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EXPLORING THE EFFICACY OF INTERPERSONAL PSYCHOTHERAPY VIA TELEHEALTH

BY

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BY

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Submitted to the Faculty of the Graduate School of
Eastern Kentucky University
in partial fulfillment of the requirements for the degree of

DOCTORATE OF PSYCHOLOGY

2023

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DEDICATION

This is dedicated to my loving family who have supported me throughout my entire educational career, those who are still here and those who are no longer here in the physical sense. My future is brighter because they helped guide me towards the light.

ABSTRACT

The COVID-19 pandemic caused abrupt changes for healthcare providers across the globe. As a result of social distancing measures and stay-at-home orders, it was necessary that providers adapted their services to continue to reach their clients/patients. Specifically for the field of mental health, practitioners quickly and extensively adapted from a face-to-face format to providing their services using various forms of technology, otherwise known as telepsychology. Although telepsychology was established prior to the COVID-19 pandemic, the rapid adjustment forced practitioners to adapt their interventions to formats in ways that had not been proven to be effective. The purpose of the current project was to explore the research establishing the clinical utility of telepsychology as a treatment modality, in addition to a therapy style known as interpersonal psychotherapy, to treat various psychological disorders. Additionally, case studies from a clinician's perspective are presented to demonstrate the effectiveness of interpersonal psychotherapy delivered via telepsychology. Results indicate that interpersonal psychotherapy provided through telepsychology may be an efficacious treatment for psychological disorders. The limitations of this study and future directions to further establish interpersonal psychotherapy via telepsychology as an appropriate treatment method are discussed.

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Section I: INTRODUCTION

"*What's dangerous is not to evolve." – Jeff Bezos*

Mental health has emerged as something equally as important as physical health following research showing the interconnected relationship between mental health and a person's overall health (Luo et al., 2019). With increased awareness and additional emphasis being placed on the impact of mental health on one's overall well-being, the fields of counseling, social work, and clinical psychology have experienced an increased demand for mental health services. Clinical psychology became more widely popular in the United States following World War II, because of the need to address the concerns of the soldiers and their families as they returned from combat (Kramer et al., 2019). At that time, the therapeutic orientation of psychoanalysis pioneered by Sigmund Freud was the primary approach used by professional psychologists. However, the field of clinical psychology has experienced dramatic changes since the days of Freud and psychoanalysis.

While psychotherapy remains an incredibly useful tool for clinical psychologists to use with their patients, there are different styles of psychotherapy that can be implemented depending on a clients' concerns. Clinical psychologists are trained to use Evidence-Based Treatments (EBT) such as Cognitive-Behavioral Therapy (CBT) (Beck, 2011), Acceptance and Commitment Therapy (ACT) (Hayes et al., 2012), and Interpersonal Psychotherapy (IPT) (Weissman et al., 2018) to address the concerns that clients want to work on. As technology has developed, the ability to provide clients with psychological services has advanced beyond the traditional face-to-face format. This has become especially poignant as psychologists have had to adapt to working with

clients throughout the COVID-19 pandemic. The purpose of the current project is to explore the research establishing the efficacy of using technology to provide psychological services, the efficacy of IPT to address various concerns, and the efficacy of delivering IPT using technology.

Section II: LITERATURE REVIEW

Defining Telepsychology

The use of technology in counseling as a therapeutic tool first emerged in the 1960's at the Massachusetts Institute of Technology with a program known as ELIZA. This program was meant to simulate a conversation that a person might have with a psychiatrist (Weizenbaum, 1966). However, it was never used with actual client populations. Prior to the development and large-scale adoption of the internet, the technology that practitioners were more likely to use modalities such as telephones to contact and work with their clients and patients (Car & Shiekh, 2003).

As advanced technology like broadband internet and video communication became more widely available throughout the 1990's and early 2000's, the concept of using technology as a therapeutic tool began to be considered more seriously (Davidson & Santorelli, 2009). In 2013, the American Psychological Association (APA) established guidelines to help define telepsychology (which is also known as telehealth and telemedicine) and determine its appropriateness for practitioners of psychology. Within these guidelines, telepsychology is defined as the provision of psychological services using telecommunication technologies (APA, 2013). Telecommunication is defined as the preparation, transmission, communication, or related processing of information by electrical, electromagnetic, electromechanical, electro-optical, or electronic means (Committee on National Security Systems, 2022). Further, telecommunication technologies are defined as including but not limited to telephone, mobile devices, interactive videoconferencing, email, chat, text, and internet (e.g., self-help websites, blogs, and social media) (APA, 2013).

Telepsychology as a Therapeutic Tool

Telepsychology is a developing area of psychology that has quickly become a focus for many clinicians as a result of the constantly changing landscape following the global pandemic. Since the COVID-19 pandemic upended our typical way of life in March of 2020, many restrictions were placed on the majority of in-person activities and services, with exceptions being granted only for services and workers deemed "essential." This resulted in many individuals being faced with an unexpected discontinuation of psychological services as providers were not prepared to adjust to the virtual provision of services.

Prior to the pandemic, there had been a number of studies conducted with the goal of establishing the efficacy of telehealth. Now that attention has shifted to life after the pandemic, significantly more studies have continued to reinforce and further explore the efficacy of using telepsychology for treatment with various client populations, a wide range of presenting concerns, and effectively delivering different styles of psychotherapy. However, despite the research and the evidence of its importance over last two years, there are many practitioners who have been reluctant to incorporate telepsychology into their normal practice.

In some cases, practitioners display reluctance with telehealth due to their own negative perceptions toward telepsychology, such as a belief that it is more difficult to establish a strong therapeutic relationship through videoconferencing than it to do so in-person (Pierce et al., 2022). One literature review conducted by Simpson and Reid (2014) found that clients generally do not have a preference between in-person or online therapy, and telepsychology does not interfere with developing a therapeutic alliance.

Kocsis and Yellowlees (2018) suggested that telepsychology could offer novel ways to form strong therapeutic relationships and potentially even promote a stronger relationship than in-person therapy.

A study by Geller (2020) explored how to build and maintain therapeutic relationships in an online environment. She described a common factor necessary to build a strong therapeutic relationship, known as therapeutic presence. Therapeutic presence is defined as a therapist being fully in the moment with their client physically, emotionally, cognitively, relationally, and spiritually (Geller, 2020). When a practitioner is able to bring their therapeutic presence into a meeting with a client, they are grounded in themselves while being aware of the client's verbal and nonverbal experience and responding appropriately in the moment (Geller, 2019). If a practitioner can utilize their presence effectively then it communicates to clients that they are understood, met where they are, and creates a sense of safety in the therapeutic environment for them to participate in therapy appropriately.

This sense of safety mentioned above is crucial to enabling the change process that is desired by both the practitioner and the client in therapy. When safety is established in a therapeutic environment, clients receive the positive social interactions and can begin to develop new neural pathways that allow them to address underlying attachment concerns (Allison & Rossouw, 2013). Geller (2020) mentions the challenges of establishing therapeutic presence in an online format. These include the physical distance which limits the nonverbal communication between the practitioner and client, increased practitioner countertransference and fatigue from working online,

technological challenges such as connection issues or glitches, and the physical environment of the client being limiting on their ability to express themselves.

Regarding ways to cultivate therapeutic presence online, Geller (2020) recommends creating safety, optimizing client's presence, creating routine around the day of session, and techniques to use during session. Safety can be established by using an encrypted platform to communicate and videoconference, hosting sessions in a consistent location, find an optimal distance between the practitioner and the screen, maintain eye view at the level of the camera, use optimal lighting without a glare, and dress professionally as you would in a face-to-face session. Optimizing client's presence involves encouraging clients to use headphones, have a private environment, minimize distractions, prepare emotion regulation tools that might be available in-person, and prepare them for what they may need to transition after sessions. Techniques to use during session include, but are not limited to, communicating verbally and nonverbally with our face and voice, mirroring clients verbal and nonverbal communication, tracking and reacting to clients' responses and checking in regularly with your clients for an optimal experience.

Practitioners may also display reluctance to use telehealth due to a perceived lack of competence in using the technology, the legality, or the appropriateness surrounding the modality for their clients. Fortunately, there are numerous trainings and best practices that have been created to guide practitioners in using telepsychology. For example, Shore and colleagues (2018) provided guidance compiled from the APA and American Telemedicine Association (ATA) to aid practitioners in methods to develop and deliver effective telehealth to clients.

Barnett and Kolmes (2016) published an article to address concerns associated with competence and the use of technology. They encourage practitioners to educate themselves on the clinical, ethical, and legal guidelines that are relevant to the use of telepsychology. In order to use technology as a therapeutic tool, clinicians need to possess technological competence and clinical competence. Technological competence requires knowledge of and familiarity with the technologies being used in telehealth (Barnett & Kolmes, 2016). This is especially important when choosing the technology that one employs in their practice. At its base level, a practitioner needs to choose a platform that remains compliant with the Health Insurance Portability and Accountability Act (HIPAA) so as to protect client privacy of medical records and personal health information.

Additionally, practitioners should be familiar with the systems being used to conduct telehealth so that they can make the necessary adjustments to ensure that audio and visual quality are appropriate for the client, while also being able to provide instructions to the client regarding the use of the system (Godine & Barnett, 2013). For example, when a practitioner chooses a HIPAA compliant email platform, they should have a good enough understanding of how it operates to be able to describe it to the client and guide them through the operation of it. Similarly, if a client joins a videoconference and appears to have trouble connecting their audio, video, does not have adequate lighting, or experiences connectivity issues, a practitioner should be familiar enough with the technology and software to troubleshoot with their client and overcome the issue.

Telepsychology Utilization with Different Populations

In addition to the evidence that telepsychology effectively allows practitioners to establish a strong therapeutic alliance with clients, there are also studies that demonstrate its ability to enable many client populations who have logistical challenges or otherwise do not have access to in-person services to benefit from psychological services. For example, individuals who live in rural communities face unique issues regarding their access to mental health providers (Gamm et al., 2010). Rural locations do not typically have the resources available to afford numerous practitioners and experience issues retaining them once they are there. Therefore, those who do practice in rural locations tend to see a large number of clients and are required to have competency as a generalist to treat a wide variety of concerns. This limits the quality of services that practitioners are able to offer as well as the options that members of these communities have when they are faced with seeking out care. The increased availability of telepsychology helps to address these limitations.

Members of rural communities often face issues that are not as prevalent in urban communities. For example, rural communities report higher poverty rates, unemployment rates, and lower levels of insurance coverage compared to more urban areas (Wagenfeld, 1994). Residents of rural communities may not have access to transportation that would allow them to participate in mental health treatment. They may not have the financial means or access to insurance that would enable them to address their concerns. There is evidence that rural residents experience higher suicide rates and attempts among depressed adults than their urban counterparts (Gamm et al., 2010). Similarly, those who do report a mental health diagnosis in rural areas are more likely to be seen by a primary care physician than a mental health practitioner (Gamm et

al., 2010). However, rural residents have been shown to be incredibly receptive when presented with the option to utilize telehealth to receive services that they otherwise would not have access to (Richardson et al., 2009).

The incorporation of telehealth to reach rural communities can serve to overcome some of the barriers noted above, for practitioners and for residents needing treatment. To investigate this further, Gray and colleagues (2015) conducted a study to explore the impact of telepsychology on clients' response to treatment for PTSD and depression symptoms. They also explored clients' satisfaction with the services they received via telehealth and examined the perspectives and perceived benefits of trainees and crisis center staff working in a Wyoming Trauma Treatment Telehealth Clinic. The researchers found that clients reported comparable reduction in PTSD and depression symptom levels to those expected in face-to-face therapy. Additionally, clients reported very high satisfaction with the services that were provided to them while trainees and crisis center staff reported similarly high levels of satisfaction with the ability to provide the services their clients needed. The results from this study emphasize the importance of telepsychology in providing rural clients with access to EBT's and provide a viable alternative for these rural residents' limited options for treatment providers that would otherwise require them to drive long distances to more urban areas or to a university clinic (Gray et al., 2015).

Another study conducted by Chang and colleagues (2016) explored the use of telepsychology to address a need for group counseling in a rural community. This study took place in a telehealth counseling clinic established by Texas A&M to address a shortage of psychological services available for the rural population in the surrounding

area. This group was a psychoeducational and support group focused on grief processing and the clients participated together in a remote site conference space while the facilitators participated together at the telehealth clinic. Chang and colleagues (2016) found that clients reported high levels of satisfaction with the grief counseling they received, and many would have not been able to receive services at all if telehealth had not been available. This study reinforces the important role that technology and telepsychology play in bridging the gap between access to services in rural and urban areas.

Telepsychology is also an important tool to enable individuals who are not native English speakers to receive services in their first language. Dwight-Johnson and colleagues (2011) conducted a study to determine the efficacy of telephone-based CBT to treat depression for Latino patients living in rural areas. This study took place in Washington state and allowed for CBT to be provided using either English or Spanish, based on the patient's preference. What the researchers found was that patients who received CBT experienced greater reductions on measures of depression compared to antidepressant medication and discussion with their primary care provider as measured by the Hopkins Symptom Checklist and Patient Health Questionnaire-9. Similarly, patients reported higher levels of satisfaction with the telephone-based treatment than they did with the antidepressant and primary care provider treatment method (Dwight-Johnson et al. 2011).

Telepsychology Treatment Effectiveness for Psychological Disorders

In order to determine the appropriateness of using telepsychology to work with a specific client, one must determine the client's presenting concerns and consider the

potential benefit versus the potential costs compared to offering face-to-face services. A practitioner should review the relevant research to ensure that there is evidence to suggest that telepsychology can effectively provide symptom relief for the client. Fortunately, there is a quickly growing body of research for the use of telepsychology with numerous different psychological disorders.

Depression is among the most common psychological disorders in the United States. As of June 2022, approximately 8.4% of adults (21 million) have experienced a Major Depressive Episode (MDE) in the last year (NAMI, 2022). An MDE is defined as a period of two weeks or longer where an individual experiences a depressed mood most of the day, nearly every day and/or a loss of interest or pleasure in all, or almost all activities most of the day, nearly every day along with additional, secondary symptoms (APA, 2022). Despite its prevalence, as of 2014 only 35% of people in the US with severe symptoms of depression reported having seen a mental health professional in the year prior (Pratt & Brody, 2014). This discrepancy between the number of people with depression and those who sought out treatment could be attributed to various factors, such as the lack of mental health providers or access to mental health resources. Telepsychology can help to address this lack of availability.

A review conducted by Berryhill and colleagues (2018) examined studies that used telehealth to treat depression. Each of the studies they chose utilized videoconferencing and individual therapy, and studies that included clients or patients who were also receiving pharmacological treatment were excluded. Berryhill and colleagues (2018) found that out of the 33 studies they examined, 22 of them reported statistically significant reductions in depression symptoms when using telehealth.

Additionally, they found that numerous studies found no statistically significant differences between telehealth groups and in-person groups receiving the same intervention to treat depression.

In a separate study, Forney and colleagues (2013) compared the outcomes of individuals with depression between patients who received care in-person and patients who received care from a telehealth collaborative care team. This team consisted of a primary care provider who was seen in person, while a nurse and pharmacist were seen by telephone, and a psychologist and psychiatrist were seen by videoconference telehealth. Patients in this study who were seen by the telehealth collaborative team received CBT. Those who received telehealth experienced significantly greater reductions in depression symptoms than those who received services in-person.

Another study conducted by Gonzalez and Brossart (2015) examined the effectiveness of telehealth on reducing symptoms of a variety of psychological and physical health indicators, one of which included measures of depression, over the course of three years. This study analyzed results from four individual patients as well as for the entire group of participants to determine whether the effectiveness differed depending on characteristics unique to certain patients. Through group analyses, Gonzalez and Brossart (2015) found that mean depression symptoms were reduced from the moderately severe range to the mild range following telehealth treatment. Through individual analyses, the researchers found that patients with more severe mental illness or who continued to experience psychological distress throughout the course of treatment did not experience as much improvement. This, however, could not be attributed to the telehealth provision of treatment.

Anxiety disorders are the most common psychological disorders in the United States. As of June 2022, approximately 19.1% of adults (48 million) have experienced symptoms of an anxiety disorder in the last year (NAMI, 2022). However, according to the Anxiety and Depression Association of America (ADAA), of that 48 million only 36.9% of people who experience anxiety receive treatment for it (ADAA, 2022). Similar to depression, by increasing the availability of mental health resources and access to providers, the number of individuals who receive treatment for their anxiety can also be increased. Telepsychology is one way to overcome these barriers.

A study conducted by McLellan and colleagues (2017) explored the efficacy of providing an anxiety treatment to children in rural communities in Australia using videoconferencing telehealth. These sessions took place through schools and included four phone calls with the children's parents throughout the treatment program. McLellan and colleagues (2017) found that the telehealth treatment resulted in a significant reduction in the number of anxiety disorder diagnoses, as well as a significant improvement in the functional impact and severity of anxiety on the children.

Symptoms of depression and anxiety may be present, or resemble, some of the symptoms evident in clients who have experienced trauma. Studies investigating the efficacy of telehealth to treat post-traumatic stress disorder (PTSD) have found evidence that it is a reliable and effective method of treatment. For example, Gray and colleagues (2015) found that using videoconferencing telehealth resulted in a large reduction of symptom severity from PTSD. Fortney and colleagues (2015) conducted a study to examine the impact of providing collaborative care from nurses, pharmacists,

psychologists, and psychiatrists via telehealth on symptoms of PTSD within a rural veteran population. The psychologists in this study provided cognitive processing therapy (CPT) through videoconferencing. Those veterans that were placed in the collaborative telehealth group attended significantly more CPT sessions than the group that continued strictly in-person services, experienced a significant reduction in PTSD ratings and in depression rating severity at the six-month and 12-month follow-up.

A major component of psychological treatment has been and continues to be evidence-based psychotherapies. The studies that have been described thus far have utilized CBT and CPT, but there are various other styles of psychotherapy that have been proven to be efficacious over telehealth. These include Mindfulness-Based Chronic Pain Management (MBCPM; Gardner-Nix et al., 2008), ACT (Browning et al. 2022), and IPT (Heckman et al., 2017; Anderson et al., 2017). Throughout my training, I have been introduced to numerous styles of psychotherapy that have required the use of telepsychology because of the constraints imposed by the COVID-19 pandemic. The psychotherapy style that has resonated with me the most has been IPT. Therefore, the remainder of this project will focus on the impact of COVID-19, IPT, its established efficacy with certain disorders, and the studies using IPT with telepsychology.

The Impact of COVID-19

Despite the research demonstrating the efficacy of telehealth, it was not widely utilized by psychologists prior to 2020. More specifically, Pierce and colleagues (2021) found that approximately 7.07% of psychologists' clinical work was conducted by telehealth. In early 2020, a new type of Coronavirus was identified and due to its expeditious spread and severity, quickly was acknowledged as a pandemic by the World

Health Organization (WHO) (WHO, 2020). The WHO recommended that certain precautionary measures be taken, such as physical distancing and staying home if feeling sick, in order to help reduce the spread of COVID-19. Based on recommendations from the WHO, the United States encouraged any agency, business, and institution to adjust to providing their service online if they were able to do so (Adalja et al., 2020). Eventually, the United States imposed mandatory social distancing which led to large health care organizations, mental health professionals, and professional psychology training programs to adapt their provision of services to an electronic format. As a result of these changes, Pierce and colleagues (2021) found that the amount of clinical work completed by psychologists via telehealth rose to approximately 85.53% during the pandemic.

In addition to the mandated social distancing measures that were put in place to respond to COVID-19, individuals who contracted or were exposed to the virus were expected to quarantine. Brooks and colleagues (2020) examined studies on the psychological impact of quarantine that took place during previous viral outbreaks and pandemics. They identified certain qualities that, if present prior to quarantine, are predictive of experiencing a psychological impact after quarantining. Individuals who have a history of psychiatric illness are more likely to experience anxiety and anger four to six months following quarantine (Jeong et al., 2016). Brooks and colleagues (2020) also found that multiple studies associated healthcare workers who were quarantined with higher symptoms of post-traumatic stress, feeling more stigmatization, demonstrating more avoidance behaviors, and reporting more negative emotional impacts than those who did not work in healthcare. The stressors that were identified as

having a psychological impact during quarantine included a longer period of quarantine, fear for one's own health or the possibility of infecting others, feelings of isolation, having insufficient supplies, and insufficient information from public health officials (Brooks et al., 2020).

Due to the lack of knowledge and all-encompassing nature of the lifestyle changes associated with the emergence of COVID-19, unique mental health challenges arose throughout the pandemic. For example, Gruber and colleagues (2021) asserted that the uncertainty regarding access to resources or the overall length of the pandemic, interpersonal disruptions, and lack of protective factors resulting from social distancing measures led to lower levels of overall mental well-being. More specifically, Gruber and colleagues (2021) identified the psychological impacts and risks of COVID-19 on individuals in different developmental stages.

For children, many schools closed and transitioned to remote instruction in order to reduce the spread of COVID-19. This interrupted the routines that were in place and reduced their access to adult and peer resources. The impact of social distancing and school closures also impacted adolescents, as they lost opportunities to exert their autonomy, further establish their social lives, and participate in milestone events such as high school graduation. Young adults were faced with challenges embracing their independence and fully establishing their identities as unique individuals. A number of challenges are shared by individuals in young and middle adulthood, such as the stress of financial uncertainty, high levels of unemployment, unexpected furloughs, an abrupt loss of childcare, and having to transition to work from home while attempting to serve as teachers for their children. Because individuals in older adulthood were some of the

most susceptible to severe illness as a result of COVID-19, they faced a loss of social support from family members who may have also served as caregivers (Garnier-Crussard et al., 2020). The numerous challenges created by COVID-19 across the lifespan placed individuals at all ages at greater risk of experiencing anxiety, depression, and traumatic stress symptoms. This aligns with findings from Bridgland and colleagues (2021) who proposed that direct exposure, such as contracting or close contact with COVID-19, and indirect exposure, such as consuming media related to COVID-19, exacerbated anxiety, depression, and impaired psychosocial functioning.

Bell and colleagues (2020) explored unique issues related to or worsened by COVID-19 for healthcare professionals and members of the general public. Regarding healthcare professionals, they identified being at higher risk of infection, being the only caretaker for numerous COVID-19 patients, and balancing their own health and well being with that of their patients. These risks could increase the likelihood of healthcare professionals experiencing depression, anxiety, post-traumatic stress, guilt, and suicidal thoughts (Greenberg et al., 2020). Another issue that has arisen from COVID-19 is due to the overabundance of information available, and the challenge of deciphering the information that is trustworthy. Because COVID-19 originated in China, some of the misinformation that exists attributed the virus to members of the Asian and Pacific Islander communities which led to an increase in discrimination and hate crimes against these communities. Bell and colleagues (2020) also indicated that racial and minority stress for lower-income families increased because of the abrupt transition to online platforms without the provision of resources to fully participate. Another issue Bell and

colleagues (2020) raised was that the deaths associated with COVID-19 may create a need for spiritual and existential dynamics to be addressed in therapy.

Since COVID-19 was discovered and quickly spread across the globe, unexpected changes took place that had an impact on various aspects of daily life. The emphasis on social distancing to reduce the spread of the virus resulted in social isolation, school closures, the implementation of remote instruction, and employers transitioning to remote work wherever possible. This served as an impetus for many healthcare professionals to adjust the delivery of their services to an electronic format, especially those in the mental health field. Although the purpose behind these changes were to protect the physical health of the community, the restriction of access to social support also increased the risk for individuals to experience negative mental health consequences.

Interpersonal Psychotherapy

Interpersonal psychotherapy (sometimes referred to as interpersonal therapy) is a brief, attachment-based therapy designed to relieve clients' suffering and improve their interpersonal functioning (Weissman et al., 2018; Stuart & Robertson, 2013). As its name suggests, IPT is interpersonally focused and emphasizes interpersonal relationships and social support with its interventions. IPT is based on a biopsychosocial/cultural/spiritual model, meaning that the practitioner is encouraged to view the clients' functioning as a product of biological factors, temperament, personality, attachment style, social relationships and support, and cultural and spiritual components (Stuart & Robertson, 2013). Similar to other solution-focused therapies such as CBT, practitioners are not encouraged to discuss the patient-therapist

relationship overtly. Rather, it is suggested to use the patient-therapist relationship as a way to understand the client's interpersonal functioning and asses their attachment style. This enables the focus of therapy to remain on immediate symptom relief and interpersonal issues.

Interpersonal therapy asserts that a practitioner has five essential tasks: creating a strong therapeutic alliance, identifying the client's maladaptive communications, helping the client to become aware of their maladaptive communications, helping the client modify their communication and practicing these new skills, and assisting the client to build a better social network as well as utilizing their existing social supports. Initially IPT utilized a structured format with three segments. However, following acute treatment, a fourth segment can be included to account for client needs following the conclusion of treatment. These segments include the assessment/initial phase, middle phase, conclusion of acute treatment/termination phase, and maintenance treatment (Weissman et al., 2018; Stuart & Robertson, 2013).

The assessment/initial phase of treatment consists of reviewing the clients' presenting problem, attachment style, and specific examples of interpersonal interaction to develop a sense for their typical style of communication (Stuart & Robertson, 2013). Important aspects of the assessment/initial phase include establishing a therapeutic alliance with the client, defining and diagnosing the clients' presenting concerns, providing a client with a "sick role", conducting an interpersonal inventory, defining an interpersonal focus, and linking the interpersonal focus to the client's diagnosis (Weissman et al., 2018). Interpersonal therapy emphasizes providing the client with a diagnosis because it allows the framing of their concerns as a treatable illness, aims to

relieve any potential blame the client may place on themselves for their diagnosis, and serves as an opportunity to present hope that the clients concerns can be addressed to improve their functioning. Additionally, by giving the client a "sick role", it allows the client an opportunity for self-compassion for the difficulties they are experiencing as a result of their psychological concerns while also placing the responsibility on them to try to get better (Weissman et al., 2018).

Aligned with the interpersonal focus of IPT, a clinician needs to relate a client's concerns to an interpersonal context. This requires exploring a client's significant past and present relationships as they relate to the current psychological distress. One of the essential tools of IPT to conduct this exploration with the client is known as the interpersonal inventory (Weissman et al., 2018, Stuart & Robertson, 2013). Another tool known as the interpersonal circle can be used to help gather the information for the interpersonal inventory (Stuart & Robertson, 2013). In order to associate the client and their unique aspects that relate to their relationships and the problem they are experiencing, a tool known as the interpersonal formulation is integrated (Stuart & Robertson, 2013).

The interpersonal inventory is completed with the client and examines aspects of their interactions with others such as: the expectations they have of significant others, their perception of expectations others have of them, aspects of relationships they like and dislike, and changes the client wants in the relationships (Weissman et al., 2018, Stuart & Robertson, 2013). The interpersonal circle involves three concentric circles, with the innermost circle relating to the clients' intimate relationships, the middle circle relating to the clients' close relationships, and the outside circle relating to the clients'

extended supports (Stuart & Robertson, 2013). The interpersonal formulation examines the biological, social, cultural, psychological, and spiritual factors that influence the way the client functions, perceives their experiences, and informs their presenting concerns (Stuart & Robertson, 2013).

Another part of this structured format is the conceptualization of clients' presenting concerns as existing within four problem areas: grief, interpersonal role disputes, role transitions, and interpersonal deficits (Weissman et al., 2018). The grief and loss problem area consists of any loss experienced by the client, whether that loss is a death, loss of a job or opportunity, loss of a relationship, or anything similar as perceived by the client as impactful. The interpersonal dispute problem area involves a conflict between the client and someone else. The role transition problem area results from changes in a client's social roles, such as life-phase transitions, leaving home, getting married, or graduating from school or getting a new job (Stuart & Robertson, 2013). The interpersonal deficit problem area asserts that a client is significantly lacking in social skills which results in problems beginning or continuing interpersonal relationships (Weissman et al., 2018). These problem areas are fundamental to IPT because they guide the direction of treatment and assist the practitioner and client in keeping the focus on specific interpersonal problems.

The middle phase of treatment consists of addressing the concerns brought up by the client in the context of the problem area that was collaboratively identified. This is accomplished by gathering more information about the client's specific interpersonal problems, working with them to improve their communication skills, or modifying expectations about relationship conflicts to more realistic outcomes (Weissman et al.,

2018, Stuart & Robertson, 2013). Interpersonal therapy encourages clinicians to work with their clients to develop emotional expression skills. This enables clients to focus on aspects of their interpersonal encounters such as what they felt, what messages they communicated, and how they communicated their message. Throughout the middle phase of treatment, the client is encouraged to relate their mood and functioning to the interpersonal outcome of their encounters. The goal is to help reinforce the client's prosocial and adaptive social functioning while providing support and collaboratively engaging in problem solving for behaviors that are not addressing the presenting concerns.

The conclusion of acute treatment/termination phase consists of summarizing the progress the client has made over time. The termination phase should be discussed with the client before it is scheduled to occur (Weissman et al., 2018). In order to remain consistent with the focus of addressing a particular problem area associated with significant relationships, referring back to the interpersonal inventory is recommended (Stuart & Robertson, 2013). This also provides an opportunity for the client to witness the growth they have made since they first began therapy. During the termination phase, the client should be able to identify and develop new communication and interpersonal skills. These skills can then be used for similar problems that may occur in the future. The maintenance treatment phase refers to treatment provided to clients who have previously completed IPT and are at risk of experiencing a relapse in their depressive symptoms (Weissman et al. 2018). The goal of this phase is to minimize the residual symptoms and impede the return of other symptoms.

Interpersonal therapy is a brief, structured psychotherapeutic style that can be adapted to suit the needs of the client. It emphasizes the role of attachment and interpersonal functioning when addressing a client's presenting concerns. With a focus on a specific problem area occurring in the present, IPT assists clients to obtain a better understanding of the ways their communication, interpersonal functioning, and ability to utilize their social supports inform the issue they are experiencing.

Efficacy of Interpersonal Psychotherapy With Specific Psychological Disorders

Interpersonal therapy was initially developed as a treatment for major depression (Weissman et al., 2018). However, it has been proven to be an effective treatment for a variety of different psychological disorders including, but not limited to, anxiety, eating disorders, postpartum depression, and PTSD. There are numerous studies that demonstrate its effectiveness, as well as those that demonstrate that it can be as useful, if not more useful, than other styles of psychotherapy or psychopharmacological treatment. These studies will be explored throughout this section.

One study conducted by Ekeblad and colleagues (2016) investigated the differences in IPT and CBT using psychiatric outpatients diagnosed with Major Depressive Disorder (MDD) and other comorbidities to determine the appropriateness of IPT in treating MDD. They were also interested in determining whether IPT would prove to be an equivalent treatment method to CBT, referring to its hypotheses as a noninferiority study. Following 14 sessions of each style of psychotherapy, IPT was found to be noninferior to CBT as a treatment to reduce depression symptoms in an outpatient psychiatric clinic. This means that each of the treatments provided sufficient

ability to reduce the depressive symptoms in the patients from this study. Ekeblad and colleagues (2016) note that despite there being a large effect size for both treatments, the rate of recovery and improvement were small, which is likely a representation of attempting to treat patients with moderate to high depression and a comorbid personality disorder. In this study, patients who participated in IPT also displayed significantly lower attrition rates than those who participated in CBT.

Another study conducted by Gamble and colleagues (2013) explored the utility of using IPT with women diagnosed with comorbid alcohol dependence and MDD to reduce alcohol use and depressive symptoms. IPT was provided in a brief format, eight sessions, as part of a multidisciplinary substance use program in an outpatient chemical dependency clinic that spanned a total of 24 weeks. The researchers found that IPT was effective when delivered in addition to a chemical dependency program. Those who received IPT reported that it helped them to see the relationship between their drinking, depression, and interpersonal relationships (Gamble et al., 2013). Additionally, those who participated in IPT demonstrated a reduction in depressive symptoms from clinically severe to below the level associated with mild depression. These effects appeared consistent even when following up at the end of the 32-week substance use program.

Johnson and colleagues (2019) tested the effectiveness of utilizing IPT with a prison population diagnosed with MDD. The researchers conducted IPT in a group format, along with typical prison treatment for depressive symptoms and compared the reduction in depressive symptoms to that of typical prison alone, which typically consists of strictly antidepressant medications. Interpersonal therapy was provided in 20

group therapy sessions over the course of 10 weeks. Johnson and colleagues (2019) found that IPT and antidepressant medication resulted in larger reductions in depressive symptoms, hopelessness, PTSD symptoms, and higher rates of MDD remission than antidepressant medication alone.

A study conducted by Gunlicks-Stoessel and colleagues (2019) examined the impact of using IPT on depressed adolescents' reports of attachment anxiety and avoidance, as well as the relationship between the adolescents' attachment style and change in depression. This study utilized a style of IPT known as interpersonal psychotherapy for depressed adolescents (IPT-A). The researchers asserted that symptoms of anxious and avoidant attachment styles would be reduced as a result of working on adolescents' interpersonal relationships, which would also reduce depressive symptoms. Participants received 12 sessions of IPT-A over the course of 16 weeks, and those who did not demonstrate a reduction in depressive symptoms throughout treatment received either an additional four sessions of IPT-A or antidepressant medications. Gunlicks-Stoessel and colleagues (2019) found that following IPT-A, adolescents reported decreases in discomfort, avoidance of closeness and intimacy, anxiety about being alone or uncared for, and depressive symptoms.

Bäck and colleagues (2020) conducted a study to explore the effects of IPT on bulimia nervosa and comorbid depression. This study used a form of IPT known as interpersonal psychotherapy for bulimia nervosa modified version (IPT-BNm) specifically designed for use with those whose presenting concern involved an eating disorder. Patients in this study received 12-16 weekly sessions of IPT-BNm. The researchers found that IPT-BNm resulted in a significant reduction of eating disorder

symptoms and depressive symptoms, such that 77 percent of patients were remitted or improved in their bulimic symptoms (Bäck et al., 2020).

Another study conducted by Glanton Holzhauer and colleagues (2022) examined the effects of IPT for women diagnosed with PTSD and history of childhood sexual abuse. They used a modified form of IPT known as interpersonal therapy for trauma (IPT-T) that is adjusted specifically for women diagnosed with depression and a history of childhood sexual abuse. Patients in this study received 16 individual sessions of IPT-T or another style of psychotherapy over the course of 32 weeks. The other styles of psychotherapy that were included were supportive, CBT, dialectical-behavior, eclectic, family systems, and client-centered. Glanton Holzhauer and colleagues (2022) found that IPT-T resulted in a reduction in PTSD symptoms by reducing the impact of emotional and physical problems on social activity.

Interpersonal therapy can be used to address numerous psychological disorders effectively, as various studies have shown. When compared to other styles of psychotherapy such as CBT, it has displayed efficacy as a comparable treatment. A benefit of IPT is that it is incredibly amenable to modifications for certain populations. Interpersonal therapy also can produce outcomes comparable to pharmacological treatment but can benefit from being provided in conjunction with it as well.

How Effective is Interpersonal Psychotherapy Delivered via Telehealth?

While there has been a breadth of research that has demonstrated the utility of telepsychology and of interpersonal psychotherapy separately, there is less evidence of the efficacy of IPT delivered through telehealth. This section will explore the existing research and discuss its findings. Additionally, case examples will follow to provide

examples of the current author's experience using IPT throughout their training due to the constraints of the COVID-19 pandemic.

A study conducted by Miller and Weissman (2002) explored the efficacy of using IPT over the phone to address treatment resistant depression in women. They used a population of women with recurrent or chronic depression who were experiencing mild to moderate depressive symptoms. Subjects who received IPT over the phone were offered 12 weekly sessions of IPT. Compared to those who received no treatment, subjects who received IPT over the phone showed a reduction of depression symptoms and an improvement of social functioning (Miller & Weissman, 2002).

Another study conducted by Dennis and colleagues (2020) examined the effectiveness of IPT delivered over the phone by nurses to address postpartum depression (PPD) compared to standard face-to-face postpartum care. Patients who received IPT were administered 12 sessions, once per week. The patients were ethnically diverse and were all members of underserved either rural or urban areas. The researchers found that the patients who received IPT over the phone reported significantly fewer depressive symptoms after 12 weeks than those who received face-to-face treatment as usual, and there was no evidence of a relapse at 24- or 36-week follow-up. In addition to reduction in depressive symptoms, patients who received IPT over the phone reported significantly lower levels of anxiety as well.

Heckman and colleagues (2017) conducted a study to explore the effects of IPT delivered by telephone for HIV-infected rural individuals who had been diagnosed with MDD or dysthymic disorder compared to those who only received standard care. Standard care for this study was considered access to community-based support

services, whether this included support groups, individual therapy, or antidepressant medication. This study utilized clients who were from 28 states, lived in a rural area, had a diagnosis of HIV infection or AIDS, and had a diagnosis of MDD or dysthymic disorder. Clients who participated in telephone administered IPT were offered nine weekly, individualized sessions. Heckman and colleagues (2017) found that clients who received IPT delivered over the phone experienced significant reductions in their depressive symptoms compared to those who only received standard care.

Nillini and colleagues (2018) conducted a review of studies on different treatment methods for depression, anxiety, and trauma related disorders during the perinatal period. In these studies, IPT was examined to determine its efficacy to treat depression through either an in-person format or over the telephone. The researchers found that face-to-face IPT was associated with a significant decrease in depressive symptoms in both pregnant and postpartum women and these decreases were maintained in follow-ups conducted at six weeks and six months following treatment. Telephone-delivered IPT was associated with a significant reduction in depressive symptoms compared to women who received treatment as usual (Nillini et al., 2018). The researchers also examined the utility of IPT for low income and/or minority populations, which featured the provision of IPT through both face-to-face and phone sessions. Clients who participated in IPT with the flexibility to receive treatment as it suited their needs (i.e.., by phone or face-to-face) experienced a reduction in depressive symptoms and no longer met criteria for MDD at the conclusion of treatment or the six-month follow-up.

Roffer (2017) wrote a chapter expanding upon the ways in which clinical video telehealth (CVT) has expanded access to care for veterans. The researcher described how CVT enables veterans who live in areas where specialty trauma treatments are not offered to participate in them either in their community-based outpatient clinics or even in their own home. In addition to geographic concerns, veterans suffering from emotional and behavioral concerns may have difficulty leaving their home or accessing a healthcare provider (Roffer, 2017). However, the Veterans Administration (VA) has been increasing the amount of specialty programs it can provide via CVT to reach these veterans' needs. The researcher described the emphasis the VA places on evidence-based treatments and the different interventions they have approved for use with telehealth. Of these, Roffer (2017) mentioned IPT as an option that can be offered to veterans seeking treatment.

Section III: Case Studies

In order to illustrate the efficacy of Interpersonal Psychotherapy delivered via telehealth, the experiences of the author, a clinician in training who utilized this method in vivo, will be expanded upon. Examples of the interpersonal circle (Figure 1) and interpersonal formulation (Figure 2) that have been adapted for telehealth can be viewed in Appendices A and B, respectively. The factors listed in the interpersonal formulation are examples that clinicians can offer if the client is encountering difficulty coming up with their own. The clients who are referenced in the following examples have been deidentified to protect their identities and maintain confidentiality.

Case One

Background

Shelly Shams was an adult cisgender female who sought out therapeutic services to address depressive symptoms associated with her sexuality and her faith. This client had been seen at the clinic previously by a different clinician, but because of a worsening of her depressive symptoms she decided to return.

Ms. Shams reported a typical childhood. She reached all of her developmental milestones on time. Regarding social support, Ms. Shams described her mother, father, members of her religious congregation, and expressed no complaints establishing or maintaining friendships with her peers throughout her childhood or early adolescence. Ms. Shams graduated high school and proceeded to move away from her family to attend college at a religiously affiliated university. As Ms. Shams entered early adulthood, she became more aware of her sexual orientation as a lesbian which created challenges for her socially that will be expanded upon further.

Mental Health History

Ms. Shams first became impacted by her depression when she recognized her attraction to members of the same sex. Her depression caused her to withdraw from her peers, develop negative self-perceptions, created uncertainty around the centrality of her faith as a part of her identity, and led to feelings of anxiety. Ms. Shams' faith was an important factor in her development and had an influence on many facets of her life, including her choice of where to attend college. However, her faith also perpetuated the belief that her sexuality was deviant and represented a sin that went against the teachings of her religion.

As Ms. Shams began to engage in her first same-sex relationship, she encountered a dissonance between her identity as a lesbian and her identity as a

Christian. Ms. Shams' social support system was comprised of individuals who shared her faith, many of which also shared the beliefs that contradicted aspects of her identity. She felt inhibited to be vulnerable with those around her because of fear for how her sexual orientation would be received. Adding to the feelings of isolation and anxiety, soon after starting college the COVID-19 pandemic began which led to the closure of campus and forced Ms. Shams to relocate back to her parents' home.

Ms. Shams chose to reveal her sexual orientation to her parents which resulted in a negative, invalidating response. Ms. Shams greatly valued the perception of her parents and receiving a response that reinforced her fears led to a worsening of her depressive symptoms. This led Ms. Shams to seek out counseling services to address concerns related to her parents' reception of her sexual orientation. She successfully completed a CBT treatment to manage the symptoms of her depression and was able to return to a more manageable baseline.

Presenting Concerns and Treatment Summary

Ms. Shams sought out therapy services following a worsening of her depressive symptoms in the summer before her final year of college. She had to leave her dorm and return to her parents' home which increased her negative self-evaluation and withdrawal from the support system she had developed on campus. Although she lived in a different city than the clinic and clinician, her previous experience had been so positive that she was eager to return even if it meant that services would be provided via telehealth.

The initial session consisted of establishing rapport with the client and developing a better sense of her presenting concerns. The client informed the clinician

that she had previously completed therapy to address concerns related to her families lack of acceptance of her sexual orientation. However, she felt as though returning to her parents' home and no longer being able to openly engage with her partner were inhibiting her ability to address her depressive symptoms. Additionally, Ms. Shams indicated that the coping skills she had previously developed were no longer as effective as they had been. Based on the concerns that Ms. Shams was experiencing, the clinician presented IPT as a new way to conceptualize her experiences and address her symptoms. Ms. Shams and the clinician examined her presenting concerns collaboratively in an interpersonal context and entered into the initial phase of treatment.

Ms. Shams and the clinician created an interpersonal circle to determine approximately five relationships that could be examined in relation to the depressive symptoms she was currently experiencing. Further, Ms. Shams described the kind of support received and expected from these relationships, the closeness of these relationships, and the aspects of them that she enjoyed as well as those she would like to change. In addition to the interpersonal circle, Ms. Shams and the clinician created an interpersonal formulation to develop a better understanding of how her background, relationships, and presenting concerns were related. Once the interpersonal circle and formulation were completed, Ms. Shams and the clinician explored the problem areas central to IPT and identified the role transition as the most appropriate to her depressive symptoms.

Throughout the middle phase of treatment, Ms. Shams and the clinician further explored how her background, the relationships, and the problem area she identified in

the initial phase could be addressed to reduce her depressive symptoms. Ms. Shams was able to identify some supportive individuals and positive qualities present within herself using the interpersonal circle and formulation. More specifically, Ms. Shams indicated that she was struggling to adjust to her new role as an autonomous adult after returning to her parents' home. She experienced conflicting goals of perceiving herself more positively despite many of her peers, congregation, and parents' consistent disapproval of her sexual orientation. As Ms. Shams examined the influence of her social environment, she began to acknowledge that the messages she received about the deviance of same-sex relationships was causing her to question her own adherence to her faith.

Throughout the middle phase of treatment, Ms. Shams developed skills to acknowledge and embrace characteristics she associated with being a good Christian, separate from the perceptions she maintained and had been imposed upon her related to her sexual orientation. As an embodiment of her ability to act as an autonomous adult, Ms. Shams began to seek out healthy support from relationships, distanced herself from relationships that reinforced her negative self-perceptions, and recognize the importance of attending to her own emotional needs. The final phase of treatment allowed Ms. Shams to reflect upon her growth throughout treatment. She was able to identify the influence that her relationships and perceptions could have on her overall well-being. Ms. Shams also developed skills to communicate her needs more effectively which assisted her in obtaining support when necessary.

Case Two

Background

Tina Timid was an adult, transgender woman who was referred to the clinic from a college counseling center to address persistent symptoms of depression. Ms. Timid was born and raised in rural Kentucky. She had an identical twin brother and grew up in a household with her biological family. Ms. Timid was a talented musician and enjoyed performing as a member of an orchestra beginning in middle school.

Ms. Timid noted social difficulties beginning in childhood, reporting a lack of close relationships persisting throughout adolescence and adulthood. Ms. Timid's family perpetuated traditional, conservative ideologies and strictly encouraged heteronormative gender roles. As a result, Ms. Timid felt restricted in her ability to fully explore her gender identity until she left her parent's home to attend college. Ms. Timid was enrolled as a full-time college student completing her freshman year.

Mental Health History

Ms. Timid first began experiencing depression during her adolescence when she described an inability to feel connected with her peers or family. Ms. Timid acknowledged difficulty identifying and expressing emotions beginning in adolescence and continuing into young adulthood. She experienced a traumatic incident while attending a camp during her adolescence in which she was sexually assaulted by a peer. Ms. Timid then became more isolative, experienced a significant drop in her self-esteem, and began engaging in self-injurious behaviors (i.e., cutting thighs and forearms). Out of fear for how her parents would respond, Ms. Timid did not reveal her assault or the depressive symptoms that occurred as a result until she met with a counselor after beginning college.

Upon moving to campus and beginning college, Ms. Timid was excited for the opportunity to embrace her trans identity. However, she experienced difficulty with the transition of discovering how to express her gender identity in addition to managing her own schedule, responsibilities, and creating social connections. This was exacerbated by the fact that her last years of high school were constricted by the COVID-19 pandemic. As a result of challenges with maintaining attention, motivation, low levels of energy, dissociation, and thoughts of suicide, Ms. Timid sought out services.

Ms. Timid received counseling for adjustment difficulties and symptoms of depression through her university's counseling center. She found herself unable to develop a strong therapeutic relationship with her counselor because of the provider's lack of comfort and competency discussing issues related to gender identity.

Presenting Concerns and Treatment Summary

Ms. Timid sought out therapy services following a referral from her university counseling center. While she did not receive a formal diagnosis, she was exhibiting symptoms that suggested depression and wanted to explore potential alternatives such as Attention Deficit Hyperactivity Disorder ADHD and Autism Spectrum Disorder (ASD). Ms. Timid had not participated in therapy via telehealth previously, but she expressed hope that the experience would be more effective than her experience in person.

During the initial phase of treatment, rapport was quickly established between Ms. Timid and the clinician. Ms. Timid began with an emphasis on the depressive symptoms she was experiencing, including the isolative behavior, lack of energy, anhedonia, and negative self-perception. She and the clinician proceeded to

collaboratively create an interpersonal circle and formulation to develop a sense for the relationships and perceptions currently present in her life as they pertained to the depressive symptoms she was experiencing. Ms. Timid identified approximately four individuals on her interpersonal circle, only one of which she considered to be an intimate support. Regarding the interpersonal formulation, Ms. Timid described the social, cultural, and psychological factors as being most impactful on her current experience of depression. Following the completion of the interpersonal circle and formulation, the clinician presented the different problem areas that are central to IPT and worked with Ms. Timid to determine that a role transition felt most appropriate to focus on throughout the remainder of treatment.

Throughout the middle phase of treatment, Ms. Timid deeply explored the aspects of relationships she identified to determine how they were reinforcing the depressive symptoms she was experiencing. As Ms. Timid developed skills to acknowledge, convey, and manage her emotional responses, she began to recognize that relationship dynamics with her partner were driving her to engage in her maladaptive coping skills including self-isolation, substance use, and self-injurious behavior. She examined the aspects of relationships where she felt more supported and determined the aspects that would help her to feel more comfortable embracing her identity as a trans woman. Ms. Timid's partner was the only intimate support she identified during the initial phase, but as the middle phase progressed, she removed them entirely as a social support and sought out individuals who better aligned with the positive aspects she desired. The final phase of treatment allowed Ms. Timid to acknowledge that, through a combination of distress tolerance skills, thought challenging, behavioral activation, and

developing more effective communication skills, she was able to experience a remission of her depression symptoms.

Section IV: Limitations and Future Directions

Limitations

The research and case examples of utilizing IPT through telepsychology suggests an accessible, effective treatment method that can result in significant symptom reduction for various psychological conditions. However, the current sample did not require clients to complete more objective measures of their symptoms like the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), or Trauma Symptom Inventory. As a result, it is difficult to identify the strength of improvement indicated aside from the anecdotal accounts of the clients. Additionally, the current sample is limited to young adult clients from a private practice clinic whose primary concerns were symptoms of depression. As a result, results may not be generalizable to the general population.

Future Directions

To expand on the study of this doctoral specialization project, it would be beneficial for additional research to be conducted with more objective measures of client symptom burden. For example, if clients were to complete a BDI, BAI, or a measure like the Patient Health Questionnaire-9, when services were initiated than it would provide a baseline to compare against throughout the course of therapy. If results are consistent with the findings from the current project, clients would report a significant reduction in symptoms equal to or greater than that of individuals who receive IPT in an in-person format.

Another aspect of this project is to continue to develop the tools, such as the interpersonal circle and interpersonal formulation, which have been adapted for telehealth. In its current format, the clinician describes the purpose of the documents and adjusts the wording of the factors being explored in a way that the client can best understand. The clinician then shares access to the document with the client and encourages them to enter in the relevant information during the session. However, presenting the tools in this way results in a lack of consistency between clients that could lead to confusion and a potential rupture in the therapeutic alliance at a critical juncture in treatment. Consulting with additional providers and clients to gauge whether the tools would benefit from a set of more straightforward instructions may help to improve their accessibility and utility.

Additional research could also be conducted to demonstrate the efficacy of IPT via telehealth with more diverse clinical presentations. To date, much of the existing research that has been conducted investigated the use of IPT for specific diagnoses, such as for MDD and PPD. While the research has done a good job of demonstrating the effectiveness of face-to-face IPT for anxiety disorders, eating disorders, and PTSD, further research that replicates these findings via telehealth would strengthen providers' confidence in making these services more widely adopted.

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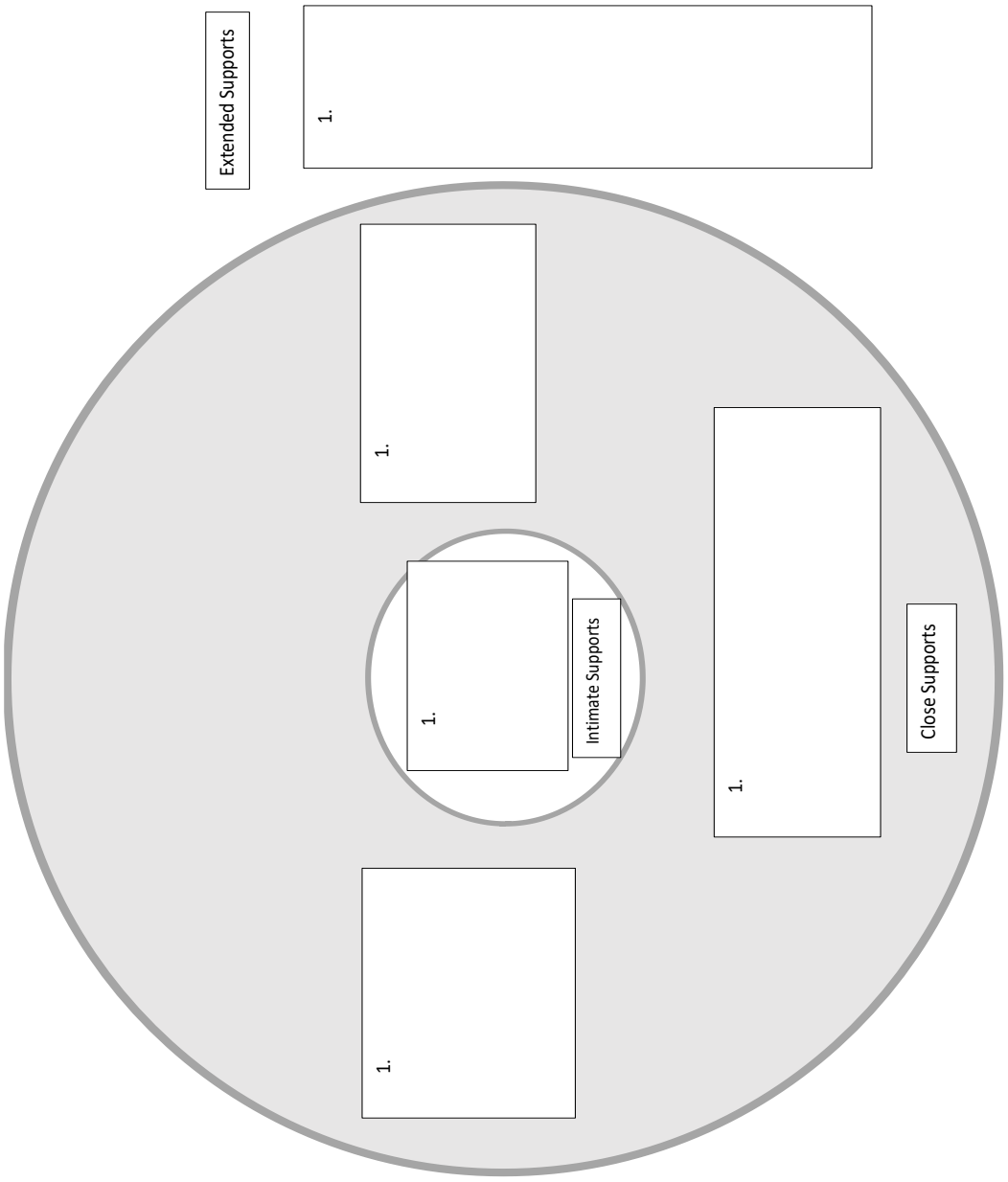
Appendix A

Figure 1

Interpersonal Circle Example



Appendix B

Figure 2

Interpersonal Formulation Example