Behavioural and Cognitive Psychotherapy, 2003, 31, 451–456
Printed in the United Kingdom DOI: 10.1017/S1352465803004065

Brief Clinical Reports

USING AN IPT CONCEPTUALIZATION TO TREAT A DEPRESSED PERSON WITH DEMENTIA

Ian A. James, Kirstine Postma and Lorna Mackenzie

Newcastle General Hospital, UK

Abstract. Interpersonal therapy (IPT) was developed in the late 1960s, but has only recently gained real prominence. The interest in this approach has grown further following the positive findings obtained in the NIMH study (Elkin et al., 1989). In this extensive, multi-site US study it was found to be as effective as CBT and, in some methods of analyses, more effective. There is a growing literature on IPT's use with older people (Miller & Reynolds, 2002), but very few articles, with the exception of Bauer's (1997) work, have examined its use with people with cognitive impairment. The present paper describes the use of IPT to treat a man (Mr M) with dementia suffering from depression. The case is presented chiefly as a vehicle to explore the applicability of the conceptual framework, although details regarding treatment are discussed.

Keywords: Interpersonal therapy, dementia, conceptualization.

Introduction

Despite the therapy services background being firmly established in CBT, Mr M was engaged in IPT. IPT was chosen following consultations with the multidisciplinary team whose members argued that owing to his concentration, memory difficulties and cognitive fluctuations, he was not suitable for CBT. This decision was supported by the primary therapist (IJ), because initial discussions with Mr M revealed that the patient had a problem moving between abstract and concrete modes of thinking; an ability that is essential when working with even the simplest of the CBT cycles. Hence, the team was in favour of treating Mr M with an IPT approach. The details of the IPT approach are explained below, following some information about Mr M's difficulties.

Overview of the case

Mr M, a 71-year-old widower with Lewy Body Dementia (DLB), was referred owing to his

Reprint requests to Ian James, Newcastle Integrated Older Peoples Service, Newcastle General Hospital, Westgate Road, Newcastle upon Tyne NE4 6BE, UK. E-mail: ianjamesncht@yahoo.com An extended version of this brief clinical report is available online in the table of contents for this issue: http://journals.cambridge.org/jid BCP

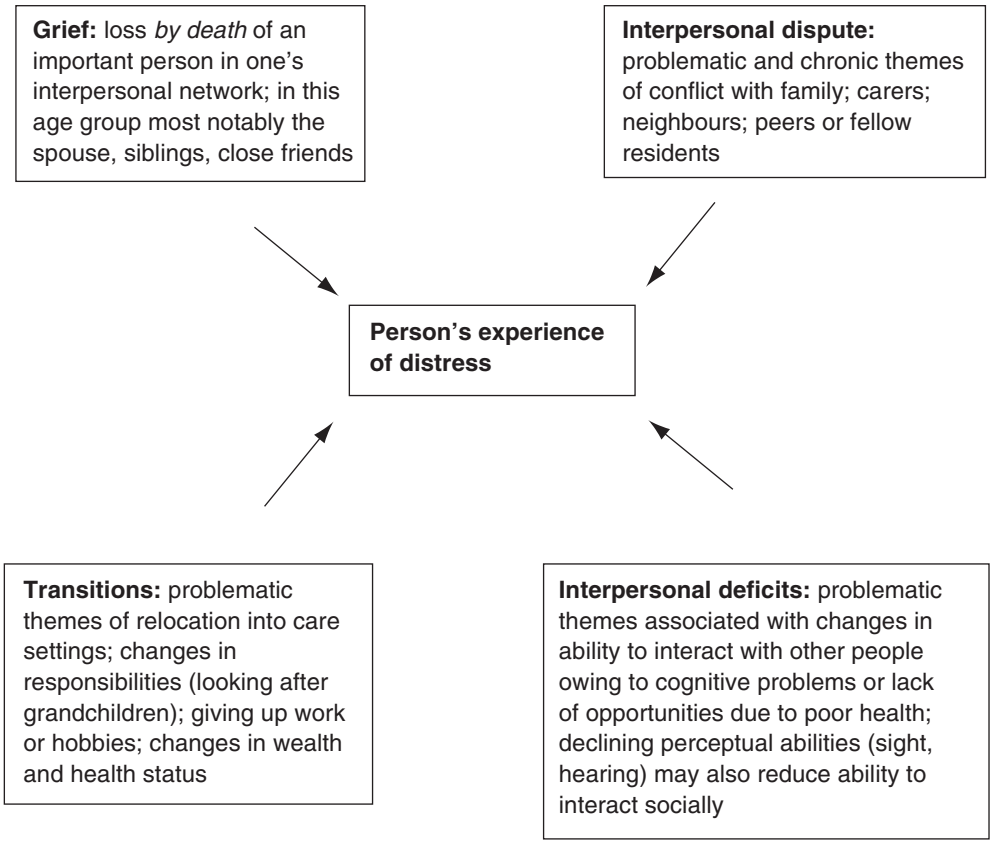
7-month history of depression. DLB is characterized by fluctuating cognitive ability, falls, hallucinations, and a sensitivity to anti-psychotic medication. Mr M had a Mini-mental status examination (Folstein, Folstein, & McHugh, 1975) score of = 21/30, having specific deficits in memory, attention and concentration. He had a Geriatric Depression Scale (Yesavage et al., 1983) score of 19/30; at his initial interview he stated he had lost all the things that gave him a reason for living, namely his work, his friends and his social life. He was forced to retire as a market stall holder at the age of 70, when he started to have difficulties calculating his customers' change. The initial management of his problems involved bringing him into the hospital's Elderly Day Hospital (EDH) for an assessment of his condition and to provide him with some social contact. Unfortunately, he found it difficult to settle, believing he had little in common with the other people attending the EDH. He stated that he preferred the company of ''real blokes'', men who could talk about football and horse racing. His daughter had tried previously to help with the loneliness by moving in with her father. She was a single parent with two children. Unfortunately, this move had made things worse as her children did not cope well with their grandfather's rather strict house-rules, and a great deal of inter-generalized conflict was evident.

As part of the conceptualization process, various details concerning Mr M's background were obtained. In brief, Mr M had been a market trader, travelling all over the North East of England on his stall. He was a widower of 10 years standing, with two sons and two daughters. He had a previous history of heavy social drinking, although a stomach disorder had curtailed his recent imbibing. He found this latter restriction particularly difficult because his social life was centred around the local pub. It is noteworthy that he was not prepared to go to the pub and drink non-alcoholic beverages. Now let us examine the IPT approach, and determine its utility with respect to the above presentation.

Interpersonal therapy (IPT)

IPT is a short-term therapy in which a medical model is used overtly. Indeed, the approach emphasizes that depression is a medical illness that requires treatment. In this vein, the patient is recommended to temporarily take on a ''sick role'', which may involve dropping routine responsibilities (household chores, child-care, etc) to allow him/her to concentrate fully on the therapy. During the socialization phase of the treatment, attempts are made to link the depressed feelings to features and/or changes within the patient's interpersonal context. Thus, an in-depth analysis of the person's current and past interpersonal networks is undertaken. In operational terms, when conceptualizing people's distress, one domain (occasionally two) must be selected from a group of four potential domains (Figure 1). The four domains are: Grief, Interpersonal disputes, Transitional difficulties, or Interpersonal deficits. Figure 1 outlines how these domains might apply to someone with dementia. Using the material already provided about Mr M, a review of the case is now provided using the IPT framework.

The first step was to identify a ''focus'' or key domain (i.e. the domain most strongly associated with the start of his distress). At a case conference, involving all the various professionals associated with the case, it was unanimously agreed that the key domain was a ''transition'' (Figure 2). Some of the professionals on the periphery of the case were surprised initially at this decision, suggesting that his main difficulties were surely due to the dementia. However, it was noted that he had lived with the diagnosis of DLB for 18



Note: The diagram highlights that a person's problematic experience of a particular event can be better conceptualized by examining the IPT themes that are providing a contextual backdrop.

It is relevant to note that the manner in which "Interpersonal deficits" are described here is somewhat different to that presented in the standard IPT model. Indeed, in standard IPT, the deficits are more associated with chronic personality difficulties, which interfere with someone's socializing.

Figure 1. An adapted form of the IPT framework for understanding a person with dementia's experience of distress

months prior to the present difficulty without becoming depressed. Indeed, on reflection, it was his transition into retirement that seemed to bring on the depression. As a consequence of this transition, Mr M had experienced a series of losses. Firstly, he had lost the structure to his life that his work had formerly provided. Secondly, he had lost status, as he had previously perceived himself as the head of the family business. Thirdly, he had lost social contact with ''like-minded'' people – due both to his retirement and his own decision not to go to the pub anymore. The above transition had resulted in other changes in his life (daughter moving-in), and these were evidently maintaining his low mood. However,

https://doi.org/10.1017/S1352465803004065 Published online by Cambridge University Press

because the depression preceded the changes they would not be considered as the primary focus area. They would, however, be viewed as an important consequence of the transition, and would need to be dealt with as part of the treatment package.

Treatment and discussion

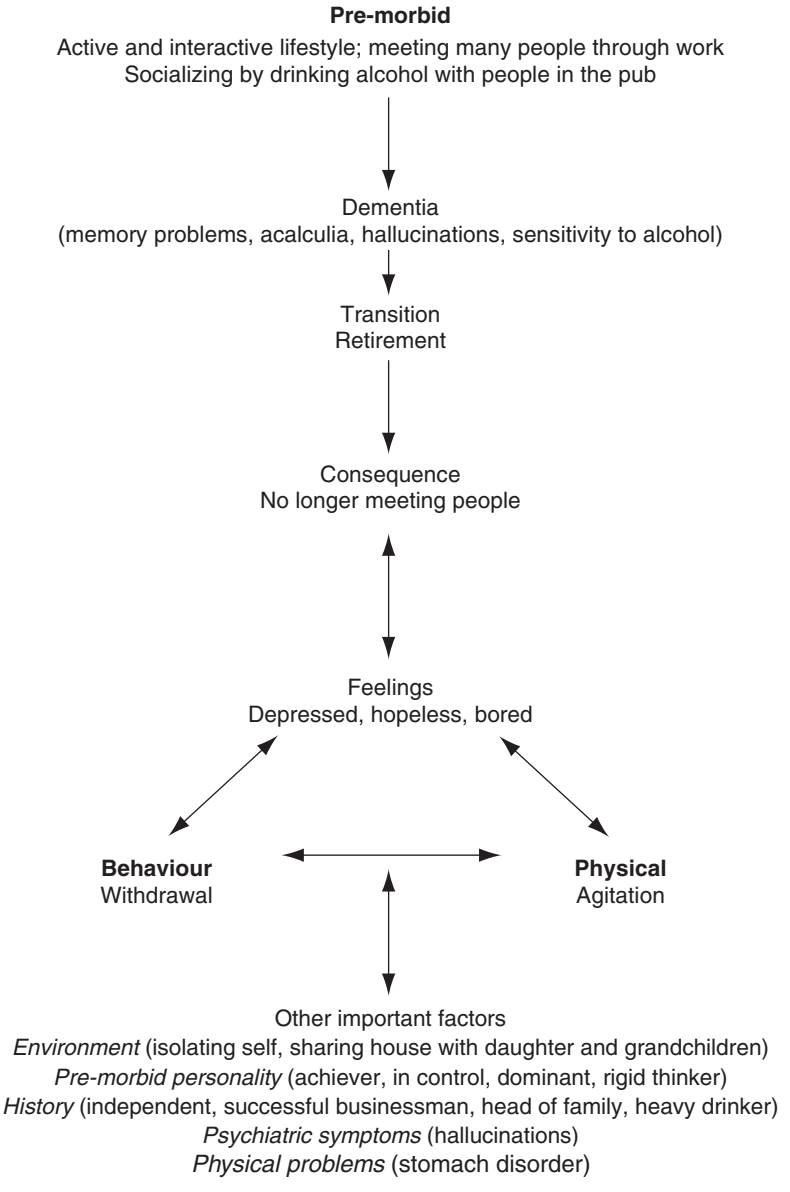
Generally in IPT, when working with transitional difficulties, the main goals of therapy are three-fold; one is to help the person mourn the loss(es) of the old role; another is to help the patient to see the new role more positively, and thirdly, to try to restore self-esteem within the demands of the new role. In the case of Mr M, the first goal of treatment was to attempt to resolve the interpersonal losses that he had experienced since retiring. To this end, Mr M's family was encouraged to try to contact some of his old friends. Investigations revealed that some of his friends, now also retired, had started to spend some of their time at the local social club. Indeed, it transpired that two of his friends went to play snooker at the club. So the first target was to encourage Mr M to attend this club. The second goal was targeted at improving social support from within the family. Indeed, it was evident that until recently Mr M had seen himself as the head of the family. In times of trouble, or when they needed financial help, the family had always come to him for practical assistance and/or advice. Unfortunately, over recent months, his sons, in particular, had stopped visiting. Mr M was a proud man and, although clearly upset by the lack of contact, was not willing to visit his sons. This issue was tackled through the intercession of one of the daughters, who agreed to organize a family meeting to encourage social contact with their father. Thirdly, the difficulties with the grandchildren were addressed. After a number of unsuccessful strategies were abandoned, the most effective solution to the dilemma was to designate certain areas of the house as ''no go'' zones with respect to the children.

The results of the interventions were initially good, with Mr M's mood improving as he re-integrated himself with his friends at the club. Within a month he reduced his time on the day hospital from three days to one. His daughter was particularly pleased with his progress, and encouraged him to visit friends at their homes within the locality. Unfortunately, however, as Mr M's cognitive impairment progressed, it became increasingly more difficult for him to maintain his social activities independently. Despite finding it very hard to do so, he eventually accepted a male ''befriender'' to join him on his local walks and other outings to the club.

It is relevant to note that the type of interventions used with Mr M would be wholly in keeping with a CBT approach. Indeed, one could argue that any good CBT treatment programme would have addressed the interpersonal issues discussed above. However, in our opinion, it would have been incorrect to label the present work as CBT, owing to the fact that the patient was not socialized to the cognitive framework, and the treatment was not underpinned by the cognitive rationale.

Summary

In the present case, IPT was selected as the treatment of choice for three reasons. Firstly, IPT provided a good way of representing his interpersonal difficulties. For example, it highlighted his social ambivalence; with him both wanting and rejecting interpersonal contacts. Secondly, it accommodated some of his cognitive problems, particularly his memory diffi-



Note: It is relevant to note that although the dementia was an important feature, it was regarded as a contextual issue in terms of Mr M's low mood. The actual trigger to the depression was his retirement, and the interpersonal consequences associated with this.

Figure 2. IPT Formulation for Mr M

https://doi.org/10.1017/S1352465803004065 Published online by Cambridge University Press

culties and inability to generalize material from session to session. For example, his default statement when asked about the contents of the previous session was usually: ''I think it was the old problem of not being able to mix with people since giving up work.'' Evidently, he had conceptualized his problem in interpersonal terms – thus both he and the therapist were able to use interpersonal language to discuss his difficulties. To this end, he did not need to be socialized into a new way of understanding his dilemma, as he already had good insight with respect to this. Hence, the focus of treatment could quickly move towards increasing his social support, rather than helping him to understand why he felt so badly. The third reason for using IPT was that it is a relatively simple model compared to other forms of psychotherapy. It is our experience that it is readily understood by patients, carers, families, nursing staff and medical staff (psychiatrists, neurologists and physicians), and particularly by those who have little experience of working collaboratively within a psychotherapeutic framework. In addition, its high level of face validity and overt structure make it especially useful in conceptualizing cases in ward rounds and multidisciplinary meetings.

Despite these advantages, it is relevant to note that we believe that a good CBT conceptualization is likely to incorporate many, although not all, of the aspects identified in IPT (James, 2002). Thus, in our view, we would regard CBT as a more comprehensive form of psychotherapy. However, we suggest that in some situations (e.g. working with people with cognitive impairment) the less cognitively demanding approach offered by IPT may be an advantage. Finally, we would like to stress that the paper is not criticizing CBT for paying insufficient attention to social issues. Indeed, we acknowledge that interpersonal features form, and have always formed, a very important part of the CBT model. Nevertheless, it is argued here that the degree of emphasis on interpersonal features is different in IPT and, hence, the conceptualizations derived and the treatment goals selected tend to differ.

References

Bauer, J. (1997). Möglichkeiten einer psychotherapeutischen Behandlung bei Alzheimer-Patienten im Früstadium der Erkrankung. *Nervenarzt, 68*, 414–424.

Elkin, J., Shea, M., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., Glass, D. R., Pilkonis, P. A., Leber, W. R., Docherty, J. P., Fiester, S. J., & Parloff, M. B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Programme: General effectiveness of treatment. *Archives of General Psychiatry, 46*, 971–983.

Folstein, M., Folstein, S., & McHugh, P. (1975). Mini-mental state: A practical method for grading cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12*, 189–198.

James, I. A. (2002). The treatment of distress in people with severe dementia using cognitive-behavioural concepts. In S. Benson (Ed.), *Dementia topics for the millennium and beyond*. London: Hawker Press.

Miller, M. D., & Reynolds, C. F. (2002). Interpersonal psychotherapy. In J. Hepple, J. Pearce, & P. Wilkinson (Eds.), *Psychological therapies with older people: Developing treatments for effective practice* (pp. 103–127). Sussex, UK: Bruner-Routledge.

Yesavage, J., Brink, T., Rose, T., Lum, O., Huang, V., Adey, M., & Leirer, O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research, 17*, 37–49.