista läheisen menetyksestä aiheutunut suru yhdistyi samanaikaisesti johonkin toiseen ongelma-alueeseen. Osalla paine roolimuutokseen (esim. sairauseläkkeelle jääänti) aiheutui vakavasta somaattisesta sairaudesta. Lisäksi kaikkien ei-toipuneiden saama tuki läheisiltään oli niukkaa.

Monitapaustutkimuksen tulokset viittasivat siihen, että hoidon alkuvaiheen ongelman määrittelyllä voi olla ratkaiseva merkitys hoidon onnistumiselle. Hoitajan kykyä kutsua potilasta vastavuoroiseen ongelmanmäärittelyyn tulee painottaa lyhyttä strukturoitua hoitoa tarjottaessa. Lisäksi huomiota tulee kiinnittää masennuksen erilaisiin muotoihin, jotka riippuvat niitä laukaisevista tekijöistä. Tärkeä merkitys on myös sosiaalisella tuella. Ne potilaat, joiden masennus liittyy selkeämmin ihmissuhderistiriitoihin ja joiden sosiaalinen tuki on herätettävissä, hyötyvät lyhyestäkin ohjaus- ja neuvontamuotoisesta hoidosta. Vastaavasti potilaat, joiden ongelma-alueet liittyvät vaikeisiin menetyksiin ja niistä seuranneeseen yksinäisyyteen ja näköalattomuuteen, tarvitsevat pidempää hoitoa.

Tutkimuksen kolmannessa vaiheessa kuvattiin tarkasti hoitoprosessia yhden tapauksen avulla. Tuloksista ilmeni, miten hoitajan IPC-menetelmän mukainen aktiivinen ja vastavuoroinen toiminta auttoi potilasta päästämään irti itsesyytöksistä ja ottamaan vaikeat asiat esille läheisensä kanssa. IPC:n aloitusvaiheessa painottuivat tunteiden käsittelyn helpottamiseen liittyvät tekijät. Ongelmien käsittelyvaiheessa lähisuhdeongelmista tuleva stressi lievittyi ja läheisiltä saatu sosiaalinen tuki lisääntyi. Päätösvaiheessa havaittiin selvästi, että sosiaaliset taidot olivat parantuneet. Nämä tekijät avasivat mahdollisuuksia muutoksille potilaan lähisuhteissa, mikä auttoi häntä toipumaan masennuksesta.

Väitöskirjan löydökset ovat suoraan sovellettavissa masennuksen hoitoon perusterveydenhuollossa. Väitöskirjan keskeisin sanoma on, että masennuksen lyhytkin hoito perusterveydenhuollossa on vaikuttavaa, kun siinä aktivoidaan läheisiltä saatavaa tukea ja kun se tapahtuu toisiaan täydentävässä vastavuoroisessa terapeuttisessa suhteessa.

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# ORIGINAL PAPERS

# I

## IS INTERPERSONAL COUNSELLING (IPC) SUFFICIENT TREATMENT FOR DEPRESSION IN PRIMARY CARE PATIENTS? A PILOT STUDY COMPARING IPC AND INTERPERSONAL PSYCHOTHERAPY (IPT)

by

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Short Communication

# Is interpersonal counselling (IPC) sufficient treatment for depression in primary care patients? A pilot study comparing IPC and interpersonal psychotherapy (IPT)

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ABSTRACT

*Background:* Psychotherapeutic treatment is underused in primary care, where even short-term psychotherapy can be perceived as too lengthy and labour-intensive. We tested here for the first time the preliminary efficacy of seven sessions of interpersonal counselling (IPC) by comparison with sixteen sessions of interpersonal psychotherapy (IPT) in regular clinical settings.
*Methods:* Patients seeking treatment for the first time who met the DSM-IV criteria for major depressive disorder (MDD, mild/moderate) were randomized to either IPC ($n=20$) or IPT ($n=20$). The efficacy of the treatments was assessed using the 34-item Clinical Outcomes in Routine Evaluation (CORE-OM) scale and the Beck Depression Inventory (BDI) scale.
*Results:* 90% of the patients completed all the treatment sessions. IPC delivered by psychiatric nurses in primary care proved equally as effective as IPT delivered by psychotherapists/psychologists in secondary care. The pre-treatment to 12-month follow-up within-group effect sizes were large: 1.52 (CORE-OM) and 1.41 (BDI) in the IPC group and 1.58 (CORE-OM) and 1.40 (BDI) in the IPT group. At the 12-month follow-up 59% of the patients in the IPC group and 63% in the IPT group were classified as recovered on the CORE-OM scale, with corresponding remission rates of 61% for both groups on the BDI scale.
*Limitations:* The small sample size limited the power to detect differences between the groups and the naturalistic settings may have confounded the results.
*Conclusions:* This clinical trial suggests that IPC is an appropriate and even sufficient first-phase intervention for handling previously untreated mild to moderate depression in primary health care.


## 1. Introduction

Most psychotherapies in primary care settings, even short-term ones, can be perceived as too lengthy and labour-intensive. Based on 2 systematic reviews and 15 randomized controlled trials involving brief psychotherapy (eight sessions or fewer) for depression, Nieuwsma et al. (2012) concluded that major depressive disorder (MDD) or depressive symptomatology can be efficaciously treated with six to eight such sessions. Practise-based studies in routine service settings have similarly shown short-term psychotherapeutic treatment to be effective, with 40–58% of the patients who completed the treatment recovering (Gyani et al., 2013; Holmqvist et al., 2014; Richards and Borglin, 2011; Stulz et al., 2013). Systematic studies of the ideal dosage of short-term psychotherapy for gaining the optimal outcome are rare, however. The Second Sheffield Psychotherapy Project (SPP2) of Shapiro et al. (1995) and the reports of Dekker et al. (2005) and Molenaar et al. (2011) found no overall difference in the reduction of depressive symptoms between courses of 8 or 16 psychotherapy sessions.

Interpersonal counselling (IPC) in its original form was developed to serve as a simplified version of IPT to be administered by non-mental health professionals to treat patients with subsyndromal depression. It is a brief, manualized psychological intervention lasting for six or optionally seven sessions (Weissman and Klerman, 1993). Although there have been distinctly fewer efficacy studies of IPC than of IPT, it has been shown to have an effect on mild depression at the primary health care level and in hospital settings relative to control groups (Judd et al., 2001; Klerman et al., 1987; Mossey et al., 1996; Neugebauer et al., 2007; Oranta et al., 2010).

Menchetti et al. (2014) recently evaluated the efficacy of IPC as compared with selective serotonin reuptake inhibitors (SSRIs) in

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287 depressed primary care patients in Italy. The proportion of patients who achieved remission at 2 months following IPC was 58.7%, significantly higher than with SSRIs (45.1%). IPC was impressively effective for primary care patients experiencing their first depressive episode.

While IPC appears to be an effective approach to the treatment of mild depression as compared with treatment as usual (TAU) or moderate depression compared with antidepressant medication, more research would be required to determine whether IPC is sufficient for treating depression in primary care patients in relation to high-intensity psychotherapy. We conducted this pilot study to assess the efficacy of IPC among patients seeking treatment for mild to moderate depression for the first time by comparing it with IPT in naturalistic clinical settings. Importantly, there has been no research comparing IPC with IPT up to now (Weissman et al., 2007).

## 2. Methods

### 2.1. Participants

The participants were recruited between March 2010 and April 2012 from among those seeking treatment at primary care units in the hospital district of East-Savo (population approximately 50 000), Finland. The protocol was approved by the ethical committee of the East-Savo Medical District. The participants were required to have a diagnosis of major depression assigned by the screening psychiatrist (T.L.) in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) and following the Mini International Neuropsychiatric Interview protocol (M.I.N.I interview; Sheehan et al., 1998). The inclusion criterion for age was 18 years. Exclusion criteria were: acute suicidal risk, bipolar disorder, psychosis and psychotic or severe depression. Depressive severity was evaluated with the 10-item, clinician-rated Montgomery–Åsberg Depression Rating Scale (MÅDRS; Montgomery and Åsberg, 1979), and alcohol abuse was screened by means of the Alcohol Use Disorders Identification Test (Audit; Babor et al., 1992). Demographic factors were assessed at the screening visit. The use of antidepressant medication at any phase in the treatment was assessed from the medical case records at the end of the interventions.

Forty-four patients were referred to and screened by a psychiatrist (T.L.), four of whom were excluded: three who failed to meet the inclusion criteria and one who refused screening. No patients refused to participate after having been informed to which treatment they were allocated. The 40 were randomized by the screening psychiatrist (T.L.) after obtaining written consent at the end of the screening visit: 20 patients were assigned to the IPC group and 20 to the parallel IPT group. The original study design had allowed for a total of 60 (30+30) patients to be randomized, but it was decided to terminate the study at the end of April 2012 due to the forthcoming changes in personnel. It was possible to combine the patient's antidepressant medication with IPC/IPT if deemed clinically desirable, the decision to prescribe medication being the responsibility of the treating physician. Eighteen patients in each group (90%) completed the treatment. One patient (male) attended only the first IPC session and another (female) attended 3 sessions, reporting that they did not need the treatment any longer, while one IPT patient dropped out during the third session because she needed psychiatric in-patient care and another (male) fell developed a somatic illness and was admitted to hospital after the 8th session of IPT.

### 2.2. Interventions

Interpersonal counselling (IPC) was carried out in the five municipal primary care units and the control interpersonal psychotherapy (IPT) interventions at one psychiatric outpatient clinic (in Savonlinna). The recommended number of therapy sessions was set at 6+1 following the structure of IPC as laid down by Judd et al. (2004) and the protocol of Menchetti et al. (2010, 2014). It was recommended that the sessions should last 45 min (not the original 30 min). The purposes of the visits were outlined in a 30-page session-by-session checklist based on the descriptions by Weissman and Klerman (1993) and Judd et al. (2004) of the structure of IPC. The aim of the first session was to establish rapport, determine the presence of depression and introduce IPC. In the second session the nurse explored the patient's current interpersonal and social situation and suggested a relationship between the patient's symptoms of distress and current life stress, focusing on one IPT problem area (grief, interpersonal disputes, role transitions, or interpersonal sensitivity). In the middle phase (sessions 3–5) the nurse helped the patient deal more positively with the identified problem area, and the last two sessions addressed the termination of the IPC relationship by reviewing developments over the course of treatment and the patient's current state. It was also possible for the nurses to give the patients homework sheets for intervening work between the sessions in order to accelerate the process of change in each problem area (Weissman and Klerman, 1993; Weissman, 1995a, 1995b). Maintenance sessions were recommended if the patient's problems required them, but only after a new contract had been negotiated.

Eight psychiatric nurses from the primary health care units received 3 days of theoretical training in IPC and underwent a supervision period of 40 h with at least one pilot case before the research began. All the nurses had at least 10 years of outpatient or in-patient experience with depressed patients. The first author (J. K.) served as the IPC trainer and supervisor, and supervision according to a group format continued monthly during the research.

The control regimen for IPC was an empirically validated high-intensity treatment modality, interpersonal psychotherapy (IPT) (Cuijpers et al., 2011; Markowitz and Weissman, 2012). In order to assess the benefits of a therapy method, one should design the control therapy so that it is similar in all other respects (e.g. the frequency and length of the sessions, clinical supervision of therapists and patients, and equal opportunities to address the major problems). This means that in a well-organised study the control group should contain the general and essential elements of treatment (Baskin et al., 2003; Wampold et al., 2011). The control treatment (IPT) was delivered by two registered psychotherapists and two licensed psychologists. All of them had been treating depressed patients for over fifteen years and had practiced IPT with more than five patients before the research began. Their training material in Finnish (Kontunen et al., 2007) was based on the Comprehensive Guide to IPT (Weissman et al., 2000) and additional literature on IPT (Hinrichsen and Clougherty, 2006; Klerman et al., 1984; Mufson et al., 2004; Weissman et al., 2007).

Adherence to the treatment protocol was ensured in both groups by using session-by-session checklists, audiotaping all treatment sessions and discussing the treatment protocols in regular supervision groups. Session-by-session progress or possible deterioration was monitored during the trial with CORE-5 (Wright et al., 2009). Any complaints or severe side-effects were discussed in regular supervision groups with the therapists and by asking patients directly about possible problems related to their treatment or the trial in a follow-up interview conducted by one of the researchers (J.K. or T.L).

### 2.3. Baseline assessments and outcome measures

Our primary measure of efficacy was the Clinical Outcomes in Routine Evaluation, Outcome Measure (CORE-OM; Barkham et al., 2001; Evans et al., 2002), the strength of which lies in its coverage of a broad range of issues in welfare and psychological health. We followed the advice of Leach et al. (2006) to multiply the CORE-OM points by 10, yielding a more convenient range of 0–40, because it is easier to perceive and assign meanings to scores expressed in whole numbers. Beside CORE-OM, the Beck Depression Inventory (BDI; Beck et al., 1961) was used as a secondary outcome measure. Both assessments were performed at the beginning and end of the intervention and repeated 6 and 12 months after the beginning of the intervention.

### 2.4. Statistical analysis

The data were first analysed descriptively to check baseline range and distribution of each of the demographic and clinical variables in both groups. The demographic variables were then compared between the patients assigned to IPC and IPT using *t*-tests for continuous data and $\chi^2$ analyses for categorial data.

Differences in the changes brought about by IPC and IPT were analysed using hierarchical linear modelling (HLM) with Mplus version 7 (Muthén and Muthén, 1998–2012). A full-information approach was adopted in the estimations, yielding standard errors that are robust in the case of a non-normal distribution. The Wald test was used for testing differences in changes between the groups and for testing changes in the IPC and IPT groups separately.

The reliability and clinical significance of the changes were assessed with the criteria set out by Jacobson and Truax (1991) the strengths of which are that it considers change at the individual patient level and is especially useful for small-sample studies in which group variance may mask the individual changes. Lambert and Ogles (2009) recommend using this clinically significant method whenever possible in psychotherapy outcome research. The method comprises two steps for evaluating individual recovery. The first step calculates the reliable change index (RCI) from a function of the remainder of the post–pre-test, the initial standard deviation of the measure and its reliability:

$$RCI = \frac{(SCL_{post} - SCL_{pre})}{\sqrt{2S_E^2}}, \text{ in which } S_E = SD\sqrt{1 - reliability},$$

and the second calculates the cut-off *C* value to find a weighted midpoint between the means for a patient and a non-patient population:

$$Cutoff\ C = \frac{(SD_{patient}M_{nonpatient}) + (SD_{nonpatient}M_{patient})}{(SD_{patient} + SD_{nonpatient})}.$$

These two steps are used to classify individuals into one of four categories: (1) recovered (the patient has passed the cut-off and the RCI in a positive direction), (2) improved (the patient has passed the RCI in a positive direction but not the cut-off), (3) unchanged (has passed neither criterion), or deteriorated (has passed the RCI in a negative direction). Those patients, whose baseline scores were under the cut-off *C* value were not categorized in this way. The results quoted by Connell et al. (2007) for a non-patient population were used when calculating the RCI and cut-off for CORE-OM.

## 3. Results

As shown in Table 1, the IPC and IPT groups were comparable in terms of age, sex, educational level, and marital status. Most of the patients were female and were married or cohabiting. The mean age of the sample was 38 years. The patients in the IPT group received more antidepressant medication ($n=14$) than the IPC cases ($n=9$), but the difference was not significant ($p=0.20$). Altogether 12 of the IPC patients were diagnosed as having recurrent depression, as compared with 10 IPT patients ($p=0.52$). Treatment completion rates did not differ between the groups, nor were there any significant differences in baseline demographic or clinical characteristics between the 36 completers and the 4 non-completers, although the material offered little power for finding such differences.

**Table 1**
Demographic and clinical baseline data on the treatment and control groups (intention to treat).

| Variable | IPC ($n=20$)[a] | IPT ($n=20$)[a] | $\chi^2$ or *t* Value | *df* | *P* Value |
|---|---|---|---|---|---|
| Age, mean (SD) years | 38.6 (12.6) | 37.5 (13.0) | 0.27 | 38 | .84 |
| Sex | | | | | |
| Female | 13 (65%) | 16 (80%) | 0.29 | 1 | .48 |
| Male | 7 (35%) | 4 (20%) | | | |
| Marital status | | | | | |
| Married or cohabiting | 15 (75%) | 13 (65%) | 0.48 | 1 | .73 |
| Single or divorced | 5 (25%) | 7 (35%) | | | |
| Educational level | | | | | |
| Low | 1 (5%) | 2 (10%) | | | |
| Intermediate | 14 (70%) | 12 (60%) | 0.58 | 2 | .79 |
| High | 5 (25%) | 6 (30%) | | | |
| Job status | | | | | |
| Employed or studying | 14 (70%) | 11 (55%) | 0.96 | 1 | .51 |
| On sickness benefit or unemployed | 6 (30%) | 9 (45%) | | | |
| Alcohol use (Audit) | | | | | |
| Lower risk (0–7) | 17 (90%) | 16 (89%) | 0.00 | 1 | 1.00 |
| Increasing or higher risk (8+) | 2 (10%) | 2 (11%) | | | |
| Depression | | | | | |
| Current | 7 (37%) | 10 (50%) | 0.69 | 1 | .52 |
| Recurrent | 12 (63%) | 10 (50%) | | | |
| Antidepressant medication | | | | | |
| No medication | 11 (55%) | 6 (30%) | 2.56 | 1 | .20 |
| Medication | 9 (45%) | 14 (70%) | | | |
| CORE-OM, mean (SD) | 17.5 (4.1) | 16.6 (5.5) | 0.58 | 38 | .57 |
| Well-being scale | 22.5 (5.8) | 22.5 (7.2) | 0.00 | 38 | 1.00 |
| Symptoms scale | 22.5 (5.6) | 22.5 (7.6) | 0.02 | 38 | .99 |
| Functioning scale | 18.1 (5.7) | 15.5 (5.1) | 1.49 | 38 | .15 |
| Risk scale | 3.2 (3.9) | 3.3 (5.7) | 0.05 | 38 | .96 |
| BDI, mean (SD) | 22.5 (8.5) | 21.8 (8.0) | 0.26 | 36 | .80 |

Note: IPC=interpersonal counselling, IPT=interpersonal psychotherapy, Audit=Alcohol Use Disorders Identification Test (scale range 0–40), CORE-OM=Clinical Outcomes in Routine Evaluation (scale range 0–40), BDI=Beck Depression Inventory (scale range 0–63).

[a] Data are expressed as numbers and percentages.

Our primary measure of efficacy, the Clinical Outcomes in Routine Evaluation (CORE-OM) scores correlated closely with the Beck Depression Inventory (BDI) findings, the Pearson correlation coefficient between CORE-OM and BDI being 0.70 at baseline and 0.82 at 12 months of follow-up. The CORE-OM scores also exhibited good internal consistency in this sample, as Cronbach's alpha varied from 0.90 at baseline to 0.96 at 12 months of follow-up.

There were no statistically significant differences in the changes in clinical outcome measures between the treatment groups, as confirmed using hierarchical linear modelling with Mplus (Muthén and Muthén, 1998–2012) (see Table 2). Both groups benefitted from the treatments, and there were large and highly significant differences between the initial and final scores on all the scales. Within-group effect sizes for CORE-OM from baseline to

**Table 2**
Parameter estimates for the IPC and IPT groups.

| Groups | Parameter | CORE-OM | BDI |
|---|---|---|---|
| IPC | Baseline | 17.515*** | 22.627*** |
| | End | −8.231*** | −13.172*** |
| | 6-MFU | −0.351 | −0.778 |
| | 12-MFU | 0.280 | −1.026 |
| IPT | Baseline | 17.515*** | 22.593*** |
| | End | −8.294*** | −13.278*** |
| | 6-MFU | −0.327 | −0.657 |
| | 12-MFU | 0.262 | 1.056 |
| Group differences | Baseline | −0.880 | −0.785 |
| | End | 0. 929 | 3.069 |
| | 6-MFU | −0.185 | −1.090 |
| | 12-MFU | −1.130 | −1.675 |

Note. The IPC and IPT parameter estimates at baseline are outset scores and the other IPC and IPT parameter estimates are changes with time. The group difference parameter estimates at baseline are differences in outset scores between the IPT and IPC groups, and the other group difference parameter estimates are group differences in changes. The *P*-values of the group differences are all greater than 0.1, IPC = interpersonal counselling, IPT = interpersonal psychotherapy, MFU = month of follow-up.

*** $P < 0.001$.

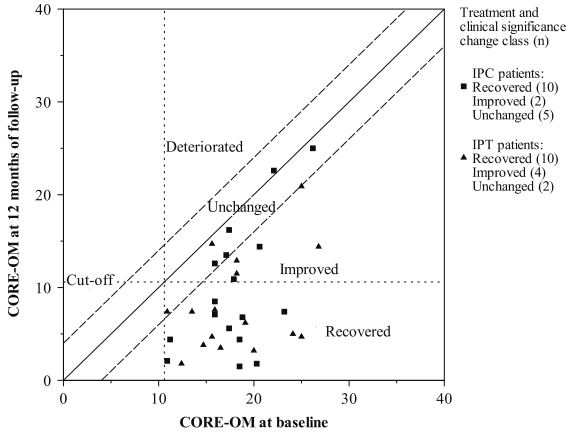


**Fig. 1.** Scatter plot comparison between pre-therapy and post-therapy (12 month follow-up) CORE-OM scores. Those scores below the lower interrupted linear equation line and below the horizontal cut-off line on the plot reflect those individuals who demonstrated recovered and scores below interrupted linear equation line but above the cut-off line reflect the individuals who demonstrated improved. The scores between interrupted linear equation lines on the plot reflect those individuals who demonstrated unchanged. Clinical significance (see Jacobson and Truax (1991)). CORE-OM Clinical Outcomes in Routine Evaluation.

12 months of follow-up were $d = 1.516$, 95% CI (0.788, 2.244) in the IPC group and $d = 1.575$, 95% CI (0.866, 2.285) in the IPT group while those for BDI were $d = 1.414$, 95% CI (0.584, 2.244) in the IPC group and $d = 1.397$, 95% CI (0.627, 2.168) in the IPT group. No complaints related to the treatment or the trial were expressed and no severe side-effects were recorded.

In the method of Jacobson and Truax (1991) used to examine clinically significant changes, clinical significance was defined as showing reliable improvement and reaching the specific cut-off score of 10.60 or below on CORE-OM defined for the purposes of this work, thus being considered to have recovered. Three of the 36 completers (1 in the IPC group and 2 in the IPT group) had started with pre-treatment scores on CORE-OM below 10.60 points, and they were not divided into recovered or improved cases, although their scores had decreased. Overall, 59% (10/17) of the IPC patients and 63% (10/16) of the IPT patients had recovered by the time of the 12 months follow-up. No significant differences were found between the groups ($\chi^2 = 1.924$, df = 2 $p = 0.382$). A detailed comparison of the patients' outcomes in terms of the differences between the pre-therapy and post-therapy (12-month follow-up) CORE-OM scores are shown in the scatter plot in Fig. 1. The remission rate, defined as the absence of depressive symptoms or the presence of minimal depressive symptoms (score < 10) and a 50% reduction in BDI scores from the baseline, was 61% (11/18) in both groups, IPC and IPT.

## 4. Discussion

To our knowledge, this is the first comparison of interpersonal counselling (IPC) and interpersonal psychotherapy (IPT) to be published. The results of this preliminary study show that both IPC and IPT are helpful for previously untreated primary care patients with mild to moderate major depression. The remission rate for the IPC group in BDI, 61%, was approximately the same as in the earlier, shorter follow-up study of Menchetti et al. (2014), in which the proportion of depressed primary care patients who achieved remission on the Hamilton Rating Scale for Depression (HRSD, 21-item) after two months of IPC was 59%. Comparison of the results with those of practise-based studies in routine service settings is more complicated, because the recovery rates depend upon how the sample is chosen (Barkham et al., 2012). However, the present outcome results exceeded those of the selected completers' group in practise-based studies, where 40–58% had recovered (Richards and Borglin, 2011; Gyani et al., 2013; Holmqvist et al., 2014).

In order to interpret these results, however, we have to acknowledge a number of limitations. The main one was the small sample size, which limited our power for detecting differences between the groups. Also, the naturalistic setting was not exclusively a strength of this study, as the differences in detail, including prescribed pharmacotherapy, could potentially have had differing effects on the outcome. Likewise the recruitment procedure may have restricted the sample to more motivated and psychotherapy-oriented patients. The general practitioners and nurses who referred patients for an assessment interview may have done a certain measure of preliminary selection, because only four patients were excluded and 90% of those accepted completed the treatment and attended the post-therapy interview.

IPC delivered by psychiatric nurses in primary care proved equally as effective as IPT delivered by psychotherapists and psychologists in secondary care. This result validates the conclusion reached by Nieuwsma et al. (2012) that major depressive disorder (MDD) or depressive symptomatology can be efficaciously treated with six to eight sessions and access to non-pharmacological treatments for depression could be improved by training nurses to deliver structured psychotherapy or counselling. We take IPC to be a good additional tool for nurses treating depression. Our impression is that both patients and nurses accept IPC and its structured techniques, but the review of symptoms, the interpersonal inventory and the formulation of the problem in the two initial sessions is very challenging. Although the treatment method requires learning the IPC structure, it is also essential to emphasise the nuances of a therapeutic relationship in training and to support the nurses through supervision.

We hope that a further comparison between IPC and IPT can be made in the future with a larger sample size and better control over possible confounding variables. Apart from statistical research, additional value could be gained from investigating the therapeutic process itself, examining both therapeutic processes applied to a number of patients and also individual cases (cf. McLeod (2013)). In these ways we might be better placed to find answers to the question of what factors regarding the content or

other aspects of counselling affect the achievement of a satisfactory outcome.

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# II

# PREDICTING RESPONSE TO INTERPERSONAL COUNSELLING (IPC) FROM CASE FORMULATION: A QUALITATIVE COMPARISON BETWEEN RECOVERED AND UNCHANGED DEPRESSIVE CASES

by

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# Predicting response to interpersonal counselling (IPC) from case formulation: A systematic comparison between recovered and unchanged depressive cases

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Abstract

**Objective:** We sought to explore how the process between the counsellor and patient for arriving at a case formulation may predict the outcome of manualized interpersonal counselling (IPC) for depression in primary care. **Method:** Qualitative content analysis and applied conversation analysis (CA) were used to achieve depth in the understanding of case formulation process among five patients who recovered and five who were unchanged according to quantitative post-treatment change rates derived from Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM). **Results:** Interaction in the case formulations for the recovered group was generally characterized by a joint construction effort between the counsellor and the patient centred on one problem area. The ability to delimit problems to one area was associated with the patient's role disputes in social relationships. For the unchanged patients, the case formulation typically reflected unilateral construction of the problem area, and more than one problem area was selected as the focus. The problem areas in the unchanged group were associated with complicated grief or loneliness. **Conclusions:** The process between counsellor and patient of arriving at and agreeing on a case formulation might potentially contribute to recovery, and it deserves greater attention in training counsellors and conducting research.

*Keywords:* case formulation, multiple case study, content analysis, conversation analysis, interpersonal counselling, IPC

# Predicting response to interpersonal counselling (IPC) from case formulation: A systematic comparison between recovered and unchanged depressive cases

It has been suggested that manualized interpersonal counselling (IPC) can be an effective first-line treatment for mild to moderate depression (Judd, Piterman, Cockram, McCall, & Weissman, 2001; Klerman et al., 1987; Kontunen, Timonen, Muotka, & Liukkonen, 2016; Menchetti et al., 2014; Weissman et al., 2014). Although the efficacy of IPC is statistically relevant, results may vary considerably at the individual level and little is known as to which processes may account for the efficacy of IPC. The crux of IPC is case formulation, in which the clinician links the patient's symptoms with interpersonal life events, as this drives the treatment process and becomes its focus. Case formulation has received little specific attention to date, however (Markowitz & Swartz, 2007). We examine here how the process of case formulation during the initial two sessions contributes to the outcome of IPC in the treatment of depression.

"A psychotherapy case formulation is a hypothesis about the causes, precipitants and maintaining influences of a person's psychological, interpersonal, and behavioural problems" (Eells, 2007a, p. 4). The process of formulation provides an opportunity for a shared understanding of the patient's difficulties and can offer a way of tailoring treatment to the individual and his or her singular situation that diagnosis alone does not (Eells & Lombart, 2011; Macneil, Hasty, Conus, & Berk, 2012; Sturmey, 2009). Although case formulation models in psychotherapy and counselling share many common features, each is also distinct from the others (Eells, 2007a). IPC case formulation is based on empirical research demonstrating an association between patients' interpersonal circumstances that appear to be temporally related to the onset of their depression and how complicated bereavement, role disputes, role transitions or interpersonal deficits may predispose patients to depression in these situations (Markowitz & Swartz, 2007).

## Steps in IPC case formulation

In its original form, IPC was developed to serve as a simplified version (lasting from three to seven sessions (Weissman & Klerman, 1993)) of interpersonal psychotherapy (IPT) to be administered within primary care. IPT is one of the most empirically validated short-term treatments for diagnosed depression (Cuijpers et al., 2011). It has been tested on different age and target groups, in different treatment settings and against different cultural backgrounds (Markowitz & Weissman, 2012). IPT usually consists of 12-16 sessions (Mufson, Moreau, Dorta, & Weissman, 2004; Weissman, Markowitz, & Klerman, 2000). IPT is designed for use by health professionals who have already achieved proficiency in some form of psychotherapy, whereas IPC is designed for those who lack psychotherapeutic training (Weissman et al., 2000). At the outset, IPC was used with patients who have low levels of depressive symptoms or distress (subsyndromal symptomatic depression), but in recent years it has also been used with patients who have met the criteria for major depressive disorder (Kontunen et al., 2016; Menchetti et al., 2014). As the IPC procedures, although simplified, are derived directly from interpersonal psychotherapy (IPT) (Weissman & Klerman, 1993; Weissman et al., 2000, 2007), the structure of IPT and studies concerning it also deserve to be considered here. The structure of IPC is based on the IPT manual (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman et al., 2000), i.e. it is divided into assessment, middle and termination phases, although the treatment can be shorter if the patient had made adequate progress by the sixth session. The structure and time limit of IPC are aspects that have scripts to follow, and it require that the case formulation should emerge no later than the second session. The conduct of IPC case formulation occurs through the following steps (Weissman & Klerman, 1993; Weissman et al. 2014).

### Step 1: Clarification of symptoms and diagnosis

Symptom identification is accomplished by having the patient complete a self-report measure such as the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Then, after reviewing the symptoms, it is important to discuss what depression is. Giving the patient a sick role is also a crucial part of this diagnostic clarification, as this role allows the patient set aside temporarily some activities which seem to be overwhelming or pass certain responsibilities to someone else while recovering. The sick role allows the patient to receive help from others and to cooperate with the counsellor in the process of recovering.

**Step 2: Evaluating interpersonal relationships**

It is important in IPC to find out what was going on in the patient's social and family life at the time the symptoms began, what may have been the triggers of the symptoms and who are the important people in the patient's life. The counsellor should conduct a brief "Interpersonal Inventory", i.e. a review of the people who are involved in the patient's life. In addition to knowing more about what problematic relationships there may be, this review will also allow a discussion to take place on the emotional support, social companionship, or practical help available to the patient while coping with the depressive episode.

**Step 3: Establishing an interpersonal problem area**

Case formulation should concentrate on current relationships and link the onset of the patient's mood disorder or distress to one of four foci, i.e. interpersonal problem areas (Markowitz & Swartz, 2007). *Interpersonal role disputes* as a problem area implies conflicts or disagreements within a significant relationship. Here role expectations or values are non-reciprocal and communication problems are serious. *Role transitions* may be normative and developmental (e.g. graduation, becoming a parent, retirement) or else unwished for or unexpected (e.g. divorce, being diagnosed with a severe illness, becoming unemployed). In a role transition the nature of relationships changes. For example, receiving a diagnosis of a

serious illness can involve changes in familial responsibility or treatments that may isolate the patient from sources of social support. Loss of work often involves ending close relationships at the workplace and may also complicate other relationships associated with diminished self-esteem. *Complicated grief* refers to depressive symptoms that result from serious difficulties in going through various phases of the normal mourning process following the death of a significant person in the patient's life. *Interpersonal deficits, loneliness, isolation or sensitivity* is chosen as the focus of treatment when a patient presents with a long-standing pattern of impoverished social relationships. One (or at most two) of these problem areas may be labelled and explicitly included in the case formulation which the therapist and patient together agree to work on before the IPC proceeds to its middle phase.

**Step 4: Making the interpersonal formulation**

An IPC case formulation is a collaboratively constructed summary of earlier discussions about the symptoms and their relation to interpersonal events and social relationships. Deciding which focus will be the most appropriate for the patient involves identifying options. The choice should be guided by its relevance to the patient's depression, its overlap with the time for which the patient has been feeling depressed and the potential support available to the patient in making a change in the problem area (Law, 2013). The counsellor must check that the patient agrees on the case formulation if it is expressed in the counsellor's own words, as it affirms the therapeutic alliance and underscores the patient's active role in the treatment.

## The present study

Case formulation has been highlighted as central to the IPT approach (Markowitz & Swartz, 2007), but although case formulations are achieved in and through interaction, there has been no previous systematic research into the process of IPC or IPT case formulation.

Previous research into other forms of therapy has shown that case formulation is a complex interactional activity (Antaki, Barnes, & Leudar, 2004; Davis, 1986) and this reality may explicate the limited amount of direct evidence linking case formulation with outcome. A new insight into how the process of case formulation is associated with the outcome of the counselling would clarify our picture of IPC and the factors that influence a positive response to counselling.

## Methods

### Study design

A systematic case comparison method was chosen for this study (Iwakabe & Gazzola, 2009; Iwakabe & Gazzola, 2014). First, quantitative outcome measures were used to select recovered and unchanged cases. Then, qualitative analyses by multiple judges in each case were used to capture factors associated with different outcomes.

### Setting

The present sample of patients was drawn from a broader group who were participating in a major outcome study (Kontunen et al., 2016) designed to compare interpersonal counselling (IPC) with interpersonal psychotherapy (IPT). The participants for this broader project (N=40) were recruited from among those seeking treatment at primary care units in the hospital district of East-Savo (population approximately 50 000), Finland. The participants were required to have a diagnosis of major depressive disorder (mild or moderate) assigned by the screening psychiatrist (T.L.). Demographic factors (current age, marital status, educational level and job status) were assessed at the screening visit. The use of antidepressant medication and data concerning continuing or auxiliary psychotherapeutic treatment for depression were assessed one year after the end of the 12-month follow-up by conducting a retrospective review of the medical records of each patient. The protocol was approved by the medical district's ethical committee, and informed consent was obtained

from all the patients. The patients' names quoted in this study are pseudonyms and all the details of the individual cases are obscured so that the subjects could not be identified.

**Measures and categorization of outcomes**

The quantitative outcome data on the treatments were assessed using the Clinical Outcome in Routine Evaluation – Outcome Measure (CORE-OM) (Barkham et al., 2001) and Beck Depression Inventory (BDI) scales (Beck et al., 1961). The BDI is a 21-item self-report instrument**,** in which the items are scored on a four-point scale from 0 to 3 and summed to obtain a total score ranging from 0 to 63. The BDI is one of the most common self-reported measures of depression, and has been viewed as the gold standard in depression outcome research. The strength of the CORE-OM lies in the breadth of its coverage of welfare and psychological health. Its 34 items are designed to assess the level of psychological distress and the outcome of psychological therapy. The items are scored on a five-point scale from 0 to 4, ranging from "Not at all" to "Most or all of the time" during the previous week. Thus higher scores indicate greater distress. The items comprise four domains: 1) Specific problems (depression, anxiety, physical problems, trauma), 2) Functioning (general day-to-day functioning, close relationships, social relationships), 3) Subjective well-being (feelings about oneself and optimism about the future), 4) Risk (risk to oneself, risk to others). The sum of the total scale is divided by the number of items. We followed the advice of Leach et al. (2006) and multiplied the CORE-OM points by 10, yielding a more convenient range of 0-40, because it is easier to perceive and assign meanings to scores expressed in whole numbers.

The CORE-OM and BDI scoring systems have shown excellent psychometric properties. Validation of the CORE-OM instrument for the Finnish population has demonstrated similar results to those found for the UK population: Internal consistency (Cronbach's alpha) for the total CORE-OM score was excellent in both clinical ($\alpha = 0.94$)

and non-clinical (α = 0.91) samples (Honkalampi et al., 2017), and correspondingly, the internal consistency of the BDI-21 was 0.89 in a large nationwide population-based sample in Finland (Elovainio et al., 2009). The CORE-OM and BDI scores also exhibited good internal consistency in the original sample of the current study (N=36) as Cronbach's alpha varied from 0.90 at baseline to 0.96 at 12 months of follow-up in CORE-OM and from 0.82 to 0.93 in BDI. The Pearson correlation coefficient between CORE-OM and BDI was .70 at baseline and .82 at the 12-month follow-up in this sample.

The method of Jacobson and Truax (1991) was used to examine clinically significant changes, where a significant change means one that is unlikely to be due to simple measurement unreliability. This method includes two steps for evaluating individual recovery. The first step calculates the reliable change index (RCI) which specifies the amount of change a patient must show between the pre- and post-test situations for that change to be larger than that reasonably expected due to measurement error alone. The second step calculates the cut-off value to find a weighted midpoint between the means for a patient and a non-patient population. In the current study, the RCI for CORE-OM was set at 6.1 points and the cut-off value at 10.6. These two steps were used to classify individuals into one of four categories: recovered (the patient has passed the cut-off and the RCI in a positive direction), improved (has passed the RCI in a positive direction but not the cut-off), unchanged (has passed neither criterion), or deteriorated (has passed the RCI in a negative direction).

**Inclusion of patients**

The attrition from admission to the selected subsample is shown in Figure 1. For the present purposes, 10 patients were selected to be integrated into the sample for the current qualitative study: all five cases meeting the criteria for unchanged cases and five recovered cases in terms of their CORE-OM scores using the criteria set out by Jacobson and Truax

(1991). The selection of five out of the ten recovered cases was made in an attempt to render the two groups comparable in terms of psychological health at baseline but with a different outcome at the end of treatment. The CORE-OM score at baseline should be moderate (not mild), because none of the unchanged patients had a mild baseline score and such a patient would have needed no auxiliary treatment for depression, thus preventing any confounding treatment effect on the outcome. Using these criteria before any qualitative analysis, we found 5 patients who had recovered to serve as counterparts to the unchanged patients.

**Counsellors**

Six psychiatric mental health nurses from primary health care units constituted the sample of counsellors for the study. One nurse treated 3 patients, 2 of whom recovered and 1 remained unchanged, one treated 1 recovered and 1 unchanged patient and one treated 2 recovered patients. The remaining three nurses treated only unchanged patients in this sample. The nurses had received 3 days of theoretical training in IPC and had undergone a supervision period of 40 hours with at least one pilot case before the research began. All the nurses had had at least 10 years of outpatient or in-patient experience with depressed patients.

**Researchers**

The research team was composed of a clinical psychologist and psychotherapist (J.K.), a sociologist and occupational therapist (E.W.), a physician specialized in psychiatry and family therapy (T.L.), a professor specialized in general practice and psychiatry (M.T.) and a professor, psychoanalyst (IPA) and family therapist (J.A.). In terms of biases, all five researchers liked training community therapists in psychosocial treatment skills, although they varied in how comfortable they felt using brief psychotherapies or counselling.

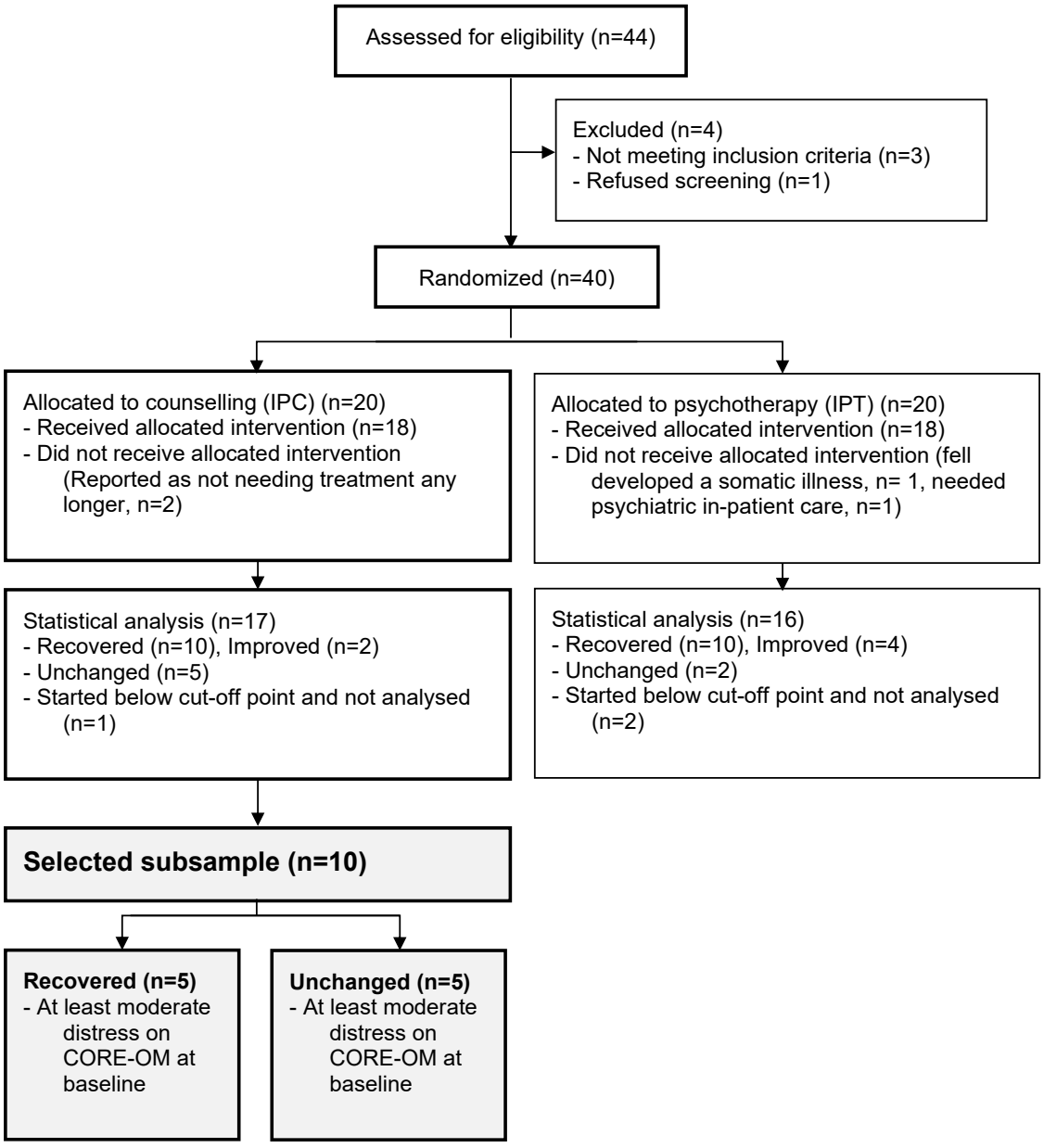


Figure 1. Attrition flow-chart from admission to the selected subsample.

**Treatments**

The treatments consisted of 7 weekly sessions following the structure of IPC as laid down by Judd et al. (2004) and the protocol of Menchetti et al. (2010, 2014). The sessions lasted 45 minutes and the purposes of the visit were outlined in a 30-page session-by-session

checklist for the structure of IPC in Finnish modelled on Weissman and Klerman (1993) and Judd & al. (2004). The first two pages introduced the basics of IPC, the assessment process and how to orient the patient with respect to the subsequent IPC sessions. The provision of a written description of the conduct of the IPC for the patient (a patient information sheet) was included here. The third page guided the counsellor in identifying depression symptoms, educating the patient with regard to depression and giving the patient permission to adopt a "sick role", i.e. taking a break, asking for help and accepting responsibility for working towards recovery. It was also possible for the counsellors to give the patients homework sheets (pages 4-7) at the end of the first IPC session and review the answers during the second session. These patients' self-report forms comprised questions concerning life events in the IPC problem areas (Weissman 1995). The following three pages contained a closeness circle and the charts for summary notes based on an interpersonal inventory in order to obtain an overview as to who were the important people in the patient's life, which relationships would give them support and which might be most closely tied to the depressive symptoms. Based on all the information obtained in the interpersonal inventory, and reviewing what was going on in the patient's life at the time the symptoms began, the counsellors were guided to suggest a relationship between the patient's symptoms of distress and current life stress, focusing on one (or at most two) IPC problem areas (grief, interpersonal disputes, role transitions, or interpersonal deficit/isolation) (on page 11). The manual emphasized that these connections should be made explicit, but also open-ended when talking with the patient. The patient should agree with the case formulation in a manner which signals that it is jointly shared by the patient and counsellor. After the pages concerning the initial phase, the next pages targeted the middle phase containing guides to encourage the patient's capacity for coping with the problem area that had been identified, using such techniques as clarification, communication analysis or role play (pages 12-28).

These pages included optional worksheets for the four problem areas to be completed along with the sessions. On the last pages the counsellor was guided to discuss the major problem area in depth and review the development achieved in the course of the treatment and the patient's current state. Adherence to the treatment protocol was ensured by using session-by-session checklists, audiotaping all treatment sessions and discussing the treatment protocols in regular supervision groups. Any complaints or severe side-effects were also discussed with the therapists in the regular supervision groups.

**Qualitative data and data analysis**

The qualitative data analysis was carried out through four stages.

**First stage: the rich case record.** As a useful starting point, the first author (J.K.) gathered all the data obtained from the 10 patients in rich case record form (cf. Elliott, 2002), comprising basic facts demographic and characteristics forms filled in by the patient at the screening visit, the researcher's counselling process notes about the patient's history, present illness, quantitative outcome measures and an overview of the initial sessions from the transcribed audiotapes.

**The second stage: content analysis of the patients' descriptions of their close relationships and the problem areas.** Since it is stated in the IPC manual that the case formulation needs to be established and presented during the initial two IPC-sessions, the audio recordings of these sessions (N=20) were selected for each of the ten patients for more precise qualitative analysis. As each session lasted 45 minutes, the data examined for this study involved approximately 15 hours of interaction (10 patients x 2 sessions x 45 minutes).

In the data analysis, the original recordings were listened to a number of times by the first (J.K.) and the second (E.W.) authors separately and all sequences in which interpersonal relationships, the problem areas or the goals of the treatment were explicitly mentioned by the counsellor were identified, transcribed, and entered into Atlas.ti 7.5.16 (1993-2017)

(http://atlasti.com/) software for coding and analysis. Atlas.ti is a workbench for the qualitative analysis of textual, graphical, audio, or video data. Although the coding techniques are based on the ideas and terminology used in grounded theory (Glaser & Strauss, 1967), it is possible to use this methodology with any systematic approach to unstructured data.

Next, the first author (J.K.) used directed content analysis (Hsieh & Shannon, 2005) to evaluate the patients' descriptions of their close relationships and the problem areas from the transcribed audiotapes. This directed content analysis, also referred to as deductive category assignment (Mayring, 2014), means that categories are deduced from the theory, other studies or previous research. In this study, the categories of close relationships were deduced from the theory and practices of IPC (Weissman et al., 2000): Who are important people in the patient's life and is it possible for the person to perceive or evoke support from a close person? The categories of the problem areas were derived from the four problem areas of IPC (Klerman et al., 1984; Weissman & Klerman, 1993; Weissman et al., 2000): Which problem areas were negotiated and decided upon as foci for the intermediate sessions?

Using the qualitative software program Atlas.ti, the first author (J.K.) coded the transcribed material into topic segments according to content shifts in the case formulation phases (discussing symptoms, evaluating interpersonal relationships and establishing an interpersonal problem area). To explore the segments more specifically, each topic segment was coded in terms of a key issue. Code names for the key issues were first taken as far as possible from the patient's own words, e.g. the code for the closest interpersonal relationship: "husband similar to dad and unable to tolerate worries". Then this and other similar codes were collated into a more general code: "Inadequate perceived support from spouse" (See Appendix 1).

**The third stage: conversation analysis of the case formulations.** In the third stage of analysis, the second author (E.W.) conducted an applied conversation analysis (CA) concerning what the therapists actually did in the session when they were making the interpersonal formulation. At this point the analyst was unaware of the outcomes of the cases.

Conversation analysis is a qualitative micro-analytical approach to the study of the organization of human interaction at its finest level of detail. CA highlights the fact that different kinds of social actions are organized into sequences (Sidnell & Stivers, 2013). This means that each utterance gains its meaning in relation to the prior utterance and poses implications for subsequent utterances (Heritage, 2011). Following this idea, the analyst explored the process of case formulation as an interchangeable conversation in which the patient and the counsellor relate their conversational moves to the preceding context. In our analytical procedure the recordings were listened to several times and passages in which the counsellor explicitly refers to the problem areas or treatment goals ("case formulation segments") were identified and collected from the data. The transcribed collection from a dataset for CA consisted of 25 case formulation segments (2-3 per case). These segments involved 1) the counsellors turn explicitly referring to a problem area or treatment goal, 2) the patient's response, and 3) the counsellor's next remark dealing with the patient's response. The detailed conversation analysis transcripts display the words as they were said and indicate pauses within and between utterances and overlapping speech (see Hepburn & Bolden, 2013, and the simplified transcription symbols provided in the footnote[1]).

[1] Transcription symbols (simplified from Hepburn & Bolden, 2013):

| | |
|---|---|
| [ ] | Overlapping talk |
| (0.0) | Pause: silence measured in seconds and tenths of a second |
| .hh | An in breath / hh An out breath |
| (h) | Laughter particles |
| ((word)) | Transcriber's comments |

Next, all these segments were qualitatively analysed case by case, to specify the nature and variation of the phenomenon in question. Attention was paid to their content and reoccurring lexical design (the vocabulary, words or morphemes of a language used). At this point in the analysis, the patients' orientation with respect to the clinicians' problem formulation was also explored. This was done by focusing on the patients' turns after the counsellors' topicalizations of a problem area.

**The fourth stage: validation of the qualitative data analysis.** The last step of the data analysis was aimed at increasing the trustworthiness of the results. The first author (J.K.) compiled the findings from the rich case record, the content analysis and the conversation analysis (See Appendix 1). To demonstrate the extent to which these represented the sample of participants (See Table 1), they were divided into categories labelled as general (including all or all but one of the cases, 4-5), typical (more than half of the cases, 3), and variant (at least two cases) (Hill et al., 2005; Knox, Schlosser, Pruitt, & Hill, 2006). Analytical observations regarding the case formulation segments that had been analysed by means of conversation analysis were also discussed at two group meetings (data sessions) attended by trained CA researchers (unaware of the outcomes). In these discussions, the analytical findings from the conversations were tested against analytical observations made by other researchers. Data sessions are a standard means of quality assurance for CA data analysis. Then the first (J.K.) and the second (E.W.) authors listened to the audiotapes while reading the transcript again and checked the categories of the content and process of case formulation once again. Finally, the selected examples and extracts and the outcome data were discussed several times with all the research team members, who shared opinions, disagreements and feelings regarding the findings, thus reducing the biases inherent when just two persons were analysing the data. These discussions were inspired by the notion of consensual qualitative research (Hill et al., 2005).

## Results

Following the steps in IPC case formulation, the results are presented in four categories (symptoms, interpersonal relationships, interpersonal problem areas and making the interpersonal formulation). The data are presented below using the frequency labels general, typical and variant (see Table 1). In order to exemplify the variation in the categories six data examples from the recovered and unchanged groups will be presented in the following sections. A detailed summary of the findings for the recovered patients (Paula, Daniel, Carolyn, Joanna and Mary) and unchanged patients (Ann, Dorothy, Helen, Lisa and Alex) is presented in Appendix 1.

Table 1. Core categories, subcategories and frequencies regarding the process and content of case formulation for the patients in the recovered group (n=5) and unchanged group (n=5)

| | Frequency | |
|---|---|---|
| Category | Recovered | Unchanged |
| **Making the interpersonal formulation** | | |
| Joint construction of the problem area between the counsellor and the patient | **General** | Variant |
| Counsellor's strong responsiveness | **General** | Variant |
| Patient's strong agreement with the problem area | **General** | Variant |
| Unilateral construction of the problem area between the counsellor and the patient | – | **Typical** |
| Counsellor's difficulties in responsiveness | – | **Typical** |
| Patient's partial agreement with the problem area | – | **Typical** |
| **Patient's problem areas** | | |
| One problem area | **General** | – |
| Two problem areas | – | **General** |
| Role disputes | **General** | Variant |
| Role transition (major life change) | – | **Typical** |
| Complicated grief | | Variant |
| Interpersonal deficit/isolation | – | Variant |
| **Patient's interpersonal relationships** | | |
| Adequate perceived support from close relations | **General** | – |
| Inadequate perceived support from close relations | – | **General** |

Note. General = 4-5 cases, typical = 3 cases, variant = 2 cases. Findings representing 0-1 =– Results in bold indicate those categories that most clearly separate the groups (labelled following Knox et al., 2006).

**Demographic factors, symptoms and outcome data**

The recovered and unchanged groups were comparable in terms of sex (4 females, 1 male) and educational level (4 vocational qualifications, 1 master's degree). Four members of the recovered group were employed or studying, and one was on sickness benefit, while 3 of those in the unchanged group were employed or studying and 2 were on sickness benefit. Three of the recovered patients were diagnosed as having recurrent depression, as compared with 2 of the unchanged patients. None of the patients had problems with alcohol consumption. The changes were significant in that there were no statistically significant differences in the pre-treatment scores between the recovered and unchanged groups (CORE-OM: $p=0.841$; BDI: $p=0.905$), but the differences between the groups at the 12-month follow-up examination were significant (CORE-OM: $p=0.008$; BDI: $p=0.016$). No subsequent psychiatric or psychotherapeutic treatment had been needed by the recovered patients one year after the last IPC follow-up session, whereas three of the unchanged patients were continuing treatment with the same counsellors, one was on a "coping with depression" course and the fifth patient had become motivated to continue in intensive psychotherapy.

**Evaluating interpersonal relationships**

All the patients who recovered were married, and they generally mentioned that they were able to discuss things with their spouses and felt they had social support available outside the treatment. For example, Mary had experienced many difficulties at work, but she felt that her husband supported her.

> "When I told him about my work, he said that the organization I work for is truly incomprehensible. When I showed him the emails that I'd received from the management, he said they really have some sick people working there."

In contrast, the unchanged patients had generally had less social support available. One example of the generally poor social support in the unchanged group, was Helen. She had had a very close relationship with her late mother but described her husband and father as being distant people for her. Helen described her relationship with her husband as follows:

> "The children say that when their father's eyes roll around, then one has to be quiet. He does not hit anybody, but he gets really mad if I ask too many questions…That's what I've been saying to mom, did I have to take a man who was similar to dad? Is it always so that a daughter looks for someone similar to her father, even if it means that she goes for an alcoholic."

**Establishing an interpersonal problem area**

In the recovered cases a single problem area was generally formulated as the focus for the treatment. Four of the foci were role disputes, including three disputes at the patient's workplace or family business (Mary, Daniel, Paula). Mary also emphasized role transition due to her husband's unemployment, Carolyn's problem area was arguments with her husband, and Joanna's depression was associated with role transition after childbirth.

> "It (childbirth) turned everything upside down, like, so you didn't know what to expect at all. That's the reason why I apparently started getting stressed about everything too much. Because it was that everything came as a total surprise."

In contrast to the patients who recovered, those whose condition remained unchanged generally had problem formulations that involved more than one focus. Typically, the problem area was role transition (major life change). Ann had suffered from cancer and was very anxious about her daughter, who had moved away from home, Dorothy's situation was unrelieved from the beginning of the treatment because of her fatal disease and she had been isolated from her friends during her sickness leave, while Alex had returned to his family home after his studies and had socially alienated when unemployed, so that he could not name a problem area of his own. As a variant, Lisa and Helen in the unchanged group

represented the complicated grief category. They had felt depressed after their mothers had died. Soon after the IPC treatment started Lisa's father also died and she had conflicts with her sisters about their parents' estate.

> " There's been this kind of misunderstanding, well, from relatives about the funeral, when there were a couple of aunts there and then my brother there and when I kind of started crying more, they said just let it out. But they kind of misunderstood that I was sort of mourning over how difficult it was to be with my sister, but they kind of understood that I was crying for my father."

**Making the interpersonal formulation**

The CA analysis yielded two main types of interaction in connection with case formulation: joint and unilateral construction of the problem area. The interaction aspect of problem formulation in the recovered group was generally characterized by joint construction of the problem area. The problem area was collaboratively discussed and the counsellors were generally responsive to the patients´ emotional expressions. They adapted to the rhythm of the patient, gave sufficient space and allowed for breaks and verbalized feelings. They also explored and deliberated over ideas together with the patient and presented their suggestions as tentative ones that were open to joint exploration. The first case example, representing commonalities among the recovered patients, is a woman (Paula) whose problem area arose naturally and the conversation analysis reflects strong affiliation and agreement between the patient and her counsellor. This extract was selected on the basis of presenting the sequences in which the problem area was labelled and the decision made concerning the focus of the therapy.

Paula was working full-time in customer service when she was diagnosed with moderate depression. Her interpersonal inventory demonstrated that she had good relationships with her husband and children, but she had had conflicts and disagreements with a co-worker that significantly affected her job satisfaction and well-being, resulting first

in burnout and then in depression and sick leave. Several rounds of negotiations had been held at her workplace to resolve the problems, but no progress had been made.

In the extract the counsellor is reviewing a questionnaire on interpersonal problem areas that the patient has filled in as a home assignment. They are discussing first the question related to grief, the death of one of Paula's relatives. After this discussion, the counsellor returns to the role of the disputes at her workplace, the interpersonal issue they had been discussing previously.

01 Couns: probably that .hh the death of your relative didn't cause
02 these ((symptoms of depressions)) either [but of course (0.2) mmm
03 Paula: [no
04 Couns: so that .hh questions of disputes with a person who is important to
05 you are really the thing that we are thinking about [that it is
06 Paula: [mmm yes
07 Couns: the focus that we are in a way
08 Paula: mm-m
09 Couns: looking for what we can start un[ravelling now
10 Paula: [indeed
11 Couns: .hhhmm it says here ((on the questionnaire form)) that you feel
12 some distrust for him

((omitted 1.5 min of talk on meetings arranged at the workplace to resolve the problems))

13 Couns: mm (0.2) krhm-hm and indeed these (0.2) because of these things
14 ((problems at the workplace)) (0.5) you ran out of strength and then
15 this sick leave came along
16 Paula: mm
17 Couns: .hh yes and then we can presumably decide quickly that this is it
18 Paula: yes

In line 4 the counsellor concludes that, based on their discussions, the role disputes (at the patient's workplace) are a suitable starting point. She uses the personal pronoun *we*, which highlights the shared process of case formulation. The counsellor also invites the patient to adopt a reflective stance towards her problems. She describes the problem area as something that can be *looked for* and *unravelled* from several perspectives (l.9). The patient responds with strong agreement (*indeed*, l.10). In lines 11-15 the counsellor explicitly links the symptoms of depression and onset of the patient's sick leave to the interpersonal problems at the workplace. The patient confirms this, and the counsellor moves on to make a decision on the problem area, stating explicitly that it is a joint decision, '*we decide'*, and using a firm declaration, *'this is it*' (l.17), which the patient confirms (l.18).

When the discussion was continued later, they proceeded to investigate the patient's thoughts concerning the goal of the treatment, whereupon the patient described her workplace problems in detail. In the first lines (1-4) the counsellor formulated the patient's description.

01 Couns: so that somehow you're sad about having a quarrel about some
02 things and then your working has become troublesome and you
03 have needed to avoid each other and maybe needle a bit and act
04 unprofessionally in these personal relationships
05 Paula: yes
06 Couns: so we wish that that would change and the goal would be for
07 instance that that (0.5) could you say it in your own words so that
08 Paula: how would I say it the goal would be perhaps that I could have
09 some collaboration with my closest co-worker and we could even
10 like advan[ce our working practices so
11 Couns: [yes indeed
12 Paula: so that we wouldn't need to think that as an obstacle

13 that which one of us is better in a way or

14 Couns: simply equal

15 Paula: which one of us shines more brightly

16 Couns: yes

The formulation (l.1-4) highlights the core feeling experienced by the patient. In this way the counsellor is emphasizing the importance of the patient's subjective experience when investigating the problem area. The counsellor also highlights the shared nature of the process. In lines 6-7 she first moves towards suggesting that she shares the patient's desire for a change and then invites the patient to define the focus of the therapy in her own words. The patient finds it difficult to respond at first, but then provides an elaborate description of the desired state of affairs (l.8-10). The counsellor provides minimal responses (l..11) to support the drift of the patient's argument, and then collaboratively complements the patient on her description (l.14).

Interaction within problem formulation varied more in the unchanged group than in the recovered group. As a variant, the interaction was similar to that in the recovered group, in that the counsellors collaboratively constructed the problem areas and emotional responsiveness prevailed in the interaction. However, the interaction typically reflected difficulties between the patient and the counsellor: unilateral construction of the problem area, counsellors' difficulties in responsiveness and fact that the counselling manual was adhered to strictly. The counsellors asked the patients to name the problem area or goal of the therapy but did not investigate their replies collaboratively or develop them any further. They also tended to overlap with the patient's speech, effectively preventing the patient from saying anything more on the subject, and then returned to reviewing the questionnaire form, bypassing the patient's expressions of emotional experiences. The case of Alex captures the commonalities among the unchanged patients for whom the conversation analysis reflects

unilateral construction of an ambiguous problem area and weak agreement between the patient and counsellor.

Alex was a young man who simply felt that life had nothing to give him. He had a vocational qualification in woodworking and carpentry, and after his studies he had returned to his family home, where he remained unemployed for months. While still studying he had met a girl and they had soon decided to live together, although he felt that they had no real relationship. He drank a lot of alcohol with his companions, and when the relationship with his girlfriend ended, he felt that this was a relief: "one area of life less that has to be coped with." He passed the days with other men in bars "chewing the fat", but he no longer perceived substance use as a serious problem; he simply felt that life had nothing to give him. The following extract is an example of an interaction in which the problem area is discussed. As in the previous example, the counsellor is reviewing the questionnaire on interpersonal problem areas that had been a home assignment.

01 Couns: well erm (0.5) I was still thinking what would be the focus because
02 when I listen to you and how you've been getting on with those
03 friends I kind of feel that you have friends and you get along with
04 them quite naturally that you get along with them and .hh that
05 there's no such sensitiveness and so how about the other thing we
06 were talking about the different areas that we went through and
07 then there was this question of taking responsibility
08 (0.5)
09 Couns: .hhhh well erm (0.5) based on that I was thinking that (0.2) that
10 (0.5) could it be connected to what we speak of (0.2) in this context
11 with the term role transition
12 (3.0)
13 Couns: so that at the end of one's studies one somehow gets that anxiety

14 and that kind of erm that kind of .hh yes anxiety and it feels difficult
15 like (0.2) to think about and make choices concerning the future
16 so erm (0.2) so it's of course natural that
17 at the end of one's studies the future is already kind of looming
18 there and where to find a job and (0.2)
19 where to settle down and those so[rts of things
20 Alex: [mm
21 Couns: so would it be that (0.5) that kind of erm
22 (3.0)
23 Couns: so in a sense it's all very natural that we have these changes in our
24 lives it is all the time we have these changes and we kind of give up
25 some old things and gain something new in their place
26 (2.0)
27 Couns: we find new things to replace the ones we have lost or
28 given up so that .hh
29 (3.0)
30 Couns: what do you think could it simply be that
31 from the role of a student (0.2) from the freedom of being a student
32 and then that kind of erm (0.2) it just came to mind from that
33 responsibility it just came to mind that
34 Alex: I gu[ess so
35 Couns: [that having a more responsible life and erm
36 quite often it is connected to the stability and a bit erm
37 like a bit more permanent
38 Alex: mm

The counsellor concludes that the patient seems to get along with his friends and it is not interpersonal sensitivity that needs to be worked on (l.1-5). He then goes on to suggest

that taking responsibility could be the focus of the therapy (l.6-7). The patient does not respond, and the counsellor goes on to connect the theme of responsibility with the concept of role transition (l.9-11). The patient remains silent and the counsellor further connects the concept with the patient's current situation (l.13-19). At this point, the patient weakly agrees (*mm*, l.20). The patient's minimal response comes right after the counsellor's list of students' concerns. This may indicate that the patient recognizes these concerns as his own. The counsellor does not elaborate on this, however. Instead, she makes a move to normalize the patient's situation, treating it as an example of more general, normal changes that people tend to experience in life (l.23-25, 27-28). The counsellor then suggests again that role transition should be selected as the focus of the therapy (l.30-33), and this time she explicitly elicits the patient's agreement (*what do you think, could it be*). The patient hesitantly aligns himself with the counsellor's suggestion (*I guess so,* l.34) but the counsellor continues to talk, overlapping with the patient's response, and thus misses the opportunity to pick up on the patient's theme. Later in the session the counsellor engaged the patient in discussing his frustrations and suicidal thoughts, and this discussion revealed his alienation, which went much deeper than the focus of role transition. He talked about how pointless people's lives are and how he had constantly had suicidal thoughts. At this point, it seemed to be extremely difficult to get the patient motivated and engaged in limiting himself to one interpersonal problem area.

**Summary of the data**

The frequencies of categories are presented in Table 1, and more detailed findings are given in Appendix 1. Joint construction of the problem area between the counsellor and the patient was general in the recovered group. When making the interpersonal formulation, the counsellors were generally highly responsive to their patients and their patients manifestly agreed on the problem area. Also, it proved possible in the recovered group to jointly limit

the patients' problem to one area, generally role disputes in social relationships. By contrast, unilateral construction of the problem area by either the counsellor or the patient was typical in the unchanged group, whereupon the counsellors bypassed the patient's responses and ended up with more than one problem area (complicated grief and role transition or role disputes), or else failed to define a manifest problem area during the initial two sessions. Simultaneously with the findings of differences in the process of case formulation, the recovered and unchanged groups also proved to have different backgrounds, the recovered patients generally feeling that they had adequate social support from their family and while the unchanged patients generally felt that they lacked external social support.

## Discussion

To our knowledge this is the first study of IPC from a process standpoint, in order to explore predictive factors in the context of case formulation, which has been highlighted as central to the IPT approach (Markowitz & Swartz, 2007). Our novel findings were that the interaction that took place in the recovered group at the case formulation stage was generally characterized by joint construction of one problem area associated with role disputes in social relationships. The process of case formulation varied more in the unchanged patients, and it was impossible to define a focus on any one problem area., The interaction typically reflected difficulties between the patient and the counsellor: unilateral construction of the problem areas associated with complicated grief and major life changes.

An interpersonal formulation procedure requires that the resulting formulation should be convincing for both the counsellor and the patient (Markowitz & Swartz, 2007), but we have known little about how an understanding of the patient's problems is negotiated in actual counsellor-patient interaction. Our conversation analysis of IPC case formulation provides a working alliance perspective on this data. It has been shown that if an emotional bond and a shared idea of the goals of the therapy cannot be formed during the initial three

sessions, it is very likely that the patient will not benefit from the intervention (Horvath & Bedi, 2002). Our findings indicate that the counsellors in the recovered group rhythmically attuned their expressions to the patients' speech, and in this way they validated the patients' emotional expressions and emphasized the importance of their subjective meanings with regard to their experiences in the investigation of the problem area (cf. Weiste & Peräkylä, 2014).

It should be acknowledged that our conversation analysis findings were reliant on several other factors that may have contributed the various processes of case formulation. The heterogeneity of depression may be one explanation. There were no statistically significant differences in the pre-treatment CORE-OM or BDI severity scores between the recovered and unchanged groups, but the present unchanged patients seemed to be experiencing a quite different form of depression from the recovered patients. Conflicts at their workplace or disputes with their spouse preceded depression in the recovered group, whereas depression in the unchanged group was associated with irreversible life changes (life-threatening illnesses, leaving work due to illness or the death of a close relative) or a lack of prospects for the future (withdrawal from life and suicidal ideation). Rantala, Luoto, Krams and Karlsson (2017) have argued that depression is not a single disease. It is a group of separate syndromes, with patients differing remarkably in symptom profile, pathophysiology and treatment responsiveness. They classified depression into 12 subtypes based on evolutionary explanations, focussing on the underlying reasons (triggers) for depression. Of these proximate mechanisms, hierarchy conflict refers to events such as unemployment or professional hierarchy conflicts. Our data support the link between focussing on and resolving hierarchy conflict at work and improvement in IPC, since three of the patients who recovered established this as the problem area. This is in line with earlier findings in IPT studies that have suggested that IPT may be most suitable when a conflict

with a significant person is in focus (Gunlicks-Stoessel, Mufson, Jekal, & Turner, 2010). On the other hand, loneliness, traumatic role transition after a serious loss of health and grief as underlying reasons for depression predicted a poorer outcome in our data. These observations support earlier findings that suffering from a concurrent physical illness may limit the benefit of IPC (Holmes et al. 2007; Menchetti et. al, 2014). Complicated grief (combined with role disputes or role transition) was also associated with a poorer outcome, which is in line with the findings of Markowitz, Bleiberg, Christos and Levitan (2006) in dysthymic patients.

Another factor related to the patient may also be an explanation for the varied processes of case formulation. All the patients who recovered had social support from their spouses. This is consistent with some previous studies of IPC concerning who might benefit most from this counselling, in that being in stable and supportive relationships was associated with a better outcome (Badger et al., 2006; Badger et al., 2013). Two of the unchanged patients were single, having isolated themselves from close relationships and three were married but without social support from their spouses. The overall evidence shows that spousal support is important and the most salient social support for adults and older adults against depression (Gariépy, Honkaniemi, & Quesnel-Vallée, 2016). In particular, the spouse's or partner's role as a provider of social support is central during the recovery phase of depression after a somatic disease (Salakari et al., 2017). This was lacking for two of the unchanged patients in this study.

**Strengths and limitations**

The strength of this systematic multiple case comparison study lies in its qualitative enrichment of the quantitative findings of our randomized controlled trial (RCT) in a naturalistic clinical setting (Kontunen et al., 2016), and thus bridges the research-practice gap (Iwakabe, 2009). It illustrates how a manualized treatment protocol can be applied to

specific individuals (Iwakabe & Gazzola, 2014). This allows one to demonstrate the complexity of the change that takes place in individuals (cf. Hill, Chui, & Baumann, 2013). Our findings here highlight the diversity of the interactional factors lying behind the statistical outcomes and explain therapeutic interaction at its finest level of detail. Thus, the findings add to our understanding of the therapeutic relationship, explaining why some patients recovered and others were unchanged, at least as far as the particular treatment method was concerned (Norcross & Wampold, 2011).

Although qualitative enrichment is the strength of this study, it encompasses a number of limitations that have to be taken into account. Our study design yielded a complex picture of the interplay between the contributions of the patient and the counsellor to the therapeutic relationship and to patient change. The study design did not allow us to isolate the effect of the counsellor on the outcome from that of the patient, but our analysis did reveal, for instance, that the recovered and unchanged groups differed with regard to the level of external social support at the pre-treatment stage. This may explain why the patients recovered or were unchanged, as may the interaction between the counsellor and the patient.

Evaluating patients' descriptions of their close relationships and problem areas according to IPC focuses by means of directed content analysis (Hsieh & Shannon, 2005) has its limitations. Although relationships and focuses are labelled explicitly in the IPC case formulation, the fact that only one person (J.K.) was identifying the categories might have directed us to find evidence that is biased to support preconceptions (Hsieh & Shannon, 2005). The same problem concerns CA analysis, even though the second author (E.W.) was unaware of the outcomes of the cases when conducting the analysis. We strived to increase the trustworthiness of the analysis by listening to the audiotapes while reading the transcript through a number of times and discussing selected segments of the recordings amongst the whole research team and at two group meetings (data sessions) attended by trained CA

researchers who were unaware of the outcomes. The selection of case examples and excerpts from the cases is also a critical matter. It ultimately remains for the readers, however, to decide whether the choice of data and excerpts illustrates the formulation as it took place with the recovered and unchanged cases in a plausible manner.

**Implications for practice**

One essential issue for clinicians is to what degree a case formulation model is applicable and useful in ordinary practice (Godoy & Haynes, 2011). Our qualitative findings address the underlying concepts and rationale for case formulation at the primary health care level, for the circumstances in which patients actually seek treatment for the first time and are treated by nurses who are sharing the responsibility for the treatment of depression with general practitioners. At its best, the content and process of IPC case formulation can be time-saving, can rely on general knowledge of depression, and can help the counsellor to identify what is workable for the patient and avoid areas that may be interesting but do not further recovery (cf. Eells, 2007b). In this regard, our findings support, at least in the context of less complex problems (cf. Groenier, Pieters, Witteman, & Lehmann, 2014; Kuyken, Fothergill, Musa, & Chadwick, 2005) the suggestion that good outcomes may be achieved by novice therapists' by staying close to the accepted protocols and manuals.

But there are also several limitations to the following of a manual-guided case formulation procedure in IPC. Since the counsellor has to label problem areas explicitly and limit the choice to one or at most two of these (Markowitz & Swartz, 2007), the case formulation may not fit the individual situation and there is a risk of not recognizing, or of misunderstanding, the patient's problems (cf. Eells, 2007b). Three IPC case formulations in this subsample were characterized by unilateral construction of the problem area and difficulties in responsiveness. The problems in these cases were complicated ones, and more than one problem area was labelled, or the problem area was indefinable. The content and

process of IPC case formulation may be an insufficient approach in complex cases of this kind, and we can postulate that some other high-quality case formulation protocol implemented by advanced practitioners would have improved the outcomes (cf. Kuyken et al., 2005).

One option for increasing the utility of IPC case formulation would be to develop the manual further. In the light of the review by Carroll and Rounsaville (2008) the challenges inherent in moving a manual from research to clinical practice and making it more "clinician-friendly", our data strongly suggest that the IPC manual should place greater emphasis on collaboration and joint construction of the case formulation, as this is a crucial element in the treatment outcome. Also, the manual should provide more guidance in troubleshooting, especially on how the counsellor can help the patient to choose the most salient problem area even when there may be several problem areas altogether. We conclude that classification of the problems in accordance with the IPC procedure should suffice if the counsellor and patient are jointly able to limit the problems to one area. Although IPC can provide structure and content to enable primary care practitioners to evaluate, support and prioritize patients with depressive symptoms (Weissman & Verdeli, 2012), counsellors would need guidance on how to manage when the patient cannot select a problem area and cannot set achievable goals and on how to make practical changes to treatment strategies. Counselling psychologists may be particularly well suited as providers of process-oriented research for this task and training for counsellors in how to use the IPC manual in a more "clinician-friendly" manner (cf. Allan, Campos, & Wimberley, 2016).

In summary, this multiple case study provides new detailed information about the content and process of case formulation which may be helpful for counsellors working with IPC or training others in its use for the treatment of depression at the primary care level. The present findings emphasize the importance of joint construction of the problem area between

the counsellor and the patient, and how the heterogeneity of depression and external social support may account for the efficacy of counselling. Further qualitative process research regarding case formulation and the mechanisms of change in IPC can be expected to provide a more comprehensive understanding of the factors that influence a positive response to counselling.

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Appendix 1. Main findings regarding case formulation for the patients in the recovered group (n=5) and unchanged group (n=5)

| | Steps in case formulation | | | | |
|---|---|---|---|---|---|
| Cases (pseudonyms) | Clarification of well-being, symptoms, function and risk behaviour (CORE-OM and BDI scores at the beginning of IPC) | Evaluating interpersonal relationships | Establishing an interpersonal problem area | Making the interpersonal formulation | Outcome of well-being, symptoms, function and risk behaviour (CORE-OM and BDI scores at follow-up) |
| Recovered group | | | | | |
| Paula<br>female, 54 years, married | Moderate distress (19)<br>Moderate depression (19) | Adequate perceived support from spouse | Role disputes with a co-worker and a boss at the workplace | Joint construction: strong responsiveness – strong agreement | Non-distressed (4)<br>Non-depressed (1) |
| Daniel<br>male, 33 years, married | Moderate distress (16)<br>Mild depression (16) | Adequate evoked support from spouse | Role disputes in a family business | Joint construction: strong responsiveness – strong agreement | Non-distressed (9)<br>Non-depressed (7) |
| Carolyn<br>female, 54 years, married | Moderate distress (19)<br>Severe depression (30) | Adequate evoked support from spouse | Role disputes with spouse | Joint construction: strong responsiveness – strong agreement | Non-distressed (7)<br>Non-depressed (7) |
| Joanna<br>female, 30 years, married | Moderate distress (17)<br>Mild depression (11) | Adequate evoked support from spouse | Role transition upon childbirth | Joint construction: strong responsiveness – strong agreement | Non-distressed (6)<br>Non-depressed (2) |
| Mary<br>female, 30 years, married | Moderate distress (20)<br>Severe depression (35) | Adequate perceived support from spouse | Role disputes at work and role transition due to husband's unemployment | Joint construction: strong responsiveness – strong agreement | Non-distressed (2)<br>Non-depressed (0) |
| Unchanged group | | | | | |
| Ann<br>female, 58 years, married | Moderate distress (17)<br>Moderate depression (19) | Inadequate perceived support from spouse | Role transition - illness and cancer surgery, leaving work and role disputes with daughter | Joint construction: strong responsiveness – strong agreement | Moderate distress (14)<br>Mild depression (17) |
| Dorothy<br>female, 51 years, married | Moderate distress (22)<br>Moderate depression (25) | Inadequate perceived support from spouse and friends | Role transition – illness and threat of death and interpersonal deficit/isolation | Joint construction: strong responsiveness – strong agreement | Moderate distress (23)<br>Severe depression (40) |
| Helen<br>female, 48 years, married | Severe distress (26)<br>Severe depression (45) | Inadequate perceived support from spouse | Complicated grief – death of mother and role transition – daughter leaving home | Unilateral construction: weak responsiveness – partial agreement | Moderate distress (25)<br>Mild depression (15) |
| Lisa<br>female, 53 years, single | Moderate distress (17)<br>Moderate depression (19) | Inadequate perceived support from relatives | Complicated grief – death of mother and role disputes with sisters | Unilateral construction: weak responsiveness – partial agreement | Moderate distress (16)<br>Mild depression (16) |
| Alex<br>male, 24 years, single | Moderate distress (16)<br>Moderate depression (19) | Difficulties in accepting support from any close relation | No commitment to work on any suggested problem area, isolation and suicidal thoughts later in the session | Unilateral construction: weak responsiveness – partial agreement | Moderate distress (13)<br>Mild depression (17) |

Note. CORE-OM = Clinical Outcomes in Routine Evaluation - Outcome Measure. Clinical cut-off: Non-distressed (healthy) < 13, Moderate = 13-25, Severe > 25 (Barkham et al., 2001). Scores are multiplied by 10, yielding a more convenient range of 0-40 (Leach et al., 2006). BDI = Beck Depression Inventory. Clinical cut-off: Non-depressed (healthy) < 10, Mild = 10-18, Moderate = 19-29, Severe >29.

# III

# MECHANISMS OF CHANGE IN INTERPERSONAL COUNSELLING (IPC) FOR DEPRESSION: A THEORY-BUILDING CASE STUDY

by

Jarmo Kontunen, Timo Liukkonen, & Jukka Aaltonen, 2019

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