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Case Study

Interpersonal Psychotherapy (IPT) for a patient with moderate depressive episodes with somatic syndrome: a single case study

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ABSTRACT

Interpersonal psychotherapy (IPT), is a short term, evidence-based treatment, has shown efficacy in treating individuals with affect dysregulation and other psychiatric condition. Interpersonal psychotherapy target helping patients to improve their interpersonal relationships or change their expectations about them. It also aims to assist patients to improve their social support network so that they can better manage their current interpersonal distress. This case study, therapeutic program consisting of 15-20 sessions based on the clinical interview and psychological evaluation. It mainly focused on interpersonal relationships as a means of bringing about interpersonal change and symptomatic recovery, with the goal of helping the individual to resolve the acute interpersonal crisis and to improve her social support system. This intervention included detailed assessment in the initial phase, interpersonal inventory, the interpersonal formulation, treatment agreement, IPT techniques (clarification, communication analysis, problem solving, use of affect, role playing, homework and other directives), conclusion of acute treatment and maintenance of treatment. The future directions of IPT involve assisting patients to improve their social support network with a view to ensure better management of their current interpersonal distress.

Keywords: *Interpersonal Psychotherapy, Depression, Affect Dysregulation, Interpersonal Difficulties, Interpersonal Skills*

Interpersonal psychotherapy (IPT) is a time-limited, interpersonally focused, psychodynamically informed psychotherapy. The goals of the therapy include symptom relief and improving interpersonal functioning. In addition, the treatment also aims to assist patients to improve their social support network so that they can better manage their current interpersonal distress (Stuart & Robertson, 2003). IPT is a evidence-based treatment that focuses on patients' social and interpersonal functioning, affect, and current life events. It is efficacious in treating major depression, bulimia, and other conditions (Weissman et al., 2000). IPT is based on both empirical research and clinical experience (Stuart & Robertson, 2003). Instead of being applied in a strict "manualized" form in which the clinician is

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required to follow precisely a treatment protocol, clinicians using IPT are encouraged to use their clinical judgment to modify the treatment when necessary in order to provide maximum benefit for their patients (Stuart & Robertson, 2003). IPT stems from the theoretical work of Harry Stack Sullivan and John Bowlby and from empirical research on the psychosocial aspects of depression. Sullivan (1953) viewed interactions with others as the most profound source of understanding one's emotions, while Bowlby (1969) considered strong bonds of affection with others the foundation for individual well-being. These theorists guide IPT practitioners as they explore their patients' affective experiences through the lens of the social and the interpersonal.

According to Stuart and Robertson (2003), interpersonal problems and psychiatric symptoms are conceptualized within a biopsychosocial framework. An acute interpersonal crisis, such as a loss, interpersonal dispute, or a difficult life transition, create problems for patients for two reasons:

1. Interpersonal communication skills within their significant relationships are not adaptive;
2. Social support network is not sufficient to sustain them through the interpersonal crisis.

IPT proceeds by helping patients to communicate their attachment needs more effectively, to realistically assess their expectations of others, and to improve their social support. This should help resolve interpersonal problems and relieve psychiatric symptoms. At the same, it is to keep in mind that IPT is a kind of Psychodynamic approach which gives high lights on two fundamental principles that is psychic determinism and the proposition that unconscious mental processes are primary influence on an individual's conscious thoughts and behavior.

The two principal empirically-based psychotherapeutic interventions for mood disorders are cognitive behavioral therapy (CBT) (Becl et al., 1979) and interpersonal psychotherapy (IPT) (Weissman et al., 2000). Both therapies are diagnosis-targeted, short term work. IPT is based on the so-called common factors of psychotherapy: a treatment alliance in which the therapist empathically engages the patient, helps the patient to feel understood, arouses affect, presents a clear rationale and treatment ritual, and yields success experiences (Frank, 1971) On this foundation IPT builds two major principles:

- Depression is a medical illness, rather than the patient's fault or personal defect; moreover, it is a treatable condition. This definition has the effect of defining the problem and excusing the patient from symptomatic self-blame.
- Mood and life situation are related. Building on interpersonal theory and psychosocial research on depression (Klerman etal., 1984) IPT makes a practical link between the patient's mood and disturbing life events that either trigger or follow from the onset of the mood disorder.

Research has demonstrated that depression often follows a disturbing change in one's interpersonal environment such as the death of a loved one (complicated bereavement), a struggle with a significant other (role dispute), or some other life upheaval: a geographic or career move, the beginning or ending of a marriage or other relationship, or becoming physically ill (a role transition) (Markowitz & Weissman, 2004).

Once patients become depressed, symptoms of the illness compromise their interpersonal functioning, and bad events follow. Although these observations seem commonsensical, many depressed patients turn inward, blaming themselves and losing sight of their environment. Whether life events follow or precede mood changes, the patient's task in therapy is to resolve the disturbing life event(s), building social skills and helping to organize his or her life. If the patient can solve the life problem, depressive symptoms should resolve as well. This coupled effect has been borne out in clinical trials demonstrating the efficacy of IPT for major depression (Markowitz & Weissman, 2004).

In Mood disorders, the utility of IPT for MDD has been strengthened by landmark studies such as the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program, in which IPT was statistically comparable to imipramine on several measures and better than a placebo control for more severely depressed patients (Elkin et al.1989). Other trials have found IPT efficacious in treating depression in medically ill patients (Schulberg et al., (1996) peripartum women (Spinelli (1997 & (Klier et al., 2001), depressed adolescents (Mufson et al.,1995), and geriatric depressed patients (Reynolds et al. 1999). Two trials have demonstrated benefits for monthly IPT as a three-year maintenance treatment for recurrent depression (Reynolds et al. 1999 & Frank 1990).

Success of IPT has shown in non- mood disorders. There have been promising developments of IPT as a treatment for social phobia (Lipsitz et al., 1999), posttraumatic stress disorder (Agras et al., 2000)- both anxiety disorders with clear interpersonal components - and eating disorders (Faiburn et al., 1995 & Wifley 2002). Further explorations are adapting IPT to borderline personality disorder, primary insomnia, body dysmorphic disorder, and other disorders (Weissman et al., 2000). More research is needed to determine the optimal use and dosage of all forms of IPT. Furthermore, it is unclear for it – as for all psychotherapies – when and how it is best to augment IPT with medication, and vice versa. IPT is also being transplanted to other cultures (Weissman & Markowitz, 2003).

IPT is a relatively young psychotherapy targeted to particular psychiatric diagnoses. Relative to many other psychotherapies, its characteristics are well defined and its efficacy is well understood. Nonetheless, far more remains unknown about its indications for various conditions, its optimal dosing, its combination with pharmacotherapy, its utility in different formats, and so forth. Although one of the best studied interventions in outcome research, particularly for mood disorders, IPT is only now spreading into clinical practice (Markowitz & Weissman, 2004).

The highlight of this particular case study is that, world-wide IPT techniques been used and this particular intervention is done in Kerala, India. Which will help us to understand the efficacy of IPT for ethnically and racially in diverse economically.

CASE STUDY

48-year-old married female, educated up to BA Economics, from upper middle socioeconomic status and hailing from Kerala, India. Presented with complaints of increased tension, frequent headaches since past 4 months; reduced sleep, not interested in doing activities at home, changes in sleep pattern, reduced interaction with family members, reduced appetite, weight loss, low energy in the past 1 month, with gradual onset, continuous course and the progress is deteriorating, precipitated after a financial crisis.

The patient was apparently maintaining well until 4 months ago, but gradually she was reported to be extremely worried based on an incident. Where her son had met with an accident 5 years ago and a person was expired in that accident; following this a case was filed against her son. In order to get out from the case the family had paid a huge amount to a person and they stated at the court that it was the driver's mistake and made another person accept the responsibility for the accident. The patient reported that 4 months back the same person started blackmailing and asking for more money very frequently, and the patient reported to be extremely worried about the problems at home where her husband frequently engaged in fights with the son despite her restricting him doing so. During this time, she had made many temple visits as she is unable to manage her distress. She had also reported of frequent headaches thinking about the same problem and used to visit the ENT department at the local hospital often; she was also hospitalized for the same and got treated. At about the same time the patient came to know that her elder son had a romantic relationship with a girl, who belonged to the different state and a different religion (they are college mates). This was also causing stress in the patient when she considered the possibility that her son is going away from her and eventually getting detached from the family and the culture he is raised in. The patient gradually experienced reduced sleep and had difficulty in doing most of the daily chores. The patient reported that multiple issues were affecting her such as, over concern about her son's romantic relationship, financial problems and the husband's health conditions (kidney stone and diabetes) most of the days, and consequently she was unable to sleep. Because of her reduced sleep she used to feel tired during the daytime and used to have an intense headache that led to the patient being admitted at local hospital in the ENT department for 2 weeks. After coming back home, the patient reported that she had lost interest in day to day activities. She had to motivate herself to get out of bed, brush her teeth and taking showers, when she had tried to do so, she was getting tired and losing all her energy within a few minutes of initiating the work.

During this time the patient's mother consulted an astrologer who said that these issues were a direct result of the inaccuracy of the architecture of the house and that the septic tank was not in the desired position. Listening to this, the mother and the patient arranged workers and demolished an entire side of the house where the septic tank was located without the consent of the husband, this led to further harrowing problems within the household, this further led to tensions and fights between the husband and the patient and he started to verbally abuse the mother. Subsequently the patient started to break down mentally, her social interactions lessened, as she found it difficult even to attend social functions like her friend's son's marriage as she was conscious of the possibility of others noticing her ailment, she was slowly being house-bound and as days went by, her symptoms prevailed, like burning sensations, throbbing headaches and was continuously on medication. However, no improvement in the symptoms were reported. She started getting depressive thoughts on loneliness and lack of acknowledgement and appreciation from the family. An incident was reported where she was fired by her husband for mixing up several ingredients in the kitchen and spoiling the meal which made her feel that that there was no point in leading a life like that. Finally, seeing that there was no end in sight, she returned to hospital and got admitted to the department of psychiatry and was referred to clinical psychology department.

Treatment history: There is a treatment history of patient been consulted in the ENT department, for frequent headaches and she was admitted.

Negative history: No history suggestive of head injury, and epileptic events, no history suggestive of use and abuse of alcohol, no history suggestive of patient seeing things others cannot see or hearing things others cannot hear, no history suggestive of patient feeling pervasively happy for a long period of time.

Family history: The patient born out of a non-consanguineous marriage, first of two siblings. Father passed away when he was 82 years due to lung cancer. Mother is 80 years old, and had worked as a nursing assistant for 10 years. As patient reported, the mother is religious person who strongly believes in God and visits the temple and practices rituals. Patient was found to have an extremely close relationship with her mother in which she shares most of her current life decisions and most of her time. Family history suggestive of excessive alcohol usage amounting to dependency in the father and the maternal family members, use of tobacco in father and seizures in a maternal family member. Parental conflicts have been reported, due to father's lack of responsibilities and financial problems in the family.

Personal history: Personal history of uncongenial family atmosphere during childhood. The patient had an above average academic performance with adequate involvement in extracurricular activities and social interaction. She has completed B.A Economics with third class. She started working at the age of 32 years as UP teacher (Hindi) worked for a year, and quit the job after about a year as her husband disapproved of it.

The patient was married at the age of 23 years and the husband was 26 years old. The husband is educated up to pre-degree, and is working as a government employee at present. It was an arranged marriage, they have two boys. The elder son is 25 years currently pursuing PG and the younger son is 21 years engineering final year. The patient had reported of significant conflicts in the marital relationship where he blames her unnecessary. Patient has expressed that there is not much of an emotional connection with him since the early days of the marriage, moreover he was an alcoholic during those days, and had survived liver cirrhosis. However, he is a person who is extremely short tempered and accuses the patient of incompetency in even the smallest of things.

Premorbid personality: She reported to be a person with low self-confidence, however she maintained a good relationship with her family members, reported of getting anxious for small things in the childhood and gets depended on mother for most of the things; however, she was able to make decisions on household matters and she had wholeheartedly taken up the responsibility of the family. She was reported to be religious and engaging in religious rituals very often. She was prone to stress, used to cry easily, and had very poor tolerance towards stressful situations.

On MSE, she was alert, well kempt, dressed appropriately, rapport was established easily, and her attitude towards examine was cooperative during the test. Eye contact was maintained. Psychomotor activity was normal and speech was spontaneous, tone, tempo and volume low and reaction time was normal and speech

was relevant and coherent. Mood was subjectively reported to be sad, affect subjectively reported to be sad and objectively found to be depressed, range of affect was restricted and reactivity was present. Thought content included ideas of hopelessness and worthlessness. Perceptual abnormalities were not present. On cognitive functions, she was oriented,

attention was aroused and sustained, immediate, recent and remote memory was intact, intelligence was average, abstractability was adequate, judgement was intact with Grade 4 insight.

PSYCHOLOGICAL ASSESSMENT

Beck Depression Inventory (BDI)

Her BDI score is 29 indicative her depressive symptoms in moderate range, with high score on crying, loss of energy, changes in sleep pattern and fatigue.

Impression

Moderate depressive episodes with somatic syndrome.

Therapeutic program and rationale

The patient was given a final diagnosis of moderate depressive episode with somatic syndrome. Based on the clinical interview and the psychological evaluation, therapeutic program consist of 15-20 sessions was planned. Interpersonal therapy was planned to alleviate her suffering and improve her interpersonal functioning. It mainly focused on interpersonal relationships as a means of bringing about interpersonal change and symptomatic recovery, with the goal of helping her to resolve the interpersonal crisis with the husband and to improve her social support system.

It consists of the following:

a) Assessment/ Initial phase
b) Interpersonal inventory
c) The interpersonal formulation
d) Treatment agreement
e) IPT techniques
f) Conclusion of acute treatment
g) Maintenance treatment

Short Term Goals	Long Term Goals
To establish a good rapport with the patient and to have true therapeutic alliance.	To facilitate the patient's independent functioning.
Understanding the patient's interpersonal relationship.	To help the patient resolve the interpersonal crisis.
To educate about the link between depressive symptoms and events in relationship.	Reduction in the depressive symptoms as the relationship improve.
To improve her social support**.**	To spend quality time with family.
To make her understand about the specific areas to be addressed.	To reinforce the gains.
To improve the communication aspects with husband	
To make her understand about the family boundaries.	

Process of therapy

Initial phase consists of 1-5 session:

Aim:

1. Detailed assessment to understand the severity of the
2. Educate about depression.
3. Conduct interpersonal inventory.
4. Identify the problem area.

This phase of therapy mainly focused on:

1. Establishing Rapport: Interviewing the patient in detail to establish rapport and to identify the problems and to select the form of therapy.
2. Psychoeducation: She was psycho-educated about the nature of her problems, some of the causes that led to the condition and therapy plans including that 15-20 sessions were discussed. She was motivated and reassured about the effectiveness of regular therapeutic sessions.
3. Activity check list: It was initiated from the first session. Simple activities like walking inside the ward, talking to mother, watching TV etc was given to the patient. Activity check list was given to the patient to increase the activity levels and to maximize the mastery and pleasure, also to limit the sick role.
4. Conducted the interpersonal inventory: Interpersonal inventory is mainly used to understanding contemporary relationships, exploring the back ground of the patient's current interpersonal problems, identifying the communication styles and pattern of interaction relevant to the interpersonal problem and identifying specific IPT problem areas which were the foci of treatment.
5. The treatment agreement: During the treatment agreement, the number, frequency and duration of session were discussed. The problem areas to be addressed, the expectation of the patient and therapist, contingency planning (emergencies and rescheduling) and treatment boundaries (non-professional relationship) were included in the discussion.

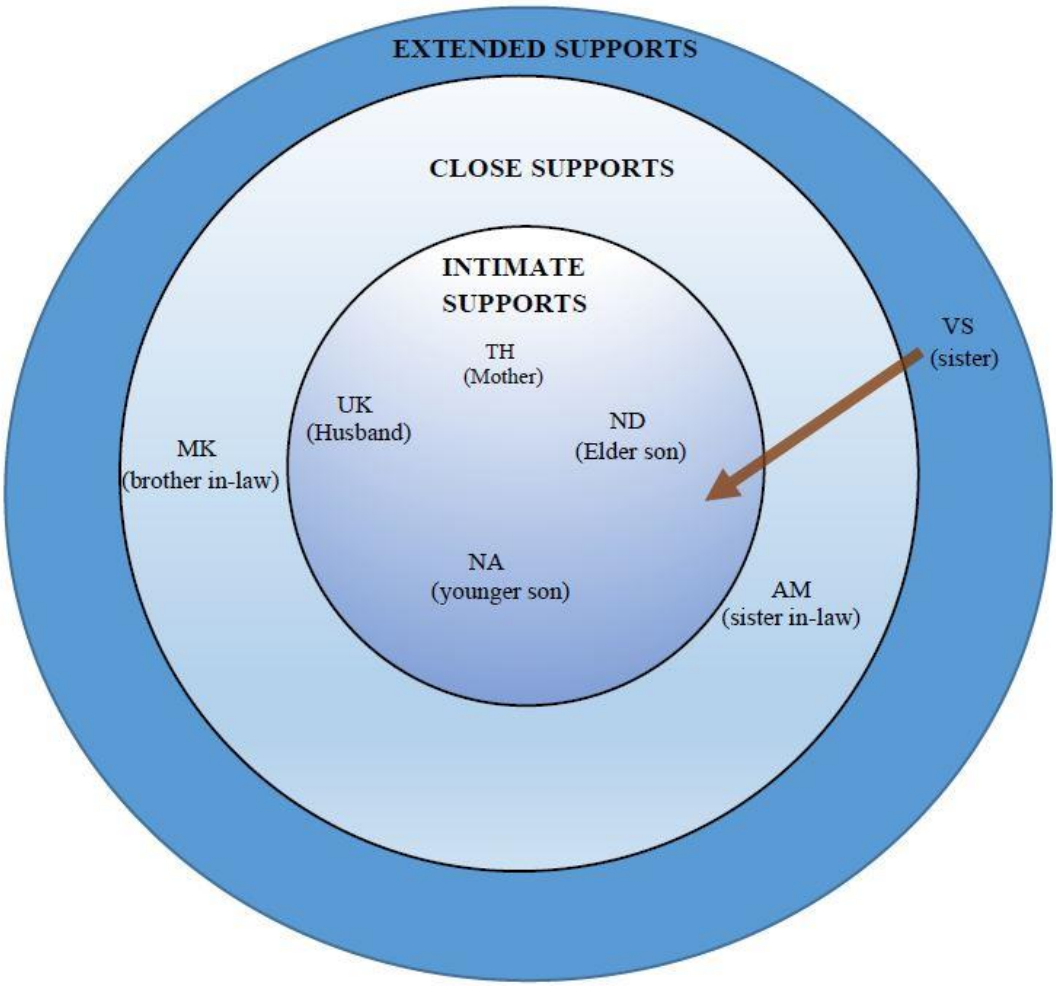
In the first session, she was cooperative and could describe her problems and difficulties in detail. She seems to have a good understanding of her problems and was motivated to attend therapy.

Session primarily focused on ventilating and she described at length about her distress regarding how it is affecting her daily functioning. Since she was admitted to the psychiatry ward daily sessions were possible. The patient was psycho-educated, about the nature of her problems, some of the causes that led to the condition and effectiveness of regular therapeutic sessions were discussed. The following sessions focused on reducing her depressive symptoms. Her daily routine was discussed and activities that she was not engaging in were identified. The relation between mood and activities was discussed. She could reflect that being inactive could be contributing to her low mood. Activity checklist was initiated and she was asked to maintain it regularly. During this phase, the therapist tried to identify whether the patient could benefit from IPT and is this the best treatment for the patient by asking her relationship with family, and the patient was able to provide a good narrative. The initial sessions focused on constructing interpersonal inventory. It basically gathered information about the patient's social support and the interpersonal problem areas. At the same time, the therapist has checked the quality of the narrative that is related and

meaningful, whether she is able to describe her experience in connection with specific individual conflicts. Following which the interpersonal formulation was done.

Interpersonal Circle

The patient was asked to think about people who are intimate and provides close support for her. She was asked to write down seven to eight people in her social support network, she was instructed that the innermost circle should include people with whom she feels intimate, the middle circle with people whom she fells close and the outermost area for the ones with extended support. A diagrammatic representation was arrived at based on the information given.



(In the interpersonal circle, the individual's full names should be given, here we have not marked it due to confidentiality)

INTIMATE SUPPORTS

1. TH (Mother)
2. UK(Husband)
3. ND (elder son)
4. NA (younger son)

"People who are close to heart, they are mine"
(As patient reported)

The patient's relationship with the mother seems to be very strong. Patient reported of being very close with her mother and takes her guidance in most of her decisions. Patient reported that, it is the mother who provides psychological support for her as her husband and children used to maintain a distance from her. The mother was very supportive and made the patient feel strong enough to take decisions independently in the presence of the mother. As the mother lived next door, the patient used to go to her place as soon as the husband goes for work, and spend the whole day with her. The mother's word and decisions were reported to be absolute for the patient and it was difficult to for her refute the mother's instructions.

The patient reported that her husband is a person with his own viewpoints and ideologies, who keeps to himself and has difficulty in connecting with others, but capable of making affection. The patient reported of having a strained communication pattern with him, that she did not know his likes and preferences, as he never opens up. He used to speak mostly to express his rejection or disapproval. It was reported that the husband did not like or approve of the patient spending time with her mother and the mother coming to her house.

Expectation from the relation: a warm and loving relationship was expected from the husband, and more understanding and loving kindness.

The patient reported of the first child as sharing similar characteristics of his father, he was always rude to the patient, even though he shares his experiences, he never liked her contributing suggestions or ideas to his life, he gets very offended and uses harsh words on her, and used to say that she has not seen the outside world, and therefore has no knowledge of anything whatsoever. He had spoken about a romantic relationship with a north Indian girl and the patient found it unacceptable considering the cultural differences and the circumstances she was raised under, though her husband had accepted it. The patient was then accused of being selfish which was extremely distressing for her.

Expectation from the relation: Expected emotional intimacy from the elder son.

The patient reported of her younger child as very childish and immature, and that he cannot accept the things being told by the mother. It was reported that there was no quality time between the patient and the younger son, as his main priority was his friends. It was reported that when he is at home, he will be involved in 75% of the household activities, but if questioned, he would become aggressive towards the patient.

Expectation from the relation: Emotional intimacy from the younger son.

Close supports

1. MK (Brother-in-law)
2. AM (MK's wife, sister-in-law)

It was reported that MK was close to the patient but there was no emotional support as her husband disapproved of this, according to him they are ones who do wrong deeds (they are not good enough to be interacted with). The communication was only through phone and it was reported that they used to talk only about finance and related aspects.

It was reported that AM used to give suggestions for the patient on how to improve the relationship with the husband, though it never worked out. The patient used to hear about the emotionally balanced and supportive relationship between AM and her husband and she used to compare it with hers. MK and AM never visited them frequently due to her husband's strict attitude, yet there was a close relationship but there was no scope for requests for financial support."

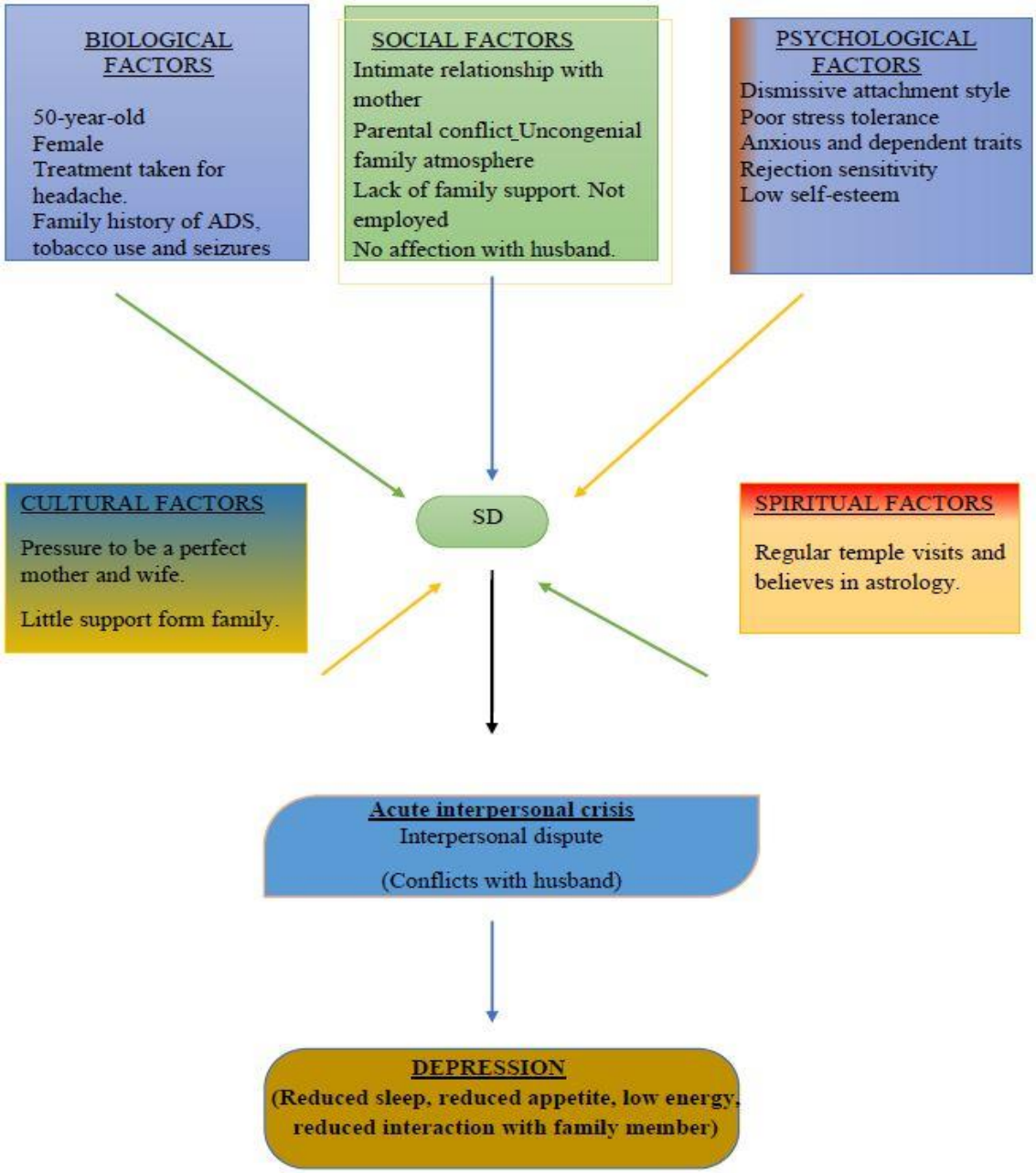
Extended supports

1. VS (Sister)

It was reported that there was no significant conflict between the patient and her sister (VS), but there was a distance and a slight underlying disharmony between them. The patient had felt that she is skilled in flattery and harmless emotional exploitation as she was reported to have extracted money from their mother often."

Expectation from the relationship: Expected her to come closer and make a transition into the closer circle. The next step was to make the Interpersonal formulation; When highlighting about certain factors that contribute to the psychopathology, the biological factors such excessive alcohol usage amounting to dependency in the father and the maternal family members, use of tobacco in father and seizures in a maternal family member. There is significant treatment history of patient consulting a specialist for headache. There are certain significant social factors which throw light into the patient's problems such as patient being a graduate and not working for a very long period of time; disinterest shown by the husband in sending her for work; enmeshed relationship with the mother where the patient crosses all boundaries and allowing the interference of the mother in her relationship with the husband; and consequent detachment shown by the husband. Since there exists a disharmony in their relationship, both their children (boys) feels that the mother is not capable enough to handle the family matters. There are certain psychological factors that contribute to the patient's pathology like insecure attachment, poor stress tolerance, and the patient having a very low self- esteem. While considering the cultural factors, the pressure to be a perfect wife and mother has been mounting upon her. She is a Hindu by religion, frequently visits temple, and she is a strong believer in astrology; and these spiritual factors have contributed to the origin of the pathology. With all the factors mentioned above, an acute interpersonal crisis was identified in the patient, which is interpersonal dispute with the husband causing a significant distress and difficulties in the relationship, leading the patient experiencing depressive symptoms.

Diagrammatical representation of psychopathology formulation

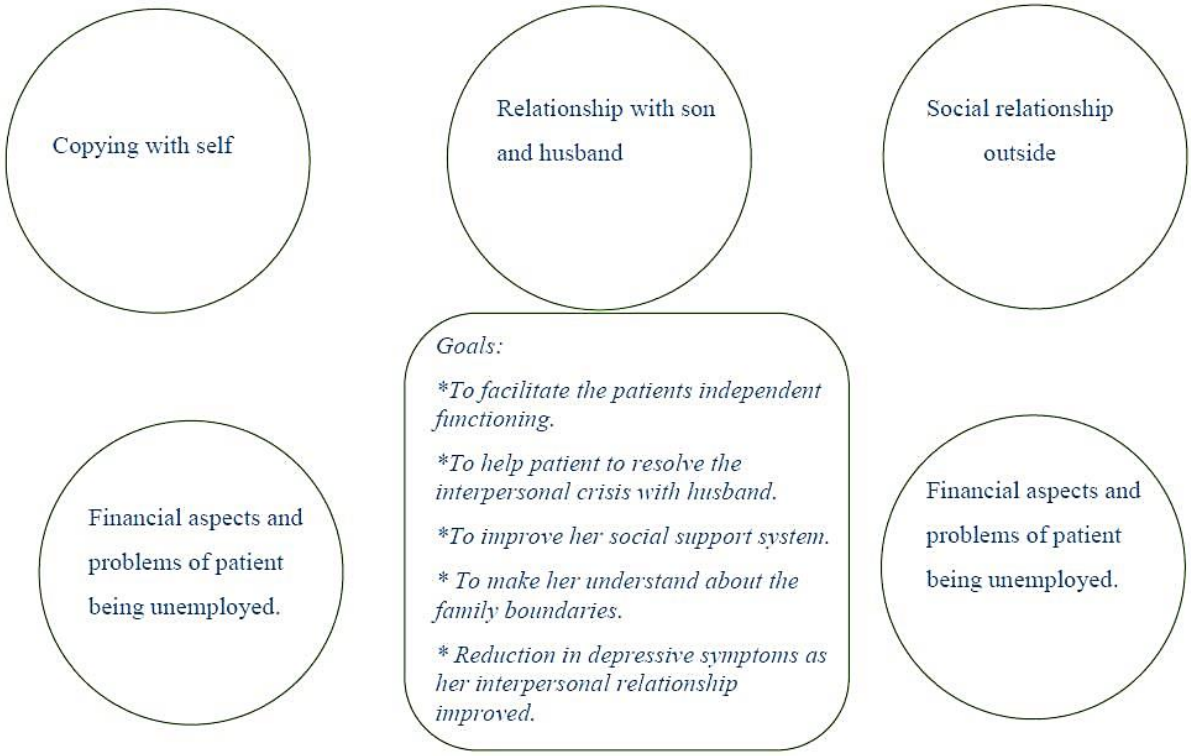


The identified problem area: The patient and the therapist arrived at an understanding about the causes of the current problems that the patient is experiencing, that is the interpersonal dispute with her husband where she feels that if her husband was bit more supportive and encouraging, she would have been more relaxed. This has also given us an idea which therapeutic intervention to be used, as well as providing information to the therapist about which specific IPT techniques are likely to be most beneficial.

The fourth and fifth sessions mainly focused on monitoring symptoms and activity checklist; she was asked to give more clarifications regarding the relationship with her husband. She expressed the need of having a close attachment and support from him and that he should accept her mother; the session had also explored the patient's feeling of humiliation. The

patient was psycho-educated from the information gathered from the interpersonal inventory with the help of the inter-personal formulation. The therapist and the patient sat together and made the interpersonal summary from the information gathered, leading to it specific goals were made. The patient was informed about the duration of the treatment involving a minimum of 12-20 sessions and the role of the patient and therapist in the process was also explained. Treatment agreement considering the number, frequency and duration of sessions, the problem areas to be addressed, the expectations of the patient and the therapist, emergencies and rescheduling and the treatment boundaries were discussed. Since she was admitted to the psychiatry ward, the therapist also educated her about the methods and techniques of interpersonal therapy hoping that she would put those into practice at home.

Interpersonal summary



The patient, agreed to work on this interpersonal focus

Middle phase consists of 6 to 12 sessions:

After the initial sessions of exploration and ventilation, goals were set for the session in the middle phase.

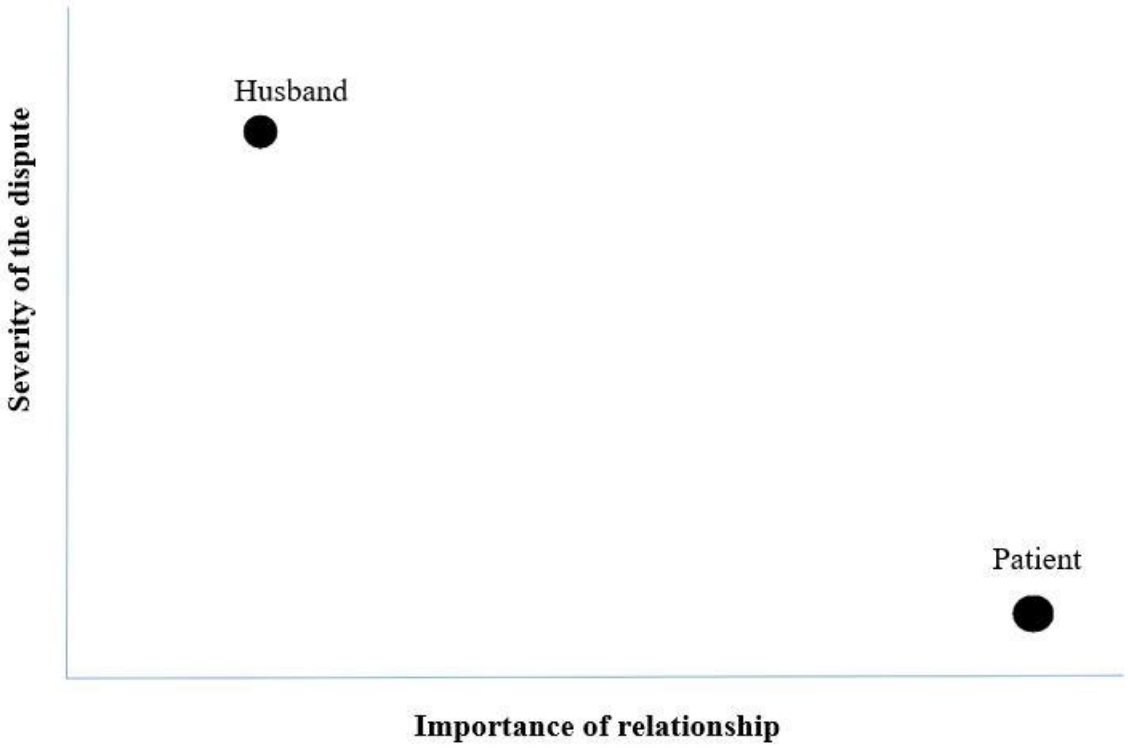
The sessions mainly focused on the following techniques:

1. Begun each session with review of depressive symptoms and mood rating
2. Graphing the interpersonal dispute
3. Role play
4. Work on interpersonal communication
5. To re-assess the symptom severity

Every session started by checking the activity checklist and rating her mood. Middle phase mainly focussed on graphing the interpersonal dispute, role playing. During the sessions, the patient's communication style and her mode of effective interaction was examined; the first session in the middle phase, as most of the others, was started off by the patient complaining

about her headache, which was disregarded and was confronted with the instruction to stay away from the sick role.

The middle phase started focusing on interpersonal dispute graph. Making the patient understand the dispute completely and helping her resolve the problems in interpersonal communication and to enlist the social support that is needed; This helped both the patient and the therapist in identifying the interpersonal dispute. **On graphing the interpersonal dispute**, certain questions were asked which could be helpful for the patient to be aware of the dispute, what are the patient's expectations from her husband in the prevailing situation, how the patient communicated regarding her needs to her husband and how it has changed over the course of the dispute, patient's attachment style and how it has contributed to the development of distress in the context of the dispute.



By analysing the graph, the therapist has been able to clarify the nature of the dispute with the patient in detail. Patient felt that the husband gives more importance to the severity of the dispute and less importance to the relationship whereas the wife gives more importance to the relationship and less importance to the severity of the dispute. The patient had a feeling of isolation from her husband due to her communication problems. It was identified that the husband had no idea what she was going through. More focus was given to the communication pattern, the patient-reported of feeling sad that she is unable to communicate most of the things with her husband. As the session passed, the therapist and the patient agreed up to the fact that it is important the husband know what the patient was going through, that the patient was not getting enough support from the family for years. The patent and the therapist then enacted a conversation using role play. First, the therapist played the patient's and role modelled some direct ways of communication. Next, the therapist played the husband's role - during this time - the communication elicited a frustrating response and provocative reaction. The patient the therapist continued to rehearse

for a few sessions, using the role play technique to improve her ability to describe how she was feeling. However, she was reminded that this has to be applied once she is back home.
The next step was to collect information about the patient's style of communication with the help of role play, as such: the therapist as the patient and the patient as the husband. On this particular session the mood rating on a scale of 0 - 10, she rated herself at 5; it was a result of a headache. She also reported that her older son and husband had called and spoke to her about the septic tank incident, she expressed her discomfort due to the husband's way of communicating with her regarding this issue, the husband was reported to be angry questioning the timing of the action as she was admitted to the hospital at the time, she also made it clear that there was great discomfort in taking a decision regarding the septic tank issue. The patient was informed about the role play and when she was informed that the same critical incident can be taken, the patient gave a warm smile of willingness. During the first half of the role play, the patient demonstrated self and therapist as the husband. When the therapist acted as the husband, it was observed that the patient was very restless and spontaneous in her way of communication, she was found to be anxious. The topic being discussed during the role play was the septic tank issue; she was clinging onto the significant point raised by her mother and it was observed that the patient was inherently provocative in nature and when the therapist reciprocated in the same provocative manner, the patient reported that this was the identical way in which her husband behaves. The patient and the therapist had arrived at this useful piece of information on how the patient communicates, and the same new way of communication was enacted with the help of the role paly. In the second half of the role play, the patient took the role of husband and therapist as the patient. When the therapist was acting as the patient, as per the initial intake assessment, the patient was playing a strict and stubborn role to stress upon the condition she was facing from her husband.

The next phase was focused on communication analysis: The primary aim was to analyse the patient's communication pattern and to help the patient identify the same, with the aim of helping her to communicate more effectively. However, as the therapist disregarded complaints from the patient of having a severe headache and tried to push forth for the communication analysis, the action backfired and the patient slumped herself on the table, thereby forcing the therapist to postpone the communication analysis.

In the next session, with the help of the supervisor, the therapist understood that it is important to address her feelings and health concerns. In the next session, this was addressed and reassurance was given and the communication analysis was continued as planned. The information about a specific situation (architecture issues) was taken and the patient and the therapist developed a hypothesis as to why the communication is progressing poorly.

Identifying the misunderstanding
Specific incident: The incident of the patient communicating with her husband regarding the architecture issue.

When the husband called her on the phone. The patient tried communicating about the architecture issue that her mother as arranged the someone for it and it has to be done as quickly as possible and her husband got angry at her.

	Specific incident	General statement
Content	When I spoke to him over phone he scolded me	My husband never listened to me.
Affect	I was irritated and sad.	I feel depressed, frustrated, hopeless.

Here the goals are to connect symptom and distress with the interpersonal problem, and help the patient become more effectively engaged in the process- Patient was told about this causing distress in her and leading to depression, frustration and hopelessness. The patient was asked about the emotional reactions during that specific interaction. Her response was "I really want him to know how sad and irritated I was with him".

The next step involved was helping the patient to recognize this by reanalysing the incident and then brainstorming to figure out how she can communicate more effectively. The idea was to move the patient from a feeling of sadness and irritation due to misunderstanding. So, the patient was asked to reframe the situation by thinking that she would have misunderstood the situation at the same time the patient was asked how well she understood the other person's point of view or feelings about the interaction. Mainly, when the patient communicates that the mother is taking initiative in the process of demolishing the septic tank. The patient was found to be honest, and non-defensive and said that she doesn't really know or understand what her husband was thinking and feeling. This actually led to an opportunity for the therapist to highlight that the communication within the dyad is unclear and she also needs to find from the husband that what he was feeling and thinking.

Changing communication: As the interaction was discussed in detailed her views changed as she began to see that she was not being understood and that she didn't really have a good idea about her husband's perspective either. The therapist was able to make her realize that she could change her communication and perhaps bring about different results. Her affect shifted to be more of a feeling of hopefulness, and the statement of "he never listens to me" was transformed into "he doesn't listen to me when I approach him critically".

	Specific incident	General statement
Content	He was angry at me because I started the conversation about architecture, saying the mother as arranged someone do the further work.	My husband gets anger and stops listening to me when I mention about the mother directly involving our relationship and being critical of him.
Affect	I felt misunderstood	I feel hopeful that things can change.

Similar other situations were analysed and patient and therapist had worked on it, mainly patient's concern about the elder son that the boy is in a romantic relationship with a north Indian girl. The patient very frequently irritated him and he used to get angry and she would feel sad for the same. This particular situation was also analysed during the session.

From the initial assessment, it was found that owing to the enmeshed relationship with the mother, and the strict and independent nature of the husband, stress was abundant in the patient's life. As the patient reported, she was able to link the dispute and the distress during the initial days of marriage; she expected a harmonious relationship between her mother and her husband. But since the mother was overly involved in their relationship, the husband started moving away from her. The characteristics of the mother and the husband were totally different. The mother is a more socially active and outgoing personality, even at the age of 80 and the husband is the complete opposite, the induction of the contents of the mother's social outings into the household was also a source of displeasure to the husband.

BDI re-administered: Her BDI score is 12 indicatives her depressive symptoms in minimal range, (pre-scores of 29, indicating depressive symptoms in moderate range). There was significant reduction in the high score of crying, loss of energy, change in sleep pattern, fatigue.

As the patient's symptoms reduced and reported of having a better mood, plan of discharge was made, a request of meeting the husband was made from the initial session, which was met by the patient's husband towards the end of the middle phase. His issues were mainly regarding the position of the mother-in-law interfering in their relationship; he mainly highlighted the late-night calls she made and when he's at home, and frequently interfering in their personal couple-time. He also highlighted the harrowing situation that came to pass when a part of the house along with the septic tank was demolished under the mother-in-law's orders without his consent, at the same time the wife is actively involved in the same, whilst it was the house he constructed. The patient and husband were psycho-educated about the therapy sessions. The husband was briefed about the problem the patient was going through and the patient was reminded about the techniques and skills that she had been taught during the therapy and to effectively put it into practice.

There is a significant reduction in the score compared to the previous test. The patient was given feedback about this and was appreciated for her greater efforts. It was found that the patient became sad when explained about the concluding the acute phase, which is a clear indication of her dependency on the therapist.

The problem-solving technique was not used in the middle phase as she was admitted to the psychiatry ward. The therapist had a detailed discussion with the supervisor and it was decided that when the patient comes on OP basis, the problem-solving techniques could be taught.

CONCLUDING ACUTE AND MAINTENANCE TREATMENT

1. To re-emphasis on skills learned.
2. To introduced the problem-solving technique
3. To explained about relapse prevention strategies.
4. Discussion follow up

The concluding acute and maintenance treatment consist of 13 to 17 sessions.

1. Re-emphasize on the skills learned: Discussed the applications of the learned skills in appropriate situations.
2. Problem-solving: How to communicate differently and to construct an effective social support mechanism, a detailed examination of the problem was made, the

patient and the therapist clarified the specific aspects of the problem; brainstorming was done; i.e.: the patient-generated a solution with therapist's input. In this situation, the main issue was the interpersonal dispute with the husband, and the factor which contributed to this was the decision regarding the vastu issue. When the patient came up with a suggestion that it is important for her to check with the astrologer and check upon the Vastu of the house; the husband preferred consulting another astrologer who happens to be his friend and arrive at the solution eventually at a later stage.

3. Relapse prevention: Discussed how to handle relapses were discussed. She has explained the need to recommit if she engages in any relapse after termination.
4. Follow-up: The patient was asked to come for follow up sessions once in 2 weeks and later increasing it to once a month.

The Interpersonal Psychotherapy has come to a conclusion but it was not actual termination; it is to be noted that the patient and the therapist will be having a therapeutic contact in the future. During maintenance period, the patient was asked to practice IPT skills and she was asked to note down her difficulties. When the patient came for OP consultation, the patient reported that after four days of discharge, she had a fall during the night while making a trip to the bathroom, and received a hairline fracture on her right arm, which subsequently resulted in the swift arrival of the mother which in turn reinforced the couple's problems; however, as the patient reported the husband was trying to adjust to the situation.

During this phase, the application of learnt skills were checked and problem-solving strategies were introduced. The patient further reported that the problem pertaining to the architecture of the house was solved after a mutual decision was taken and she was happy about the husband's change and supporting her. The patient reported of having a better mood and was more active. However, the husband was unhappy about the mother-in-law's involvement in house. The therapist discussed about modifying the response and to take measures to ensure that the mother is not intruding in their relationship.

During further sessions, it was noted that the husband had started accompanying her for the therapy sessions and maintaining a good relationship. During the therapy process, the patient had mentioned that she has started becoming involved in the local women's committee program and actively participating. As the husband was accompanying for the sessions, certain information about the communication pattern among the couple and others were discussed in detail. Patient and husband were spending quality time together and family had started going out (social activities).

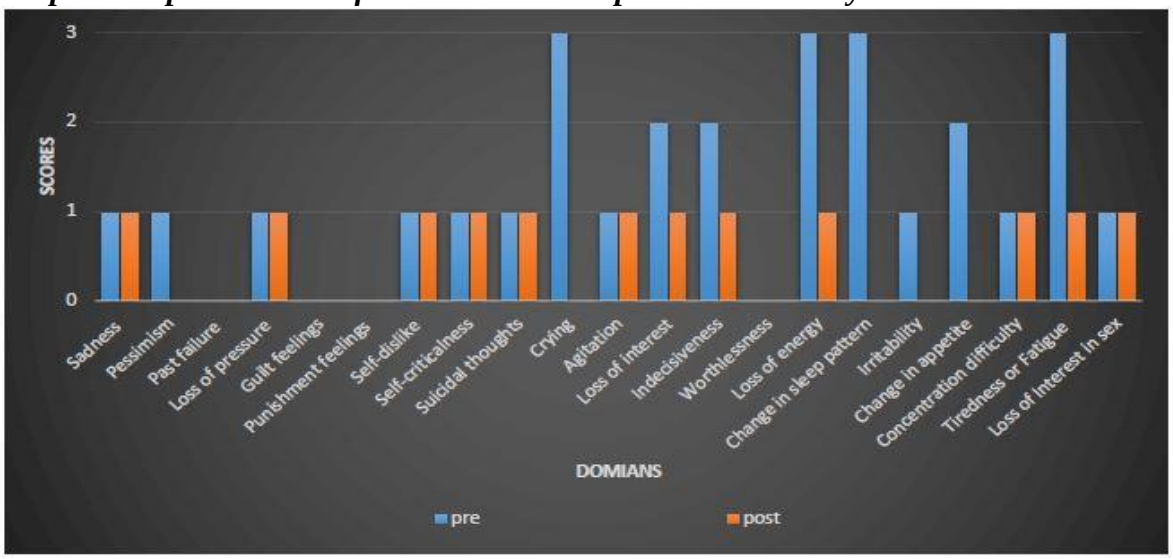
The husband reported an incident where the elder son had a fight with her and she was able to handle it in a better manner. The patient was psycho-educated about the boundaries that she has to maintain in the family and about spending time with mother and husband. She was asked not to entertain the mother inside the house when the husband is around, allot specific time for the mother, and not to attend late night calls.

Outcome achieved

Psycho-education helped her to understand the nature of her problem, how her problems could have evolved, and the factors that contributed to and maintained them. The patient had a reduction in the symptoms of depression. The severity of symptoms as measured by Beck

Depression Inventory showed a significant reduction in scores (score reduced from moderate to minimal symptoms). She also reported of having better mood and getting active.

Graphical representation of scores on Beck Depression Inventory



She was able to understand her maladaptive ways of communicating things that affects her mood. The patient had started spending quality time with her husband and family, she has improved her social support by joining local women's committee program and being active. Patient had also gathered a good understanding about the boundaries that she has to keep within the family.

Clinical observation

The patient was co-operative from the beginning with good rapport, she was initially hesitant to disclose her family problems, however, as the session progressed with better rapport and reassurance she revealed about her problems. She was a highly motivated person, cooperative and followed the instructions. During the session, the patient found to cling on to the therapist and asking opinion for very silly things like whether she is actually experiencing a problem in interpersonal relationship and how she could understand the maladaptive communication and behaviour which interfered in her overall functioning. It was also noted that if her problems have not been not addressed, she would backfire and get back to the sick role. It was also found that the patient had a tendency of forming strong attachment and found to have dependant traits. As the patient tended to project her somatic complaints, the therapist found it difficult to address her emotional problems during the communication analysis.

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Conflict of Interest
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