BRIEF REPORT

National Dissemination of Interpersonal Psychotherapy for Depression in Veterans: Therapist and Patient-Level Outcomes

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Objective: To evaluate the effects of training in and delivery of interpersonal psychotherapy (IPT) for depression throughout the U.S. Department of Veterans Affairs health care system on therapists’ competency and patients’ clinical outcomes. Method: Participants included 124 therapists and 241 veteran patients. Therapists participated in a 3-day workshop followed by 6 months of weekly group consultation. Therapy session tapes were rated by expert IPT training consultants using a standardized competency rating form. Patient outcomes were assessed with the Beck Depression Inventory–II and the World Health Organization Quality of Life–BREF. Therapeutic alliance was assessed with the Working Alliance Inventory–Short Revised. Results: Of the 124 therapists receiving IPT training, 115 (93%) completed all training requirements. Therapist competence in IPT increased from their 1st patient to their 2nd for both initial ($d = 0.36$) and intermediate ($d = 0.24$) treatment phases. Of the 241 veteran patients treated with IPT, 167 (69%) completed ≥ 12 sessions. Intent-to-treat analyses indicated large overall reductions in depression ($d = 1.26$) and significant improvements in quality of life ($d = 0.57$ to 0.86) and the therapeutic alliance ($d = 0.50$ to 0.83). Conclusions: National IPT training in the VA health care system was associated with significant increases in therapist competencies to deliver IPT, as well as large overall reductions in depression and improvements in quality of life among veterans, many of whom presented with high levels of depression. Results support the feasibility and effectiveness of broad dissemination of IPT in routine clinical settings.

Keywords: interpersonal psychotherapy, depression, dissemination, training, veterans

Interpersonal psychotherapy (IPT) is an evidence-based psychotherapy (EBP) for depression that focuses on interpersonally relevant issues that may be the precipitant to or consequence of depression. The goal of IPT is to reduce depressive symptoms and improve social functioning. Klerman and colleagues (e.g., Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974) developed IPT guided by research documenting that adverse life circumstances increased risk for depression, interpersonal support decreased this risk, and depression typically existed within an interpersonal context (Markowitz & Weissman, 2012). In IPT, the client addresses current life issues; the therapist regularly monitors the client’s depressive symptoms and underscores the reciprocal relation between events and symptoms.

IPT is effective in short and longer term treatment of depression alone or in combination with antidepressant medication (Barth et al., 2013; Cuijpers et al., 2011). IPT for depression is recommended by the American Psychiatric Association (2010) and as a first-line intervention for military service members and veterans with depression (U.S. Department of Veterans Affairs & Department of Defense, 2009). Despite the clear effectiveness of IPT for...
depression and other conditions, it is rarely taught in graduate or postgraduate training programs in the United States (Weissman et al., 2006), thus limiting its availability.

As part of an effort to promote the availability and delivery of EBPs for veterans, the Veterans Health Administration (VHA) has developed a series of national EBP dissemination and implementation initiatives (Karlin & Cross, 2014). Several of these initiatives focus on EBPs for depression (Karlin et al., 2012; Walser, Karlin, Trockel, Mazina, & Taylor, 2013), which is the second most common mental health diagnosis among veterans receiving care in the VHA. IPT is one such initiative. The goals of the current article are to examine the impact of training on therapist competence to conduct IPT and the effect of delivery of IPT for veteran patients.

**Method**

**Training Program Description**

The VA IPT Training Program is a competency-based effort that involves participation in a 3-day workshop, followed by 6 months of weekly telephone consultation with an IPT expert with groups of four trainees. The term consultation is used in VA EBP training programs, rather than supervision, because training consultants do not have a legal or formal evaluative role in staff training. Therapists are provided with training materials, including the primary treatment manual, Comprehensive Guide to Interpersonal Psychotherapy (Weissman, Markowitz, & Klerman, 2000). Training consultants provide ongoing feedback based on review of session audiorecordings using a structured rating form. Training consultants complete a structured application process, which includes submitting one or more IPT sessions to be reviewed and rated by one of the master trainers.

**IPT for depression protocol.** The IPT protocol consists of up to 16 weekly individual sessions extending across three phases of treatment: initial (typically Sessions 1–3), intermediate (typically Sessions 4–13), and termination (typically Sessions 14–16; Weissman et al., 2000). Tasks of the initial sessions include diagnosis of depression, psychoeducation about depression including its adverse impact on daily functioning, assignment of sick role, an inventory of relevant current and past relationships, discussion of the connection between recent life events and depression, and provision of a therapeutic formulation to the patient that includes the treatment plan. The intermediate sessions focus on one or two of the four IPT problem areas: role transitions, role disputes, grief, and interpersonal deficits. Goals and strategies are tied to each of the IPT problem areas. Therapeutic techniques (e.g., communication analysis, decision analysis, role play, communication skills) are outlined and in use and are achieved in the treatment of the IPT goals and strategies. During the termination sessions, the end of treatment is discussed, the course of therapy is reviewed, and strategies for handling future interpersonal stressors are identified. Treatment was considered completed if a therapist–patient dyad completed at least 12 sessions (the minimum number of sessions required for implementing all components of the therapy protocol), two of which were termination sessions.

**Program completion requirements.** Successful completion by clinician trainees required (a) attending the 3-day workshop; (b) participating on at least 75% of consultation calls; (c) conducting at least 12 IPT sessions, across all phases of treatment, for one case; (d) conducting at least four sessions for another case for the purpose of training experience and generalization of skill; (e) submitting at least 12 audiotaped sessions from two cases for review by the training consultant; and (f) achieving an overall average item score $\geq 2.5$, and a rating of $\geq 2.0$ for each specific competency, on the IPT Rating Scale (IPTRS; Clougherty et al., 2012).

**Participants.**

**Therapists.** VA mental health therapists were eligible to participate in the training program if they (a) were licensed to provide psychotherapy; (b) regularly delivered individual psychotherapy services; (c) worked in settings where depression is a common presenting issue and where IPT could be implemented; (d) committed to 6 months of continuous participation in weekly consultation; (e) committed to provide IPT following the training; and (f) were able to recruit at least two patients with depression for the consultation process.

**Patients.** Patients included veterans who (a) had a primary presenting problem of depression, typically a diagnosis of major depressive disorder, although other depression diagnoses were allowed; (b) had one or two current life problems involving a significant life change, conflict with an important person, interpersonal deficits, and/or the death of an important person; (c) agreed to receive IPT by therapists participating in the VA IPT Training Program; (d) consented to audio recording of sessions; (e) committed to in-person, weekly psychotherapy; (f) had no active psychotic symptoms or diagnosis of bipolar disorder; and (g) did not currently require high intensity, acute stabilization. Therapists in the IPT Training Program recruited patients seen in or referred to their current practice setting (typically general or specialty mental health settings). Patients with comorbid mental health or medical conditions were permitted. Therapists were encouraged to choose a second case that presented with an IPT problem area that was not addressed in their first case.

**Therapist-Level Measures**

**IPT competency.** Training consultants rated session tapes using the IPTRS. The IPTRS was developed for the VA IPT Training Program through an expert consensus process, similar to other national EBP training programs (e.g., Walser et al., 2013). The IPTRS includes the three treatment phases and ratings for general IPT competencies (the same for each session in each phase) and specific IPT competencies, strategies, and techniques unique to each problem area and phase of treatment. The IPTRS has a total of 58 items, with 18 of them specific to the relevant problem area(s) addressed. Items are scored on a 5-point scale from 0 (poor) to 4 (excellent). A rating of 2.0 (adequate/satisfactory) or greater was the criterion for competency for any single item. An overall item average of 2.5 (across all competencies and treated patients) was the criterion for demonstrating competency in the IPT protocol. Approximately 12 full sessions were rated for each therapist, covering all three treatment phases across two patients.
Patient-Level Measures

Demographics. Patients provided demographic information including age, gender, education, race, ethnicity, and military service era.

Depression. The Beck Depression Inventory—II (BDI–II; Beck, Steer, & Brown, 1996) is a 21-item self-report measure used to assess depression. Each item is scored on a 0––3 scale; total score is the sum of all items (range 0––63), with higher scores indicating greater symptom severity. The psychometric properties of the BDI–II have been well established (Beck, Steer, & Garbin, 1988). The BDI–II was administered at each therapy session.

Quality of life. The World Health Organization Quality of Life–BREF (WHOQOL–BREF) consists of 26 items assessing four quality of life domains—physical health, psychological, social relationships, and environment—and has been shown to have good validity and reliability (WHOQOL Group, 1998). The WHOQOL–BREF was completed at the beginning, middle, and end of treatment.

Therapeutic alliance. The Working Alliance Inventory—Short Revised (WAI–SR; Hatcher & Gillaspy, 2006) was used to measure patient-assessed therapeutic alliance. It consists of 12 items related to (a) patient/therapist agreement on the goals of therapy, (b) patient/therapist agreement on therapy tasks, and (c) patient/therapist interpersonal bond. The WAI–SR has been shown to have good psychometric properties (Munder, Wilmers, Leonhart, Linster, & Barth, 2010). This measure was completed by patients after Sessions 1, 3, 7, and 11.

Discussion

A total of 241 veterans participated in at least one IPT treatment session. Veteran demographic information and treatment status are presented in Tables 1 and 2. Of the 241 patients in the (ITT) sample, 167 (69%) completed a full course of treatment, 27 (11%) dropped out prior to completion of termination sessions, and 47 (20%) initiated treatment that continued beyond the end of consultation. Additional outcomes for this group were not collected after conclusion of consultation given the nature of this project as program evaluation rather than research that may incorporate follow-up procedures.

Results of the mixed-effects model (ITT analysis) for the BDI–II total score, WHOQOL–BREF domains, and WAI–SR subscales are presented in Table 3. BDI–II total score reduced by a mean of 13.48 points, \( t(211) = -15.3, p < .001, d = 1.26 \), from 29.14 in the initial phase to 15.66 during the later phase of treatment. This represents a 46% average decline in mean BDI–II scores over the course of treatment. For those patients who completed all three treatment phases to termination (n = 167), there was a reduction in mean BDI–II total score from 29.46 (10.8) to 15.53 (12.2), \( t(166) = -14.70, p < .001, d = 1.29 \). The proportion of these patients with a decrease in BDI–II total score of at least 50%, at least 40%, and at least 30% were 53% (n = 89), 60% (n = 101), and 69% (n = 116), respectively.
ITT analysis using a mixed-effects model was also conducted on the four domains of the WHOQOL–BREF to evaluate change in perceived quality of life. Mean scores for each domain increased significantly (p < .001) from the initial to later phase of treatment: physical health: t(175) = 8.8, d = 0.57; psychological: t(182) = 10.7, d = 0.86; social: t(174) = 9.2, d = 0.76; environmental: t(172) = 9.0, d = 0.63.

The WAI–SR was used to evaluate development and change in the therapeutic alliance over the course of treatment. ITT analyses for each of the three WAI–SR subscales demonstrated significant improvement (p < .001) over time: Goal: t(169) = 9.1, d = 0.59; Task: t(197) = 13.0, d = 0.83; Bond: t(192) = 8.8, d = 0.50.

Discussion

This article reports on the evaluation of the effectiveness of a national training program in promoting therapists’ competency in IPT and in improving symptoms of depression and quality of life in their veteran patients. The results reveal a very high rate of successful training program completion (93%) among therapists. Almost all therapists achieved satisfactory competency in IPT by the end of the 6-month consultation period, and there was an overall improvement in rated therapist competency both within and across patients.

In addition to reporting on therapist training outcomes, this article reports on the largest evaluation of IPT with veterans to date. Overall, veterans achieved large reductions in depression; specifically, mean BDI–II total score was reduced by almost half over the course of treatment in ITT analyses. These results are consistent with those of controlled research on IPT (e.g., Barth et al., 2013; Cuijpers et al., 2011) and with recent outcomes associated with the national dissemination of cognitive behavioral therapy (Karlin et al., 2012) and acceptance and commitment therapy for depression (Walser et al., 2013) with veterans. On average, veterans presented with initial BDI–II scores in the severe range that by the end of IPT were in the mild range. In addition to symptom relief, the findings reveal significant improvements in multiple domains of quality of life. Furthermore, the therapeutic alliance, as rated by patients, showed significant improvement in all three alliance domains over the course of therapy. It is noteworthy that the observed outcomes were achieved by therapists who overwhelmingly had no prior formal IPT training.

The present evaluation is based on experiences of veteran patients presenting for care in a variety of real-world treatment settings with minimal exclusion factors. As such, the evaluation has a high degree of generalizability. At the same time, there are important limitations that should be considered in interpreting the results. Despite the high external validity of this effectiveness evaluation, the lack of a control group or comparison group is an important limitation. A comparison group and controls on potential external effects, such as medication use, adjunctive treatment, psychotherapy treatment history, or therapist general clinical expertise, would be needed to confirm that the positive outcomes observed were due to the IPT treatment and not to other factors. In addition, data regarding comorbid conditions, which can affect outcomes, are not available. As a program evaluation effort, data on these variables were not collected. Nevertheless, the observed results are consistent with those reported in previous controlled...
trials of IPT (e.g., Barth et al., 2013). Another limitation concerns the fact that the IPTRS has not been psychometrically validated. Additionally, although calibration of tape ratings between raters was conducted in the consultant training, interrater reliability has not been established.

In short, the current findings reveal that national IPT training and implementation in VHA are associated with significant increases in therapist competencies to deliver IPT, as well as large overall reductions in depression and improvements in quality of life among veterans with often high levels of depression. Overall, the results support the feasibility and effectiveness of broad dissemination of IPT to routine practice settings and suggest that greater attention be devoted to IPT, a therapy often underrepresented in training programs and service settings.

### References


### Table 3

**Intent-To-Treat Mixed Effects Model Results: Veteran Outcomes**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Coefficient</th>
<th>SE</th>
<th>t (approximate df)</th>
<th>p</th>
<th>df</th>
</tr>
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<tbody>
<tr>
<td>BDI–II</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Intercept</td>
<td>29.14</td>
<td>0.71</td>
<td>41.1 (236)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>−13.48</td>
<td>0.88</td>
<td>−15.3 (211)</td>
<td>&lt;.001</td>
<td>1.26</td>
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<tr>
<td>WHQOL–BREF</td>
<td></td>
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<tr>
<td>Physical Health</td>
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<td></td>
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</tr>
<tr>
<td>Intercept</td>
<td>11.03</td>
<td>0.19</td>
<td>57.5 (225)</td>
<td>&lt;.001</td>
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<tr>
<td>Time</td>
<td>1.67</td>
<td>0.19</td>
<td>8.8 (175)</td>
<td>&lt;.001</td>
<td>0.57</td>
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<td>Psychological</td>
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<tr>
<td>Intercept</td>
<td>10.17</td>
<td>0.17</td>
<td>58.9 (225)</td>
<td>&lt;.001</td>
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<tr>
<td>Time</td>
<td>2.21</td>
<td>0.21</td>
<td>10.7 (182)</td>
<td>&lt;.001</td>
<td>0.86</td>
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<td>Social</td>
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<tr>
<td>Intercept</td>
<td>9.89</td>
<td>0.20</td>
<td>49.4 (223)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>2.36</td>
<td>0.26</td>
<td>9.2 (174)</td>
<td>&lt;.001</td>
<td>0.76</td>
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<td>Environmental</td>
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<tr>
<td>Intercept</td>
<td>13.34</td>
<td>0.16</td>
<td>85.8 (225)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>1.47</td>
<td>0.16</td>
<td>9.0 (172)</td>
<td>&lt;.001</td>
<td>0.63</td>
</tr>
<tr>
<td>WAI–SR</td>
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<tr>
<td>Goal</td>
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</tr>
<tr>
<td>Intercept</td>
<td>4.02</td>
<td>0.05</td>
<td>81.5 (232)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>0.50</td>
<td>0.05</td>
<td>9.1 (169)</td>
<td>&lt;.001</td>
<td>0.59</td>
</tr>
<tr>
<td>Task</td>
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<tr>
<td>Intercept</td>
<td>3.45</td>
<td>0.05</td>
<td>67.2 (230)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>0.71</td>
<td>0.05</td>
<td>13.0 (197)</td>
<td>&lt;.001</td>
<td>0.83</td>
</tr>
<tr>
<td>Bond</td>
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<tr>
<td>Intercept</td>
<td>4.24</td>
<td>0.05</td>
<td>90.3 (226)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>0.37</td>
<td>0.04</td>
<td>8.8 (192)</td>
<td>&lt;.001</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Note. Cohen’s $d$ was calculated as the estimate of change as a function of time (slope) divided by the initial standard deviation of the relevant measure. Degrees of freedom are approximate. Sample size is the intent-to-treat sample ($n = 241$). There were no significant differences between completers and noncompleters on baseline measures with the exception of the WHQOL–BREF Environmental domain, which favored the completer sample. BDI–II = Beck Depression Inventory–II; WHQOL–BREF = World Health Organization Quality of Life–BREF; WAI–SR = Working Alliance Inventory–Short Revised.


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