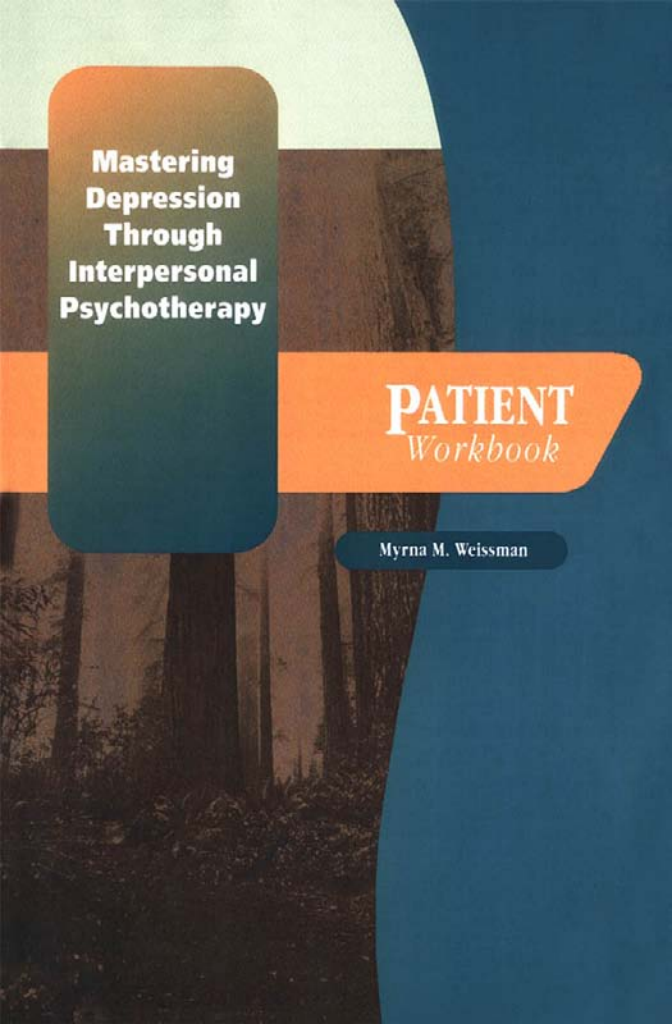
Mastering Depression Through Interpersonal Psychotherapy

PATIENT *Workbook*

Myrna M. Weissman



Mastering Depression Through Interpersonal Psychotherapy

Patient Workbook

Myrna M. Weissman

OXFORD
UNIVERSITY PRESS

OXFORD
UNIVERSITY PRESS

Oxford University Press, Inc., publishes works that further
Oxford University's objective of excellence
in research, scholarship, and education.

Oxford New York
Auckland Cape Town Dar es Salaam Hong Kong Karachi
Kuala Lumpur Madrid Melbourne Mexico City Nairobi
New Delhi Shanghai Taipei Toronto

With offices in
Argentina Austria Brazil Chile Czech Republic France Greece
Guatemala Hungary Italy Japan Poland Portugal Singapore
South Korea Switzerland Thailand Turkey Ukraine Vietnam

Published by Oxford University Press, Inc.
198 Madison Avenue, New York, New York 10016

www.oup.com

Oxford is a registered trademark of Oxford University Press

ISBN-13 978-0-19-518847-9
ISBN 0-19-518847-0

9 8 7 6 5 4 3 2

Printed in the United States of America
on acid-free paper

ABOUT THE AUTHORS

Myrna M. Weissman, PhD, is a professor of epidemiology in psychiatry, College of Physicians and Surgeons at Columbia University and Chief of the Department in Clinical-Genetic Epidemiology at New York State Psychiatric Institute. Until 1987, she was a professor of psychiatry and epidemiology at Yale University School of Medicine and Director of the Depression Research Unit. She was a Visiting Senior Scholar (1979-1980) at the Institute of Medicine, National Academy of Sciences, Washington, DC.

She received a PhD in chronic disease epidemiology in 1974 from Yale University. Her current research is on depression and anxiety disorders. She was one of the original developers of Interpersonal Psychotherapy.

Dr. Weissman has been a consultant to several agencies, including the World Health Organization, the White House Office of Science and Technology Policy, and the John D. and Catherine T. MacArthur Foundation. She also has been the author or co-author of over 400 scientific articles and chapters, and 6 books including *The Depressed Woman: A Study of Social Relationships,* (1974), with Eugene S. Paykel, and *Interpersonal Psychotherapy of Depression,* (1984), with her late husband, Gerald L. Klerman; Bruce J. Rounsaville, and Eve S. Chevron.

Dr. Weissman's awards include the Rema Lapouse Mental Health Epidemiology award given in 1985 by the American Public Health Association for contributions to the scientific understanding of the epidemiology and control of mental disorders, an NIMH 10-year Merit Award in 1990 for her study of the genetics of panic disorder, the Anna Pollock Lederer Award and the NARSAD Senior Investigator Award in 1991 for her studies of depression, and the Selo Award of the NARSAD Foundation in 1994 for her research in depression. In 1993, she co-edited with Dr. Klerman *New Applications of Interpersonal Psychotherapy.* She was also co-editor of *Panic Anxiety and Its Treatments,* and co-author of *Interpersonal Psychotherapy for Depressed Adolescents.* In 1997, she was elected to the Institute of Medicine of the National Academy of Science.

This Patient Workbook is dedicated in memory of Dr. Gerald Klerman. The book is in part based on the long-term collaboration between Drs. Klerman and Weissman. Dr. Klerman was educated at Cornell University and New York University College of Medicine. He trained in medicine at Bellevue and in psychiatry at

Massachusetts Mental Health. He was a central figure in many NIMH collaborative studies. He pioneered in planning the strategy of multi-site studies, defining affective and anxiety disorders, developing and evaluating treatments, and educating psychiatric researchers. He served on the faculties of Yale, Harvard and Cornell, was Director of Psychiatric Research at the Massachusetts General Hospital, and Associate Chairman for Research in the Department of Psychiatry at Cornell. He also served as administrator at the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Dr. Klerman published over 350 articles and several books. His honors include the Hofheimer Award, the Superior Service Award of the Public Health Service, the Menninger Award of the American College of Physicians, the Solomon A. Berson Medical Alumni Achievement Award of New York University, the Distinguished Service Award of the American Psychiatric Association, and the Thomas William Salomon Award of the New York Academy of Medicine. He died on April 3, 1992.

Dr. Weissman and Dr. Klerman also shared many prestigious awards including the APA Foundation Fund Prize in 1978, the Anna-Monika Foundation Prize in 1986, and an international award for their studies of drugs and psychotherapy in the treatment of depression. In 1990, they won the Research Awards of the National Depression and Manic Depressive Association and the Research Award of the American Suicide Foundation. In 1994, Dr. Weissman, and Dr. Klerman posthumously, were awarded the Institute of Medicine's Rhoda and Bernard Sarnat International Prize in Mental Health. This Patient Workbook represents the joint vision of Drs. Weissman and Klerman to make psychotherapy accessible and understandable to patients.

PREFACE

The purpose of this book is to describe our concept of depression and a psychotherapeutic approach to the treatment of depression. This approach has been tested by the same scientific methods used for testing medication and has been shown to be effective in helping people overcome their depression. This treatment is called Interpersonal Psychotherapy of Depression (IPT) and was developed by my late husband, Gerald L. Klerman, M.D. and myself, along with a number of collaborators.

The idea behind this book is to describe our approach to the treatment of depression so that depressed persons may be able to use it, either for learning how to cope with their own depression or to understand some of the methods that trained therapists might use to help them. We do not know whether reading a book will, in fact, reduce your depression. However, we believe that a clear understanding of the facts about depression and this particular therapeutic strategy is helpful to patients who are in treatment and may be helpful generally.

This work derives from the current climate in the United States to destigmatize psychiatric problems and to demystify treatment so that people suffering from these problems can get appropriate help early, before the symptoms have consequences in their work and family life. We believe that patients with psychiatric symptoms should know what the treatment options are, what they might expect and when they should seek alternate treatments. In general, we agree with the slogan that an educated consumer is our best customer. However, we do not believe that there is only one treatment for depression or that the treatment described here is the best for all depressed patients.

Persons who want to learn more about the scientific basis of Interpersonal Psychotherapy and who wish to read the efficacy data about these treatments are referred to Klerman et al, 1984; Klerman and Weissman, 1993; and Mufson et al, 1993*. For most people, the materials contained in this book will provide a good summary, in simple terms, of our current understanding of depression and our particular way of dealing with depression in an interpersonal context.

Interpersonal Psychotherapy has been adapted for depressed adolescents and the elderly, for people with dysthymia (chronic depression), bulimia, drug abuse, recurrent depressions, bipolar disorder and borderline personality disorder. In this workbook we will only focus on major depressive disorders.

This patient book represents many years of work and many different scientists and clinicians. I appreciate the financial support from the National Institutes

of Mental Health, the John D. & Catherine T. MacArthur Foundation and, over the years, the NARSAD Foundation, for the development and testing of IPT and its modifications; the considerable input in the development and testing of IPT from our early collaborators at Yale University, Bruce Rounsaville, M.D. and Eve Chevron, and our later collaborators at Cornell Medical School, John Markowitz, M.D., and at Columbia University College of Physicians & Surgeons, Laura Mufson, Ph.D. and Donna Moreau, M.D.

I thank the many new investigators who took IPT on for further testing and for new modification and especially Ellen Frank, Ph.D. and David Kupfer, M.D. for their monumental study testing the efficacy of IPT, with and without medication, for patients with recurrent depression who were maintained on IPT for three years.

All case material has been substantially altered so that it is not possible to relate any case material presented to actual patients treated.

The detailed material on IPT is contained in the following books:

Klerman, G.L., Weissman, M.M., Rounsaville, B.J., & Chevron, E.S. (1984). Interpersonal psychotherapy of depression. New York: Basic Books, (telephone number: 800-331-3761). Reprinted in soft-cover in 1994 by Jason Aronson, Inc. 230 Livingston Street, Northvale, NJ, 07647, (telephone number: 800-782-0015).

Klerman, G.L., & Weissman, M.M. (Eds.). (1993). New applications of interpersonal psychotherapy. Washington, D.C: American Psychiatric Press, Inc.

Mufson, L., Moreau, D., Weissman, M.M., & Klerman, G.L. (1993). Interpersonal psychotherapy for depressed adolescents. New York: Guilford Press, Inc.

Myrna M. Weissman
New York, New York
January, 1995

A Guide to this Guide

The book begins with a description of depression, then describes common patient concerns about the disorder. The second chapter is an introduction to Interpersonal Psychotherapy (IPT). Again, common patient questions about psychotherapy are answered. Chapters 3 to 8 are the descriptions of the process of treatment with IPT, with some typical cases at the end of each problem area. Throughout the book are worksheet guides to help you think about problems and solutions to your depression - these are the kinds of questions your therapist will be considering with you.

This book can be used in different ways. It might be useful if you want to learn a little bit about depression and its symptoms and how the symptoms may relate to what's going on in your life. If you are in an acute depression it might help you to decide whether or not to seek treatment and might help you review the situations in your family or work which may be contributing to your depression. If you are interested in learning about how Interpersonal Psychotherapy works, or learning some of the process or concerns that patients have about psychotherapy, this guide can provide some insight. If you are undergoing Interpersonal Psychotherapy, the guide is meant to accelerate the process by describing the issues that the IPT therapist will be raising and the areas the therapist will want to consider with you in helping to alleviate your symptoms.

The guide is meant to be user-friendly and is written in a simple language. If you are about to undertake treatment with an IPT therapist, or if you think you may want to seek IPT treatment, it might be useful to read the guide through quickly to get an overview of what the treatment is about and what you might expect. If you are undergoing IPT treatment it might be useful to follow along with the sessions and to complete the worksheets that accompany the book. The worksheet questions are incorporated into the flow of the text for continuity. It is recommended that, prior to termination of the program, all individuals redo all the forms to monitor the progress of therapy, as well as highlight any areas that may need further work. A separate booklet containing the forms included in this guide may be purchased through Graywind Publications Incorporated. In addition to purchasing the Patient Assessment Forms Workbook for Interpersonal Psychotherapy Program upon termination, these forms can also be used to continue to monitor any problem areas if they persist. It is also recommended that each patient talk over the results of these forms with his/her therapist. We welcome responses and comments to this format and encourage you to address them to me in care of the publisher.

Myrna M. Weissman
New York, New York

This page intentionally left blank

TABLE OF CONTENTS

CHAPTER 1 **Page**

CHAPTER 2

CHAPTER 7

CHAPTER 8

This page intentionally left blank

CHAPTER 1

What is Depression?

There are basic facts about depression that we would like to emphasize.

Facts about Depression

- There are different types of depression: major depressive disorder, dysthymia and bipolar disorder.
- Depression is one of the most common psychiatric disorders.
- Depression is more common in women than in men.
- Depression is otherwise an equal opportunity disorder. It occurs across all countries, levels of education and occupations. It affects rich and poor and people of all races.
- Depression is a family affair. It runs in families and has serious consequence for family life.
- Depression is increasing.
- Depression is occurring more frequently in younger persons.
- There are many effective treatments for depression: medications and psychotherapy. Sometimes these treatments are combined.
- Depression tends to be a recurring disorder. Some patients will need available treatments for long periods. Others will have one bout and never have another period of symptoms.
- There is not one treatment that is right for all patients or all types of depression. If one treatment doesn't work after a sufficient time, you ought to consider another.

Fleeting moments of feeling sad and blue or depressed are part of the human condition. These mood changes are normal and tell you that something is not quite right in your life and usually pass. Clinical depression is different. It is persistent, impairing and includes a range of symptoms. There are different types of depression. Usually your therapist will make an effort to determine the type you have (more on this later).

Major Depressive Disorder

Major depressive disorder, which is the most common of the depressions, includes a sad or dysphoric mood and loss of interest or pleasure in all or almost all usual activities or pastimes. This mood state persists for several weeks and is associated with other symptoms which occur nearly every day including a disturbance in your appetite (loss or increase in appetite), changes in weight, sleep disturbance (trouble falling asleep, waking up in the middle of the night and not being able to go back to sleep, waking up early in the morning and feeling dreadful), and a loss of interest and pleasure in things you used to enjoy: food, sex, work, your family and friends. Symptoms of agitation or feeling sluggish, a decrease in energy, feeling worthless or guilty, having trouble concentrating or thinking, thoughts of death, feeling life is not worth living, suicide attempts or even suicide are other features of depression.

You do not need to have all of the symptoms to have a clinical depression. However, if you have at least five symptoms and they persist for several weeks, resulting in impaired ability to take care of yourself or your family, or impaired ability to go to work and carry out your daily life, then you probably have major depressive disorder.

Subtypes of Major Depressive Disorder

It has been known for a long time that there are different forms of major depressive disorder usually defined by a particular group of symptoms. Many types have been suggested. However, research studies show that the type with the most important treatment implications is delusional depression.

Delusional depression, also called psychotic depression, includes the usual symptoms of depression as well as distortions of thinking which are consistent with depressive themes such as guilt, self-blame, feeling of personal inadequacy or deserved punishment. A person with delusional depression may feel that the depression was brought on because they are bad or because they deserve to be depressed. Delusional depression is quite infrequent. When it does occur, it requires medication and usually cannot be treated by psychotherapy or IPT alone.

Mild Depression

Many persons have mild depression, e.g. sleep problems or loss of interest, which do not meet the criteria for major depressive disorder. These states are referred to by different names: minor depression; depression not otherwise specified; mixed anxiety/depression; or adjustment disorder with depressed mood. People with these mild symptoms either do not go for treatment or are only seen by their family doctor, a primary care practice or a health maintenance organization (HMO). These symptoms should not be ignored if they persist since they are

impairing and can interfere with your enjoyment of life and productivity. Moreover, persons with minor depressive symptoms are at increased risk for developing major depressive disorder in the near future.

IPT has been adapted for persons with mild depressive symptoms. In one study, two groups of mildly depressed people were examined. In the first group, patients received IPT modification administered by nurses while the other group of patients received no treatment. The group involved in the IPT treatment showed a reduction in their symptoms. Another study is underway in a primary care setting.

Dysthymia

The main feature of dysthymia is a chronic disturbance of mood, i.e., feeling sad or blue, loss of interest in almost all usual activities (similar to depression), but not of sufficient severity to meet criteria for major depressive disorder. These symptoms are mild, low-grade and are constant. They must persist for at least two years to be considered dysthymia but they can last for decades. IPT has been adapted to these symptoms and is being tested in patients with dysthymia.

This book, however will concentrate on treatment for persons with major depressive disorder.

Bipolar Disorder

Bipolar disorder includes the presence of manic states in addition to depression. Mania is a predominant mood which is either elevated (feeling high), expansive or irritable. It is accompanied by excess activity, racing thoughts, feeling powerful, overly high self-esteem, a decreased need for sleep, being easily distracted, and involvement in activities that have a high potential for painful consequences, such as excessive spending or sexual activities.

IPT has been adapted and is being tested for patients who have bipolar disorder and are receiving maintenance medication. Most patients with bipolar disorder require medication.

Common Questions and Concerns about Depression

Do I Have a "Biological" Depression?

Debates about whether some depressions are biological and others psychological miss the point and are not useful for guiding therapy. All depressions are ultimately biological. They are associated with changes in sleep, appetite and energy levels and, in the more severe forms, with disturbances in thinking, memory and concentration. These biological changes do not distract from the fact that most depressions have a psychosocial context and that a person's mood can be markedly

affected by changes in their relationships with others. There may be either a real change in the situation which was upsetting; or a change in the person's perception of the situation; or a change in the person's ability to cope with the situation.

Help can be found with medication or psychotherapy. The decision to use medication should be based on the severity of the patient's symptoms, a history of recurrence and the patient's wishes. A patient with psychotic or delusional depression or bipolar disorder should first be considered for medication. There is also a need for non-pharmacotherapeutic alternatives in the treatment of depression. Many depressed patients do very well with psychotherapy as the only treatment. For some patients, combined medication and psychotherapy is the most helpful.

I've Been Chronically Depressed!

In some cases, a severe episode of depression (including sleep and appetite disturbances) may be superimposed on a long-standing depression that had only mild symptoms and a pessimistic way of viewing the world and dealing with others. Sometimes, when this severe depression is resolved, the on-going mild symptoms disappear, because they were merely a reflection of a long-standing, previously untreated depression. Also, when you are acutely depressed, you can expect to be at your worst: dependent, pessimistic, negative and irritable; when you no longer experience the symptoms you may feel very differently. However, if the chronic symptoms still remain, a longer or different form of treatment may be necessary. You and your therapist will make this evaluation.

Is My Depression Incurable?

When you are acutely depressed, it is common to feel that the symptoms will last forever. However, with proper treatment, about 80% of patients will be symptom free in 4-6 weeks. Once the sleep and appetite problems begin to resolve, you will find that your mood is better. It is important to remember that there are many different types of effective treatments for depression. IPT is just one of them. There is a range of other types of psychotherapies and a range of medications that can be used. Therefore, if one treatment does not work, your therapist and you should seek alternatives.

Give the treatment enough time (at least six weeks) to work. Don't let the hopelessness of depression discourage you from continuing.

What If I Have Suicidal Thoughts?

The symptoms of depression can be overwhelming and invade all parts of your life. You may feel that your life is out of control. Suicidal thoughts are symptoms of depression. You may experience suicidal feelings, i.e., feeling life is

not worth living, wishing you were dead or perhaps thinking about a suicide attempt. If you feel this way, you should let your therapist know and you should request that you have more frequent contacts with the therapist. The therapist's availability during these crises can be through daily phone calls or more frequent consultations.

DO NOT KEEP SUICIDAL THOUGHTS TO YOURSELF.

I Can't Accept What I Really Want.

Many depressed patients have trouble accepting their own wishes and are unwilling to act upon them because they feel that their needs are unacceptable or unlikely to be fulfilled. For example, a woman may meekly (but resentfully) accept domination by her husband if she does not believe that a different type of relationship is legitimate, appropriate or possible.

To counter the tendency to suppress or deny needs or wishes, you should try to work on expressing what these wishes or needs are. Discuss them with your therapist and decide what is reasonable. Work actively in treatment to try to bring them about, to understand your role in the behavior and to make realistic changes.

I Am to Blame for My Family Problems.

Many depressed patients blame themselves for situations over which they have only partial control. Self-blame is part of depression. There may be unrecognized family or group pressure on you to take the blame. This is a good topic to bring up during the therapy so that you can learn to avoid being made the scapegoat if that is what is happening in your family.

Can I Drink My "Blues" Away?

Some depressed people think that alcohol will relieve their symptoms. After all, alcohol can help sleep, at least in the short-run, and will dull painful memories and current experiences.

Alcohol is a **bad "treatment"** for depression. In the long-run it disturbs sleep and is a mood depressant. It can make you more depressed. Moreover, it diminishes your ability to cope, creates additional problems in family and work, interferes with your treatment and increases risk for suicide.

IF YOU ARE DRINKING, TELL YOUR THERAPIST AND ASK FOR HELP.

What about "Under the Counter" Drugs?

The same problems, as with alcohol, occur with use of illicit drugs or abuse of legal drugs - and they can even be worse.

IF YOU ARE HAVING A PROBLEM WITH DRUG ABUSE, TELL YOUR THERAPIST AND ASK FOR HELP.

Can I Give Depression to My Children?

Depression is a family affair. If you are depressed, your children are at 2 - 3 times greater risk for becoming depressed, when compared to children of parents who have never been depressed. Put another way, if the normal rate of depression is 3%, the risk to children of depressed parents is 6 - 9%. The good news is that most of the children won't get depressed. We don't know the mechanism by which depression is transmitted in families, whether it is through genes, learning, stress produced by a parent's depression or some combination.

If you are depressed and your children also seem to be having similar problems, pay attention, take it seriously, talk to them about it and get them help.

Is Seeking Treatment a Defeat?

Many depressed patients see the need for treatment as just another sign of their weakness or defeat. An alternative way to look at the situation is that seeking treatment is a constructive and courageous move to try to make changes in your life. It is an effort to take your situation in hand and actively do something about it.

Seeking treatment for your depression is a positive first step out of depression.

CHAPTER 2

What is IPT?

An Overview

Interpersonal Psychotherapy (IPT) is a specific psychotherapy which requires only limited time. It was developed over a twenty year period, mainly for persons with major depressive disorder. Designed to be administered by experienced and trained mental health professionals, it can be used with or without medication. The procedures for treatment have been specified in a book used by your therapist as a guide (Klerman, et al., 1984). The idea behind IPT is that there are probably many causes of depression, including biological vulnerability, a recent stress or a loss. **Whatever the "cause(s)", depression usually occurs in a social and interpersonal context. Some examples are:**

- **Your marriage breaks up**
- **You and your children have a dispute**
- **Your spouse becomes disinterested in you and the family and you think he/she is having an affair**
- **You lose your job or you think you will**
- **You move to a new neighborhood**
- **Your mother dies**
- **You are promoted**
- **You retire**

In IPT, we take the position that understanding the social and interpersonal circumstances that led to the development of your depression (what was going on in your life when you became depressed) will help to unravel the reasons for your symptoms. It will be the first step in helping you to learn to develop new ways of dealing with people and situations so that you are less vulnerable.

This change occurs through open discussion with the therapist who has a point of view about depression and uses specific procedures, as we will describe, during the course of your treatment.

First the IPT therapist determines whether you have a depression, then proceeds to explore with you the associated interpersonal issues. This dialogue takes place over a set period of time.

IPT was developed in order to specify what we thought were helpful procedures used in psychotherapy for depressed patients who were being treated as

outpatients. We felt that by specifying these procedures more therapists might use them effectively. The patient would also be more informed about what to expect. IPT has been tested in clinical treatment trials for depression where it has been compared to psychotropic medication, to placebo (sugar pills), to other specified brief psychotherapies and to no psychotherapy. It has also been tested in combination with medication.

IPT has been tested as treatment for acute depression (with patients seen weekly for four months) and as a maintenance treatment to prevent new episodes of depression in recovered patients (seen weekly for eight months or monthly for three years). The results of these clinical trials, which use the same scientific format as studies testing new medications, were positive.

IPT is one of the psychotherapies recommended for the treatment of depression in the American Psychiatric Association Guidelines (Karasu et al., 1993) and in the Guidelines for Primary Care Physicians. Both of these guidelines were published in 1993. The complete reference is at the end of this chapter.

IPT was first developed for adult patients with major depression (the different types of depression are explained in Chapter 1). It has now been modified for: adolescents and the elderly with depression; persons with dysthymia or chronic depressions; patients with bipolar disorder (manic depression) or recurrent depression; depressed HIV positive patients; and patients with bulimia or with drug abuse. Modifications for patients with panic disorder and with personality disorders are underway. These modifications are at various stages of development and testing and have been summarized in a recent book by Klerman and Weissman (1993). For some of these modifications, it is too early to make claims of effectiveness. The best and most solid information relates to the effectiveness of IPT for patients with major depressive disorder, for whom this book is intended.

We do not believe that there is only one right treatment for depression. There are a range of medications and a range of psychotherapies and often these are used in combination. It is in the best interest of the depressed patient to have this variety available, but all treatments must undergo scientific testing before any claims are made. IPT, cognitive therapy, some behavior therapies and many antidepressant medications have undergone such testing.

Research has shown that IPT is helpful for depressed patients. It is an important alternative to medication for patients during some periods of their life, e.g., women during childbearing or nursing; the elderly and others who have difficulties with the side effects of medication; depressed patients about to undergo surgery; and patients who just don't want to take medication. This is in no way to devalue the importance of medication as a treatment for depression, especially for patients who need rapid symptomatic relief; who are seriously symptomatic; and who have certain types of depression; for patients who are not helped by psychotherapy;

or patients who just don't want to talk about personal problems with a therapist. This broad view of treatment is part of the philosophy of IPT.

Concept of Depression in IPT

The IPT therapist has a concept of depression that guides the treatment.

IPT is based on the idea that the symptoms of depression have many different causes. However, whatever the causes, they are usually associated with something going on in your personal life, usually with people to whom you feel close and who are important to you. It is useful to identify and learn how to deal with those personal problems and to understand their relationship to your depression.

There are at least three ways an IPT therapist will try to help you:

1. By making an accurate diagnosis and making certain that you have a depression.

2. By relieving your symptoms of depression.

3. By helping you develop better ideas and resources for dealing with whatever social and interpersonal troubles you are experiencing in relation to the development of your depression.

The IPT therapist views depression as having three parts:

1. **Your Symptoms.** This involves your symptoms of depression, your problems in sleeping and eating, your loss of interest and pleasure in life, your fatigue and pessimistic outlook. (These will be described later.)

2. **Your Social and Interpersonal Life.** This involves your ability to get along with other people in your life who are important to you: your family, your spouse, your children, your partner, your brothers and sisters, your dear friends or your work associates.

3. **Your Personality.** There are some enduring ways that people deal with life, that is how they express their angers and hurts, their self-esteem, whether they are shy, aggressive, inhibited or suspicious. These traits determine your unique reaction to other people. These personality patterns may even contribute to the reason for developing your depression or how you deal with it.

Many therapists begin by trying to treat a person's personality difficulties and see personality as the underlying cause of depression. The IPT therapist does not try to treat a person's personality and, in fact, recognizes that many behaviors which may seem enduring and life-long may be a reflection of the depression itself. That is, when you are feeling depressed, you may seem dependent, self-preoccupied and irritable; yet, when your depression lifts, many of these supposedly enduring traits also disappear.

Therefore, the main thrust of IPT is to try to understand how the symptoms came about and how they are related to your current social and personal life. The IPT therapist will look for what is currently going on in your life (the "here and now" problems) rather than problems in your childhood or past.

The idea will be to encourage you to cope with these current problems and to develop self-reliance outside of the therapeutic situation. The time limited part of the treatment precludes any major reconstruction of your personality. Many patients feel much better once their depression lifts and go on leading lives that are fulfilling and satisfying.

Goals of IPT

The goals of IPT are:

- To reduce your symptoms of depression, and improve your sleep, appetite and general outlook on life
- To help you deal better with the people and situations in your life

The IPT therapist will focus on:

- Your current problems in the "here and now"
- People who are currently important in your life
- Helping you to evaluate your current life
- Helping you to master current problems by changing how they seem, how you deal with them and developing new friendships and relationships

The IPT therapist will not:

- Interpret your dreams
- Have treatment go on indefinitely
- Delve into your early childhood

- Encourage you to free associate
- Make you feel very dependent on the treatment or therapist

In therapy you will be seen as a person in distress who is having symptoms which can be dealt with currently.

The IPT therapist will want to know:

- When your symptoms began?
- What was going on in your life when they began?
- What are the current stressors?
- Who are the current people involved in these current stressors?
- What are your disputes and disappointments?
- How are you coping with these problems?
- What are your strengths?
- Can you talk about situations that make you feel guilty, ashamed or resentful?

The IPT therapist will:

- Offer advice and give you suggestions for dealing with the problems
- Correct misinformation and suggest alternative ways of dealing with situations
- Help you develop resources on the outside

The IPT therapist will <u>not focus on</u>:

- Why you became what you are or where you are going
- Your childhood
- Your character
- Your defenses
- Why you feel guilty, shameful or resentful
- Your fantasy life or insight into the origins of the behavior

To help develop an understanding of how your depression began and what was going on in your life that may have brought it about, you might answer the following questions:

Understanding How Your Depression Began

- What are your current problems?
- What persons are currently important to you?
- When did you start feeling depressed, sad, blue?
- What was going on in your life when you started to get depressed?
- Are there disputes in your life now?
- How are you dealing with these disputes?
- What are your current disappointments?
- How are you dealing with these disappointments?
- What situations make you feel guilty, ashamed, angry?
- What are your stresses?
- What do you see as the things that you can do well?

Common Questions and Concerns about Psychotherapy

Psychotherapy is not a "normal" experience for most people. Following are some of the common questions that patients have about psychotherapy.

Is My Therapist a Friend?

If you don't have close family or friends, the therapist can seem to be a substitute. It is important not to make this mistake. An ethical therapist will not confide in you about his/her problems or share social activities with you, but will try to help you to use this relationship to form new friendships and strengthen old ones outside of the office. The message will be: who could you talk to among your friends and family as you are talking to your therapist? The therapy should help you see problematic relationships in a different light, so that you can begin to understand why people might be acting the way they are toward you.

You do not need to bring gifts to the therapist. **You should not expect to see the therapist outside of the therapeutic relationship or to learn about the therapist's personal life and family.**

I've Nothing to Talk About

Silence occurs in any type of psychotherapy and is a normal part of the treatment. It may indicate your discomfort with the therapist or with your thoughts. However, IPT is a treatment in which patient and therapist share responsibility for

bringing up topics to discuss and explore. When emotionally laden material has been discussed, it may be followed by a period of silence. If a situation is very charged, there may be a period in which you cannot talk about it. The therapist will probably not probe because it might be more helpful to you to try to bring the material up spontaneously rather than to fit it into some preconceived questions.

Even though there is silence, this does not necessarily mean that no work is going on. The therapy involves sharing the experiences of the time, which may include silence as well as active discussion.

If silence is a persistent problem, then you and the therapist will need to discuss it. It may be possible that you have done so well and are feeling so good that there is nothing more to talk about. In this case, termination of treatment should begin. If you or the therapist do not feel that the problems are solved, then you might try to figure out what is preventing discussion of issues at hand. Are you guilty about something? Ashamed? Fearful of what the therapist will think of the information? Feel that something is inappropriate? That you will receive disapproval?

Alternatively, you and the therapist will need to consider whether silence is your way of dealing with problems interpersonally. Do you have a habit of habitually pouting rather than voicing legitimate complaints? If this is the case, it might be helpful to learn the annoying effects of silence on others and how it is a relatively unproductive form of communication for you.

I'd Like to End Treatment Early

Ending treatment early can be the most successful way to avoid work in therapy. If you want to leave early, you and your therapist ought to consider why this is so. Do you feel that the problem has been dealt with adequately and that you are no longer depressed and there is no need to continue? Or do you want to avoid issues? Are you having a dispute with the therapist or do you not find the therapist helpful? Are you so depressed that you're giving up earlier? It will be helpful to you to discuss openly and candidly these reasons for wanting to terminate early. Some of these reasons may be a reflection of how you handle close relationships and it may be useful for you to learn that.

Other reasons might be realistic; IPT might not be the appropriate treatment for you and you may wish another treatment. The therapist may be able to help you evaluate your need for other treatment and may help you to find it. **The therapist should not be insulted if you raise an issue about leaving early.**

Can My Family Come to Treatment?

It is often helpful to have significant family members (spouse, parents) participate in one or more therapy sessions. This is especially true if there are marital or parent/child problems. The joint sessions which you and the other person attend may be used to obtain additional information, obtain the cooperation of the significant other, or to facilitate some interpersonal problem-solving and communication. IPT has been developed for couples who have marital disputes (joint marital therapy) where both parties want to participate. Your therapist may feel that this would be helpful to you. You should feel free to ask the therapist if a family member can attend and the therapist may also request it, especially in the initial sessions. If you are a minor, then it is imperative that your parents attend the initial sessions.

Participation of a family member, however, does not violate confidentiality. The therapist will not discuss the content of your sessions with the other person and any additional contact the other person has with the therapist will be reported and discussed with you.

I Don't Like to Discuss Intimate Things

There may be some topics (childhood events, intimate relationships, sexual feelings) that you just don't want to discuss. When these topics come up you may repeatedly change the subject or openly refuse to discuss them.

You are free to discuss anything of concern to you and to avoid discussing those things that are difficult. However, it may be those difficult problems that are the key to some of the current ones. These topics will rarely surprise your therapist as they are part of most therapies.

Most people don't want to discuss emotionally charged material with a stranger and can find this upsetting. It is very important that you feel you can trust your therapist before you disclose these topics. Therefore, it is natural that you may not want to discuss very intimate topics in the first few sessions. Then, as time goes on, you should feel more free to open up. You should be aware that although it is hard to accept feelings of rage, fear or envy, everyone has these feelings. The fact that you have feelings does not mean that you will act on them but, if you can understand them better, they may become less troubling and even make sense.

The more freely you can discuss intimate and uncomfortable issues the better your therapist will understand your situation and will be able to provide more help.

Will I Get Depressed Again When IPT Ends?

Most recovered depressed patients are concerned about whether they are going to get depressed again. About 40 percent of people who have a depression never have another episode. Many patients have recurrences. Our information on the prevention of recurrences is increasing. In psychotherapy, you will become aware of the situations that put you at risk for another episode and will learn how to deal with those situations before they get to you and result in symptoms. You will also learn how to recognize early symptoms of depression when the sleep problems and low mood begin to return. For those times, you will have a trusted person (your doctor or therapist) to whom you can go for prompt initiation of treatment. We call this "maintenance".

Most people who have had one depression and have recovered from it return to normal and are able to do the things they used to do with zest and vigor. At times, you may get better without treatment when the situation that has put you at risk has subsided and you have learned to deal with it better.

The key is to learn what the early symptoms of your depression are, what situations bring it about and to learn to deal with these promptly and effectively. IPT tries to teach these skills.

I Think I Need More Treatment

In some cases, patients need more treatment while continuing the IPT. It may be another kind of psychotherapy or a psychotropic medication. These should be openly discussed with the therapist. An additional consultation with a psychiatrist who is experienced with use of psychotropic medication may be useful.

Am I Avoiding Treatment?

It is very common to believe that your therapist is omnipotent and that you do not need to make any effort to solve your problems yourself. It is common to feel that you can sit back and wait for the therapist to take charge. When you find that the therapist is not omnipotent, you may begin to develop subtle ways of avoiding the treatment, ways that may seem perfectly justified to you. Some of these behaviors include being late, missing appointments, silence or refusing to talk in treatment, excessive discussion of trivial material, directly being uncooperative or refusing to come to treatment. It is important to determine whether there is a realistic basis for these behaviors. Is it that you feel the therapist is unhelpful? Or perhaps you just do not like this therapist and want to discuss alternatives, in which case it will be useful for you to bring this up directly. Discuss with the therapist the alternatives and your specific dissatisfactions with the progress you are making. This type of discussion may lead to a better understanding of how to use treatment

and a clarification of your own problems, or may lead to a renegotiation of the contract with the therapist, perhaps for a different type or additional treatment.

A direct approach with the therapist is preferable to subtle sabotaging and will ultimately help you to learn how to express yourself and negotiate outside of therapy. If you repeatedly avoid discussion of issues in close interpersonal relations with friends, family and lovers, this may have a dampening effect on these relationships. You ought to consider why you do not want to bring up certain topics, what impact that has on others, and if it has impeded progress in therapy.

Depression often makes people feel helpless and incompetent even when they are not. You need to try to work in the therapy even though the fatigue, self-blame and hopelessness of depression may at first make it difficult. Hopefully, you will begin to feel better.

Can I Live Without My Therapist?

Depressed patients often underestimate their own capabilities when they are depressed and feel that others may provide things that they can easily obtain for themselves. It is natural to feel dependent on the therapist, especially if you have experienced this as helpful. However, the type of help offered is focused and limited.

The IPT therapist will help you to recognize your own personal strengths and capabilities. As you begin to feel better and to deal better with your problems some of your reliance on the therapist should disappear.

How Does IPT Work?

Most patients, especially if they have never been in psychotherapy, have legitimate questions as to how talking to a stranger can possibly help them with their problems.

The elements of psychotherapy are not a mystery. They include a relationship with someone you can trust, who will be an advocate for you, will hold what you say in strict confidence and will not take a judgmental approach or decide what is right or wrong for you.

You should begin to see unrecognized feelings and learn what it is you want, what is troubling you, what you fear and how you may find better solutions in a more constructive fashion.

Sometimes the source of your mood disturbance may be unclear. At other times, the source of the relationship problems may be unclear. For example, you

may find that you got depressed around the time of a move. Then you realize that it wasn't the new location that caused the depression but the changes in relationship that occurred around the move, e.g., your spouse became less attentive and you fear losing this relationship. Sometimes depressed mood is really anger and fear. You may learn how to deal directly with the anger feelings or unrealized wish.

Techniques in IPT

Many patients are curious about how the psychotherapy may proceed and how it differs from ordinary friendship or counseling. Of course, there are many similarities. While the psychotherapist wants to help you, the psychotherapist is not your friend and the relationship is not a substitute for friendship. In psychotherapy you can talk quite openly about your problems, your hopes and fears. Your ability to be open is one indication that you are capable of an intimate friendship. However, the therapist is not friend or family; the relationship is not reciprocal in that the therapist does not share holiday celebrations, social events or other activities outside of the office and does not confide in you about his/her own problems.

The relationship is an opportunity to talk to someone who will not judge you based on your feelings and wishes. The feelings and wishes may be thwarted in your current relationships and may be associated with your depression. Instead, the therapist will help you to process them.

The therapist will help to bring out information that will show you how to understand the problems you are having. He/She will also encourage you to express your feelings about the problems, the painful feelings as well as the pleasant ones.

The therapist will not attempt to make you feel guilty and will not be judgmental. The therapist will offer you reassurance and clarify contrasts or contradictions in your presentation and will help you to examine and identify problems you might have in discussing your feelings. At other times, the therapist will be directive, providing information and advice so you can solve practical problems. The therapist will help you to make decisions by helping you to consider a wide range of alternative actions and their consequences. **A therapist will say things such as, "What choices do you feel you now have? Let's consider all the choices that are open to you.".**

A legitimate question that patients often ask in psychotherapy is: "What are the specific techniques that my therapist is using to help me? Is it all hit or miss? Is there a planned effort?". Specific techniques are used with different frequencies and in different order depending on the characteristic of your problem.

Therapeutic Relationships. Sometimes the therapist will use your relationship in therapy as a way of helping you to understand how you come

across to others and understand some of the problems you are having in interpersonal relationships.

Exploratory. Some techniques are considered exploratory, the idea being to gain information about your symptoms and your problems. In this case, the therapist will ask you general, open-ended questions in order to obtain basic information about you. What is the nature of your symptoms? When did they begin? Who is important in your life? The therapist may: encourage you to continue on a specific topic; invite you to return to a topic discussed earlier; or repeat some key or charged words you were using if he/she feels that this is important in understanding the nature of your problem.

The therapist will use many techniques to try to encourage you to continue talking in areas where he/she feels that this will be useful to you. The therapist might say, "I see, please continue," and use other comments to encourage you to continue talking. The basic idea is to bring up new material, identify areas which were not touched on in the earlier sessions or update events that occurred since the previous session. In this way, the therapist is non-directive and refrains from trying to structure the sessions and force you to talk about things that may be more on the therapist's mind than yours.

Direct Questioning. At other times, the therapist may be very direct and ask specific questions to obtain new information, e.g., "Tell me about your husband"; "Tell me about who is important"; "Tell me who you saw this week"; or, "Tell me about your friends and family".

Encouragement of Affect. The work in therapy is not just intellectual, but is geared to helping you deal with your feelings as a way of bringing about change. This process is known as the affective experience. The therapist will help you: to acknowledge and accept painful feelings that may not be changeable; and to use your affective experience in bringing about desired interpersonal changes, e.g., to understand and explore relationships that are troublesome, that are painful, or that make you angry. Also, the therapist will help you develop new and unrecognized positive affect which, in turn may facilitate your interpersonal growth, e.g., who you feel positive about, who you love.

Accepting Painful Feelings. Many depressed patients feel guilt related to strong, angry or sexual feelings about significant others. You may only be partially aware of such feelings or you may be totally unaware of them. For example, one part of a distorted grief reaction is feeling angry about being abandoned. Perhaps because your loved one has died, you may feel it is unacceptable to express your anger. The therapist will help you to express

your anger and reassure you that most people feel this way when they have been left by a loved one. In helping you to express your hostile, angry or sexual feelings, the therapist will make clear the difference between feelings and actions. While you may have these feelings you will not necessarily act upon them.

The therapist will help you deal with your strong feelings of sadness, anger, love, hate and guilt in different ways. If you are troubled and flooded by intense feelings, you may learn to understand them and keep them under control, particularly if they are under-productive. You may also delay impulsive actions. On the other hand, the clarifications of these feelings may help you to deal more directly with what your needs are. For example, your guilt about the death of a loved one may be preventing you from moving on to the next step. Understanding guilt, as well as abandonment and anger fantasies, may help you to see this in perspective.

Clarification. The therapist will clarify some of the statements that you have made by repeating or rephrasing them him/herself, by calling attention to the logical extensions of what you say or to contrasts or contradictions in your thoughts and feelings.

Communication Analysis. Communication analysis is used to examine and identify failures in communication and to help you to express your feelings and wishes more directly. If you are unable to directly express your thoughts/ feelings/ intentions or if you present them in an ambiguous, indirect verbal way (sulking or anger), this faulty communication can be responsible for your disputes with others. In other cases, being distressed may lead you to incorrect assumptions as to what was communicated. A common incorrect assumption is that your loved one will understand you and will know exactly what you mean even if you don't state what you are thinking and feeling. An analysis of your communication pattern is aimed at identifying these and other miscommunications or problems. This helps you learn how to communicate more directly, as well as to listen to others more clearly.

The Therapist's Role

The different types of psychotherapy share many common features. But there are certain characteristics of IPT which may or may not overlap with other psychotherapies.

- **The therapist is the patient's advocate and is not neutral.**
- **The therapist will be on your side and will try to understand things from your point of view.** This does not mean that the therapist will agree with everything you do.

However, the therapist will help you resolve your problems, will not be judgmental and will not encourage you to regress into a dependent relationship.

- The therapeutic relationship is not part of transference. The patient's expectations of assistance and understanding are realistic, and are not seen as some reenactment of the patient's previous relationships with others. While IPT therapists offer assistance, it is limited to helping you learn new ways of thinking about yourself in social roles and solving interpersonal problems.

- **The therapeutic relationship is not a friendship.** While the therapist may express personal opinions or give examples of handling situations in their own lives, the therapist does not reveal him/herself nor provide a reciprocal relationship. In order to help you out of your depression, he/she may become active in helping you with life problems, perhaps by testifying in court or making arrangements with other medical or psychological professionals for care. However, the therapist will not become involved with you socially or in a business relationship.

- **The therapist is active not passive.** The therapist takes a moderate position in being active, helping you focus on bringing about improvement in the current situation. In the first session, the therapist asks the history of your symptoms and personal situation and asks direct questions in setting goals. In the intermediate sessions, the therapist is active in guiding you to cover the material that is relevant to the treatment goals and asking for more detailed information in the agreed upon problem area.

  Although the therapist is active, the ultimate responsibility for change lies with you. Even if the therapist could solve your problems, that is not the intention. The idea is to help you learn to solve your own problems and pursue your own goals.

What Credentials Should My Therapist Have?

IPT is designed to be used by psychologists, psychiatrists, psychiatric social workers and psychiatric nurses who have at least several years of clinical experience in psychotherapy with depressed patients. The therapist should also have a professional degree: an M.D., Ph.D., M.S.W., R.N., or equivalents. With the

rapidly emerging research on the efficacy of IPT, there has been considerable interest from experienced psychotherapists in learning IPT. The training programs have not kept pace with the demands. This situation is changing and many psychotherapists are receiving training in IPT. Even if your therapist has not received training in IPT, some of the issues discussed in this book may be useful if you are undergoing time-limited psychotherapy for depression as an outpatient.

In addition to the therapist's training, you should choose a therapist that you feel comfortable with. Of course, in the beginning you may not feel comfortable since the therapeutic situation is somewhat unnatural. Give it a chance. If after a month or so you just don't feel comfortable talking to your therapist, first discuss it directly. Be sure that it is not just discomfort in seeking help. However, an option of finding another therapist should always be available.

Reference for the Psychiatric and the Primary Care Guidelines for the Treatment of Depression

- Karasu, T.B., Docherty, J.P., Gelenberg, A., Kupfer, D.J., Merriam, A.E., & Shadoan, R. (1993). Practice guideline for major depressive disorder in adults. American Journal of Psychiatry, 150 (Suppl. 4), 1-26.

- U.S. Department of Health and Human Services. (1993). Clinical practice guideline. Depression in primary care: Detection and diagnosis, 1 (Publication No. 93-0550). Rockville, MD: Agency for Health Care Policy and Research.

- U.S. Department of Health and Human Services. (1993). Treatment of major depression. Depression in primary care: Clinical practice guideline, 2 (Publication No. 93-0551). Rockville, MD: Agency for Health Care Policy and Research.

- U.S. Department of Health and Human Services. (1993). Quick reference guide for clinicians. Depression in primary care: Detection, diagnosis, and treatment (Publication No. 93-0552). Rockville, MD: Agency for Health Care Policy and Research.

- U.S. Department of Health and Human Services. (1993). Depression is a treatable illness. A patient's guide (Publication No. 93-0553). Rockville, MD: Agency for Health Care Policy and Research.

CHAPTER 3

Beginning IPT

The First Few Visits

During the first few visits your IPT therapist will begin to know you and then will collect information about your symptoms in order to insure that you have a clinical depression. If you have not had a physical examination recently and especially if you are over the age of 40, one may be recommended to rule out any physical explanations for your symptoms.

During the first visits to help you with your depression your therapist will:

- **Review the depressive symptoms and make a diagnosis**
- **Explain depression and the various treatment options to you**
- **Evaluate your need for medication**
- **Relate depression to your current problem by finding out what was going on in your life when you became depressed**
- **Make a treatment contract and tell you what to expect in treatment**

Reviewing the Symptoms and Making the Diagnosis

The IPT therapist will ask you questions to determine whether you have a major depression. These questions will help the therapist determine whether you meet the criteria for a depression.

An adapted version of the most recent criteria for Major Depressive Episode according to the American Psychiatric Association is listed below. Note that almost all must occur nearly every day.

DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSIVE EPISODE ADAPTED FROM THE AMERICAN PSYCHIATRIC ASSOCIATION (DSM-IV)
A. At least five of the following symptoms present during the same two-week period. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. 1. Depressed mood, most of the day

2. Diminished interest or pleasure in all or almost all activities most of the day
3. Significant weight loss when not dieting, weight gain or change in appetite
4. Insomnia or hypersomnia (oversleeping)
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or guilt
8. Diminished ability to think or concentrate or to make a decision
9. Recurrent thoughts of death or suicide ideas, a suicide attempt or a specific plan

B. The symptoms are not associated with a manic episode

C. The symptoms cause distress or impairment in functioning socially, at work or in other areas

D. The symptoms are not due to the direct effects of a drug or a medical condition

E. The symptoms are not accounted for by the death of a loved one within the past two months. Symptoms which persist for more than 2 months after a death and are characterized by marked impairment are considered depression.

The following are some questions that will help your therapist decide whether you have a major depressive problem. They are intended to assist you and your therapist in reaching a diagnosis. **Don't try to make a diagnosis yourself. The worksheet questions in this book are not a substitute for treatment.** Complete the following questions to the best of your ability directly in the book by checking Yes, No or Don't Know. Bring the results to your therapist.

A. Depressive Symptoms

Depressed Mood

1. How has your mood been in the past two weeks?_____

_____

2. Have you felt down in the dumps? depressed? sad?

☐ Yes ☐ No ☐ Don't Know

3. Have you been tearful?

☐ Yes ☐ No ☐ Don't Know

4. Have these feelings gone on most of the day?

☐ Yes ☐ No ☐ Don't Know

If yes, nearly everyday?

☐ Yes ☐ No ☐ Don't Know

Diminished Interest or Pleasure

1. Have you lost interest or pleasure in most of the activities you used to enjoy?

☐ Yes ☐ No ☐ Don't Know

2. Has your loss of interest or pleasure been for most of the day, nearly everyday?

☐ Yes ☐ No ☐ Don't Know

Weight Loss or Gain

1. Has your appetite been poor?

☐ Yes ☐ No ☐ Don't Know

2. Have you lost weight?

☐ Yes ☐ No ☐ Don't Know

If yes, how much weight? _____lbs.

3. Have you been dieting?

☐ Yes ☐ No ☐ Don't Know

4. Have you gained weight?

☐ Yes ☐ No ☐ Don't Know

If yes, how much weight? _____lbs.

5. Have you had an increase or decrease in appetite?

☐ Yes ☐ No ☐ Don't Know

If yes, nearly everyday?

☐ Yes ☐ No ☐ Don't Know

Insomnia or Hypersomnia (Oversleeping)

For nearly every day in the past two weeks:

1. Have you had trouble with your sleep?

☐ Yes ☐ No ☐ Don't Know

2. Have you had problems falling asleep?

☐ Yes ☐ No ☐ Don't Know

3. Have you had to take sleeping pills?

☐ Yes ☐ No ☐ Don't Know

4. When you fall asleep, do you sleep well?

☐ Yes ☐ No ☐ Don't Know

5. Do you keep waking and have to get out of bed?

☐ Yes ☐ No ☐ Don't Know

6. Do you wake early in the morning?

☐ Yes ☐ No ☐ Don't Know

or

Do you sleep too much?

☐ Yes ☐ No ☐ Don't Know

Psychomotor Agitation or Retardation

1. Are you very restless?

   ☐ Yes ☐ No ☐ Don't Know

2. Do you have to keep moving?

   ☐ Yes ☐ No ☐ Don't Know

3. Are you slowed down?

   ☐ Yes ☐ No ☐ Don't Know

4. Are you so slowed down you have problems thinking?

   ☐ Yes ☐ No ☐ Don't Know

Fatigue or Loss of Energy

1. Are you tired nearly everyday?

   ☐ Yes ☐ No ☐ Don't Know

2. Have you lost your usual energy?

   ☐ Yes ☐ No ☐ Don't Know

3. Do you spend a lot of time in bed?

   ☐ Yes ☐ No ☐ Don't Know

4. Do you tire easily?

   ☐ Yes ☐ No ☐ Don't Know

Feelings of Worthlessness or Guilt

1. Do you feel you're a bad or worthless person?

   ☐ Yes ☐ No ☐ Don't Know

2. Have you blamed yourself for things you have done?

☐ Yes ☐ No ☐ Don't Know

3. Have you been down on yourself and think you are a bad person?

☐ Yes ☐ No ☐ Don't Know

4. Do you feel that you have let your friends and family down?

☐ Yes ☐ No ☐ Don't Know

If yes, do you feel guilty about it?

☐ Yes ☐ No ☐ Don't Know

5. Have you felt that you are to blame for your feelings?

☐ Yes ☐ No ☐ Don't Know

Diminished Ability to Think or Concentrate or to Make a Decision

1. Do you have problems thinking or concentrating?

☐ Yes ☐ No ☐ Don't Know

2. Do you have trouble making decisions?

☐ Yes ☐ No ☐ Don't Know

Recurrent Thoughts of Death or Suicide, or Attempts

1. Do you think about death a lot?

☐ Yes ☐ No ☐ Don't Know

2. Have you felt life is not worth living?

☐ Yes ☐ No ☐ Don't Know

3. Have you wished you were dead?

☐ Yes ☐ No ☐ Don't Know

4. Have you had any thoughts about taking your life?

☐ Yes ☐ No ☐ Don't Know

5. Do you have any plans to do so?

☐ Yes ☐ No ☐ Don't Know

If yes, discuss with your therapist or a physician immediately.

6. Have you made an attempt on your life?

☐ Yes ☐ No ☐ Don't Know

If yes, describe when and how. _____

_____

_____

B. Manic Symptoms

1. Have you ever had periods in your life when you were feeling very high, manic?

☐ Yes ☐ No ☐ Don't Know

2. Needed less sleep?

☐ Yes ☐ No ☐ Don't Know

3. Were you more talkative than usual?

☐ Yes ☐ No ☐ Don't Know

C. Impairment

1. Did your symptoms of depression cause you distress?

☐ Yes ☐ No ☐ Don't Know

2. Did they interfere with your work, social or family life?

☐ Yes ☐ No ☐ Don't Know

D. Drugs, Medical Illness

1. Were any of your symptoms due to medications or any drugs?

☐ Yes ☐ No ☐ Don't Know

If yes, describe._____

_____

2. Were they due to a medical problem?

☐ Yes ☐ No ☐ Don't Know

If yes, describe._____

_____

E. Bereavement

1. Did someone you love die within the last year?

☐ Yes ☐ No ☐ Don't Know

Anxiety, Alcohol or Drugs

It may not be possible for the therapist to determine your diagnosis immediately. It is possible to have another disorder instead of (or in addition to) depression, such as anxiety or problems with alcohol or drugs.

The following questions will help your therapist decide whether you have a problem with anxiety and/or alcohol or drugs. Again, these are to assist you and your therapist in reaching a diagnosis. **Don't try to make a diagnosis yourself.** Complete the questions as best you can right in the book by checking Yes, No, or Don't Know. Bring the results to your therapist.

A. Anxiety

1. Have you been feeling nervous?

☐ Yes ☐ No ☐ Don't Know

2. Have you been feeling anxious?

☐ Yes ☐ No ☐ Don't Know

3. Have you been feeling frightened?

☐ Yes ☐ No ☐ Don't Know

4. Do you find it hard to relax?

☐ Yes ☐ No ☐ Don't Know

5. Do you worry about little things?

☐ Yes ☐ No ☐ Don't Know

6. Have you had sudden unexpected attacks of panic or intense fear?

☐ Yes ☐ No ☐ Don't Know

7. Are you fearful when home alone or going out alone?

☐ Yes ☐ No ☐ Don't Know

8. Have you suffered from trembling?

☐ Yes ☐ No ☐ Don't Know

9. Have you suffered from shakiness?

☐ Yes ☐ No ☐ Don't Know

10. Have you suffered from sweating?

☐ Yes ☐ No ☐ Don't Know

11. Have you suffered from feelings of suffocation or choking?

☐ Yes ☐ No ☐ Don't Know

12. Have you suffered from butterflies or tightness in the stomach?

☐ Yes ☐ No ☐ Don't Know

B. Alcohol and Drugs

1. Have you felt that you ought to cut down on your drinking or drug use?

   ☐ Yes ☐ No ☐ Don't Know

2. Have people complained about your drinking or drug use?

   ☐ Yes ☐ No ☐ Don't Know

3. Have you had to drink or use drugs in the morning to steady your nerves?

   ☐ Yes ☐ No ☐ Don't Know

4. Has your drinking or drug use interfered with work, social or family life?

   ☐ Yes ☐ No ☐ Don't Know

5. If yes to any of the above on alcohol, describe what kind of alcoholic drinks and how much you drink in a usual day.

   _____

   _____

6. If yes to any of above on drugs, describe what drugs you are using and how much in a usual day.

   _____

   _____

Explaining Your Diagnosis and Treatment

If the results of your physical examination (either currently or in the past) show no specific medical cause for these symptoms, that does not mean that the symptoms are not real or that you are not feeling badly. These symptoms probably are part of being depressed. Your therapist will explain what depression is and will be optimistic about your future.

Facts about Depression

- **It is common**
- **It is not something you willed**
- **You will recover**
- **You will return to your usual self**

Depression is a common disorder. It affects three to four percent of adults at any one time. Depression may feel like a hopeless condition. Even though you are suffering now, depressions do respond to treatment. The outlook for your recovery is excellent. There are many different treatments available, many different medications and different psychotherapies, so that you do not need to feel pessimistic if the first one does not work.

Most people with depressions recover quite quickly with treatment and some recover without treatment, although it may take longer. The prognosis is good even though some people may need continuing treatment for long periods of time in order to prevent recurrence. Once you receive treatment, you should return to your normal functioning when the symptoms disappear. There are a variety of standard treatments, psychotherapy is one of them.

While you are depressed you may not feel like being sociable or doing the things that you usually do. You may need to explain this to your family members. However, you are going to be actively engaged in treatment and will be working hard towards recovery. The expectation is that as you recover you will resume your normal activities and should be back to normal if not better. In fact, there is every reason to hope that you will be better than before, although it may be harder to believe this when you're feeling down and hopeless.

The underlying message is that depression is a disorder in which you are not fully in control, but from which you will recover without serious residual damage. Treatment will hasten the recovery. Depression is not a failure, nor a sign of weakness, nor a punishment for past misconduct nor even a deliberate act. It is not something you have willed.

Do I Need Medication?

Whether medication is prescribed or not will depend on the severity of your symptoms, your preference, your previous experience with medication and medical considerations. In general, if you have a severe sleep disturbance, appetite disturbance, agitation, severe depression and there are no negative medical considerations, medication would be a choice, usually in combination with psychotherapy.

The presence of a life stress which brought on the depression does not preclude the use of medication, either with or without psychotherapy.

The clinical feature in evaluating the need for medication is the severity of the symptoms and the presence of specific ones, such as agitation, retardation, serious loss of interest in life, problems in thinking or suicidal feelings.

If you are already on medication and you and your doctor feel you should continue, there is no reason why IPT cannot be added.

Relating Depression to Your Current Problems

Once it is determined that you have a clinical depression, the therapist will ask you what is going on currently in your social and family life that may be associated with the onset of the symptoms. The therapist usually reviews the key persons in your life to get a full picture of who is important to you. There are different ways of obtaining this information, but the idea is to define the current primary problems that may be related to your depression.

It is useful to begin with a review. The therapist will ask what was going on in your life and what was happening at about the time you started feeling badly at work, at home, with your family, friends. Were there any changes? When you started to feel depressed, what was going on in your life? Was there a disappointment in a love relationship? Did your marriage begin to have problems? Were you and your children or parents in a dispute? Did your child leave home? Did you take a new job? Did someone move in with you? Did you move yourself? Was it the anniversary of someone's death? Were there any big changes? Were you put in situations where you had to meet new people and establish relationships?

These are some of the common life circumstances that are often associated with depression. Your therapist will try to understand what might have triggered the onset of this episode of depression.

The following questions are intended to help you and your therapist find the social and interpersonal context of your depression, to define your current problems and to determine which problems may be related to the onset of your depression. These questions may not be easy to answer but complete them to the best of your ability directly in the book by checking Yes, No or Don't Know. **There are no right or wrong answers. These problems may change over time. Additional copies of all worksheets may be purchased through Graywind Publications Incorporated. It is recommended that you fill out these forms once again at the end of treatment to carefully monitor changes in your depression and its interpersonal context.**

During the intermediate sessions of IPT, you and your therapist will choose 1 or 2 problem areas to work on. These problems may change over the course of treatment. Do not be concerned if this happens. If you are not in IPT treatment you may want to use these forms to help understand the problems associated with your depression.

1. When did your symptoms of depression first begin?

   _____ (Month) _____ (Year)

   Is this the first time you were depressed?

   ☐ Yes ☐ No ☐ Don't Know

   If this was not your first episode of depression when did this episode begin?

   _____ (Month) _____ (Year)

2. Think about what was going on in your life when you started to feel depressed this time.

   Did someone you care about die?

   ☐ Yes ☐ No ☐ Don't Know

   Was it the anniversary of someone's death?

   ☐ Yes ☐ No ☐ Don't Know

   Were you thinking about someone who died?

   ☐ Yes ☐ No ☐ Don't Know

   Were you having problems at home with your spouse or partner?

   ☐ Yes ☐ No ☐ Don't Know

   Were you having problems with your children?

   ☐ Yes ☐ No ☐ Don't Know

Were you having problems with your parents?

☐ Yes ☐ No ☐ Don't Know

Were you having problems with your sisters or brothers?

☐ Yes ☐ No ☐ Don't Know

Were you having problems with your in-laws?

☐ Yes ☐ No ☐ Don't Know

Were you having problems at work?

☐ Yes ☐ No ☐ Don't Know

Were you having problems with friends?

☐ Yes ☐ No ☐ Don't Know

Were you having problems with others?

☐ Yes ☐ No ☐ Don't Know

Were there more arguments with family or friends?

☐ Yes ☐ No ☐ Don't Know

Were you disappointed in a love relationship?

☐ Yes ☐ No ☐ Don't Know

Did your marriage begin to have problems?

☐ Yes ☐ No ☐ Don't Know

Were you going through a divorce or separation?

☐ Yes ☐ No ☐ Don't Know

Did your children leave home?

☐ Yes ☐ No ☐ Don't Know

Did you take a new job?

☐ Yes ☐ No ☐ Don't Know

Did you lose your job?

☐ Yes ☐ No ☐ Don't Know

Did you get promoted?

☐ Yes ☐ No ☐ Don't Know

Did you retire?

☐ Yes ☐ No ☐ Don't Know

Did you move?

☐ Yes ☐ No ☐ Don't Know

Did someone move in with you?

☐ Yes ☐ No ☐ Don't Know

Did you have financial problems?

☐ Yes ☐ No ☐ Don't Know

Did you start living alone?

☐ Yes ☐ No ☐ Don't Know

Was there serious illness in your family?

☐ Yes ☐ No ☐ Don't Know

Did you become ill?

☐ Yes ☐ No ☐ Don't Know

Were you put in a situation where you had to meet new people?

☐ Yes ☐ No ☐ Don't Know

Were you lonely?

☐ Yes ☐ No ☐ Don't Know

Were you bored?

☐ Yes ☐ No ☐ Don't Know

Were there any big changes in you life?

☐ Yes ☐ No ☐ Don't Know

Obviously these problems are not mutually exclusive and you may find during the course of treatment that what you thought was a key problem was really only the tip of the iceberg.

The problem areas that the IPT therapist will focus on tend to fall into four groups:

- **Grief**
- **Disputes with spouse, lover, children, other family or co-workers**
- **Transitions (a new job, leaving one's family, divorce, going away to school, a move, a new home, retirement.)**
- **Interpersonal deficits (loneliness, social isolation, boredom)**

You may have more than one problem, most depressed people do. But for the purpose of helping to solve a problem, the therapist will try to focus on one or two during the course of your treatment. Many times the problems will change over the course of treatment. For example a woman who comes in saying, "My children are a big problem to me," may later, as she gets to know the therapist, bring up the more pressing area of distress - her spouse's extra-marital affair. There are many such examples. The idea is to identify the most recent stresses that you are trying to deal with and try to manage those.

Don't worry if it takes a while to discover what is really troubling you.

Avoiding the Interpersonal Context

Some patients at this point will tend to focus on the physical symptoms of depression, such as the sleep and appetite problems, because these may seem the most distressing. They may even feel that there is no connection between their life circumstances and these symptoms, or they may feel fear secretly, or openly discuss their fear of having some undetected physical illness. The latter is common and often only a fear. Of course, depression can appear in a variety of physical illnesses. That is why a physical examination is usually called for to help in the diagnosis. **Over the next few weeks, you and your therapist might try to understand what is behind some of the symptoms that are making you uncomfortable. Give the opportunity to explore these issues a chance to see if this helps you feel better.**

The Treatment Contract

In the first few sessions the diagnosis of depression is established and some of the interpersonal problems in your life are identified. The therapist will then make a treatment contract with you. The therapist may explain again the relationship which often occurs between the symptoms and problems in your life. While the cause of depression is unknown, it is often associated with problems with personal relationships, including dealings with your spouse, children, family or colleagues. Problems in relating to others, loss of loved ones or significant life changes may bring on a depression in some people. For others, the symptoms of depression prevent them from dealing with other people as successfully as they usually would.

In IPT you will try to discover what you want and need from others, you will learn what alternatives there are and how to get them, and you will also learn what options are unrealistic and impossible.

The therapist will give you an initial understanding of the problem as he or she sees it and will emphasize the following:

- **The discussions will be primarily focused on your life as it is now.**
- **Therapy will focus on your relationships with important people in your life.**
- **You will be expected to discuss these relationships and your feelings honestly. If you feel that the direction of the sessions is not useful let the therapist know.**

- **The expected duration and frequency of the treatment will be discussed, including how often you'll be meeting. The usual time is once a week for about 50 minutes over three to four months, although this may vary. Depressed persons who recover but require maintenance treatment to prevent recurrence may continue treatment for extended periods. This may be at a reduced frequency, e.g., every two weeks or even monthly.**

- **The interpersonal problem areas (grief, disputes, transitions, deficits) as seen initially will be discussed with you, although the problems may change.**

- **You can expect that everything you tell your therapist will be in confidence.**

- **Your role in the therapy will be explained.**

You will be told that your job is to talk about things that concern you relative to your depression and your interpersonal life. Your therapist will be interested both in what happens to you between sessions and in your feelings about these events. It will be your job to select the topics that are most important to you, since you are the one who knows best what your problems are.

There are no right or wrong things to talk about and you are free to talk about your relationship with the therapist or the therapy itself. Sometimes ideas or feelings will come to mind that do not make sense or may seem embarrassing and it will be important to discuss these.

General Procedures for Entering the Intermediate Session

Following the diagnosis, the identification of the problem areas and the establishment of the treatment contract, the work of IPT begins. As noted before, problems usually fall into one of four areas: **Grief, Interpersonal Disputes, Transitions or Interpersonal Deficits.**

Each problem will be defined and the strategies and goals used in IPT discussed. You can expect that the therapist will usually begin each session by asking how things have gone over the past week. The typical question will be, **"What has happened since I last saw you? What would you like to talk about today?".** If you can't recall, the therapist might remind you about your discussion the previous week. The session will usually end with a summary of what has been covered and how it relates to your overall problem.

Involvement of Others

Other family members may be asked to participate in one or two sessions if you and the therapist feel that it would be helpful. This usually occurs in situations involving family, husband/wife, parent/child or disputes which cannot be resolved.

This page intentionally left blank

CHAPTER 4

Grief

Grief is selected as a problem area when the onset of the person's symptoms are associated with a death, either recent or in the past, and the person is having problems coming to terms with it.

Normal Grief

All of us at some point experience the death of a beloved person. Many of the symptoms that occur around this time are similar to those of depression but the conditions are not the same. In a normal grief reaction, the person feels sad, may have trouble sleeping and may have difficulty carrying out their usual tasks. These symptoms resolve in a few months, as there is a gradual weaning from the remembered experiences of the loved one. The availability of family and close friends can be extremely helpful during this period. This period of grief or mourning is a normal and useful adaptation to the loss of a loved one and should not be discouraged.

Abnormal Grief

Abnormal grief reactions, which lead to depression, can also occur. This may happen when a severe grief reaction lasts longer than 2 months, or when grief does not occur or is postponed and then experienced in severe form long after the person has died. Sometimes it is difficult to recognize that these symptoms actually reflect mourning of a death that occurred several years before. At other times, instead of a sadness, a patient may develop many physical symptoms or even feel that they have the same illness as the person who has died.

An abnormal grief reaction may be diagnosed when your grief is very severe and lasts longer than 2 months or when a loved one has died and you did not have the normal mourning process. Tell-tale signs are the patient's failure to mention the dead person or to discuss the circumstances around the death.

The questions on the following pages will help your IPT therapist determine if there is an abnormal grief reaction. Complete the questions as best as you can right in the book and bring the results to your therapist. If you can't answer a question, just check "Don't Know".

1. Has someone who was important to you died?

   ☐ Yes ☐ No ☐ Don't Know

   If yes, how long ago? ____ (No. Months)

2. Can you talk about the dead person(s) with others?

   ☐ Yes ☐ No ☐ Don't Know

3. Were you feeling sad or blue after the death?

   ☐ Yes ☐ No ☐ Don't Know

4. Did you have trouble sleeping?

   ☐ Yes ☐ No ☐ Don't Know

5. Could you carry on as usual?

   ☐ Yes ☐ No ☐ Don't Know

6. Were you beyond tears?

   ☐ Yes ☐ No ☐ Don't Know

7. Did you avoid going to the funeral or visiting the grave?

   ☐ Yes ☐ No ☐ Don't Know

8. Did your depression begin around the time of the death?

   ☐ Yes ☐ No ☐ Don't Know

9. Are you afraid of having the same illness as the person who died?

   ☐ Yes ☐ No ☐ Don't Know

10. Were the deceased person's possessions left in place?

    ☐ Yes ☐ No ☐ Don't Know

11. Did you preserve their possessions?

    ☐ Yes ☐ No ☐ Don't Know

12. Were there people you could count on to help you when the person died?

☐ Yes ☐ No ☐ Don't Know

13. Were there people you could turn to and in whom you could confide?

☐ Yes ☐ No ☐ Don't Know

Patients who have suffered multiple losses and did not go through a period of grief (or who have not gotten over it), and/or have avoided circumstances around the death (such as going to the grave), are fearful of developing the same illness, are trying to preserve the environment of the dead person and/or did not have family or social support during the period of bereavement, are more apt to go through an abnormal grief reaction.

Disordered and delayed grieving can lead to clinical depression. In turn, depression cuts you off from your usual friends and social supports. You have less energy to do things and less hope of things turning out well. Thus, becoming depressed usually leads to social withdrawal and isolation, which only compounds the sense of being hopeless and cut off. This further delays the grieving process.

Goals in Treating a Grief Reaction

The goals of treating a grief reaction are to help you get through a mourning process with the support of your therapist and to help you reestablish interests and relationships that can substitute for what was lost. Your therapist will help you through the mourning process by:

- **Encouraging you to think about the loss in detail and by discussing the sequence and consequences of events prior to, during and after the death, and how you felt about it.**

The following are open ended questions to think about. Try to write down your response to the questions right in the book. It may be difficult to answer these questions and it may be difficult or painful to recall details. Try to recollect by reviewing old picture albums or by calling friends or family and talking with them about the deceased.

1. How did you learn about the death? _____

2. How did you feel when you first learned about the death? _____

3. What did the person die of? _____

4. How did he/she die? _____

5. When did you learn about the illness? _____

6. What was the person like who died? _____

7. What did you do together? _____

8. What was enjoyable? _____

9. What were the problems? _____

It is very common when reviewing the relationship with the deceased person to have memories about the pleasant times together but also to have angry, disappointed or unhappy feelings towards the deceased. You may even feel abandoned by the loved one. You will be encouraged to express these feelings openly since they are normal, although they sometimes will make you feel guilty. These negative feelings will often be followed by positive and comforting feelings, as well as a positive attitude towards your loved one.

It is normal to feel upset and confused when you talk about the loss but you will feel better again. You will be encouraged to talk about your life with the person, how it has changed since, and what the "ups and downs" have been. You will also be encouraged to talk about the things you did not like, as well as the things you did like, about the relationship.

Gradually, you will be able to sort all these emerging feelings and build a clearer picture of your relationship with the person you lost, one that includes their good and bad points. You will then be able to get some distance from the relationship and you may start to develop new relationships to fill the empty space.

If you have difficulty in going through this grieving process, it might be helpful to review old memories with friends or family. A useful homework assignment between sessions might be to review old albums. This can help you recollect the past or if you have old friends you have not seen since the person died, you might meet these people and review your past times together or even go over the albums with them. Your review and meeting should be discussed with your therapist.

If you and your therapist decide that a review of old memories (either by going through old photo albums and/or talking with others) would be useful for you, please answer the following questions after having done this.

1. What did you remember about the past? _____

_____

_____

2. What were the good things? _____

_____

_____

3. What were the disappointments? _____

_____

_____

Later in the therapy, you may be given the homework assignment to do something you do not normally do, for example, call a friend or go out to dinner with a friend, just to see how it goes. Your discussion of these experiences, the good and bad, and your feelings around them will be the focus of the treatment. As you begin to talk and think about the person who has died and to relive some of the experiences of the relationship and the loss, you should gradually begin to take on some of the old activities that gave you pleasure before the death. You may begin to look for ways to meet new friends to fill the loss. These activities should be discussed in therapy. You should discuss the practical efforts you are making and the feelings surrounding these new steps.

If you and your therapist decide that a new activity would be helpful to you, please answer the following questions afterwards.

1. What was the activity? _____

_____

_____

2. What parts did you enjoy? _____

_____

_____

3. What parts were difficult?_____

_____

_____

4. Would you do it again? _____

_____

_____

5. What else would you like to do? _____

_____

_____

Depressed patients who have an unresolved grief reaction may have fears of abandonment in new relationships. These new relationships will be discussed. Your fear about these relationships, your new activities, the activities that make you feel comfortable and activities that you fear, are all concerns to be discussed in therapy. The homework in between sessions will be to undertake new activities and to use the therapy to discuss your experience and reactions.

As the therapy progresses, the sessions will gradually shift from discussions of the deceased to issues surrounding these new efforts. The deceased person will be seen in a less emotionally charged way. This is a sign that the grieving process is nearing an end.

Case Example: Grief

Mitzi is a 56 year old school teacher and mother of two lovely, grown children. Her life collapsed when her husband, aged 60, died suddenly of a stroke. The marriage had suffered some "rockiness" over finances and an extra-marital affair of the husband. Nevertheless, the two of them were looking forward to enjoying their lives together since their children were grown and they finally had enough money for vacations and relaxation. Mitzi, in her usual way, handled the funeral, comforted the children, comforted her husband's aged mother and carried on as the backbone of the family. Her husband's death occurred near Thanksgiving and, in the interest of family unity, she decided to continue with their Thanksgiving traditions. Two weeks after his death she went back to her job and began playing tennis again. She missed him and was weepy, but she felt that she had to carry on, both for her aged mother-in-law and for the children.

A year later the one problem that had developed after her husband's death, her inability to get a full night's sleep, worsened. She also began to lose interest in her teaching job and felt that she couldn't go on. She started to go to doctors, convinced that she had an underlying medical problem (maybe cancer or heart disease) which the doctors were not detecting. Her attendance at work began to falter. She couldn't carry through with the Thanksgiving plans that year. During this time she started to lose weight. Her friends felt she had aged five years in the past 12 months.

She entered IPT after her fourth medical checkup in which she was assured that she was in "tip top" health. There was nothing medically wrong with her, but her sleep problems, loss of weight, loss of energy and loss of interest in her work and family was thought to be related to depression. She came into treatment denying that this was possible and convinced that she had an undetected physical illness. In the initial sessions, it was quite clear that she fit the criteria for a clinical depression, but that she interpreted her symptoms as a physical illness. The therapist did not get into a dispute with her, but began to ask her what was going on in her life and when her symptoms began.

The death of her husband immediately became the focus of attention and the circumstances around his death, the sudden nature of it, her inability to mourn the death, and her premature resumption of activities, became apparent. It was also clear that her symptoms became worse around the anniversary of his death (several weeks before Thanksgiving), when her mild sleep disturbance became quite severe resulting in fatigue, her inability to go to work and, finally, her not being able to organize the Thanksgiving family reunion. Therapy progressed with a detailed discussion of the life she and her husband had shared. Each session began with some details of her daily activities, usually a discussion of how she used to do the same things with her husband and what the loss was like. During the course, she revealed her anger with him for not taking vacations, thus depriving them of the chance for relaxation and fun together. Towards the end of treatment she came in one day with a brochure. She and one of her close female friends were planning a cruise to the Bahamas. The end of the therapy included a discussion of what it would be like to be a single woman on a cruise, as well as her enthusiasm for the trip and her guilt that her husband would not be able to share this activity.

CHAPTER 5

Interpersonal Disputes

Definition

An interpersonal dispute is a situation in which you and at least one other important person in your life have different expectations about the relationship.

An example would be a wife who expects her spouse to take care of her financially but has had to have an outside job to help meet bills. The spouse, on the other hand, may expect the wife to share financial responsibility. This is an example of what is called a **non-reciprocal expectation. Two parties have different expectations about the relationship and these expectations are in conflict. Therefore, they have a dispute.**

Disputes are usually part of IPT when there are unresolved or repetitive disagreements with little hope of improvement. The parties may feel that they have reached an impasse (dead-end). This situation may make a person feel out of control and also threatens the relationship.

If there is evidence of some current dispute with an important person in your life and the dispute is associated with the onset of your depressive symptoms, the IPT therapist may choose role disputes as the focus of treatment. This is one of the most common problem areas with depressed patients seeking outpatient treatment.

Goals of the Treatment

The goals of the treatment in an interpersonal dispute are to help the patient first identify the dispute, then make some choices about a plan of action and finally modify communication or expectations or both so that there is some resolution of the dispute.

There is no right or wrong way and each person's situation is unique. Being in a depression can make it hard to recognize the options available either to pull the relationship out of a rut or to resolve a dispute. The idea is to reach some resolution.

Are you and someone else having disagreements or a dispute?

☐ Yes ☐ No ☐ Don't Know

If you and someone else are having a dispute, the first step is to determine the stage of the dispute. The following questions will help you and your therapist determine the stage. Fill out the answers below.

• **Renegotiation.**

Are you and the other person aware of the differences between you?

☐ Yes ☐ No ☐ Don't know

Are you trying to bring about change, even if unsuccessfully?

☐ Yes ☐ No ☐ Don't Know

• **An impasse.** There is an impasse when the discussions between the patient and the other person have stopped and when there is a smoldering, low-level resentment but there are no attempts to renegotiate the relationship. The partners may deal with each other by using the "silent treatment".

Have the discussions between you and the other person about important issues stopped?

☐ Yes ☐ No ☐ Don't Know

• **Dissolution.** This occurs when the relationship is irretrievably disrupted by the dispute and there is active effort to terminate it through divorce or separation or by leaving an intolerable work situation, etc.

Are the differences between you so large or unsolvable that you are trying to end the relationship?

☐ Yes ☐ No ☐ Don't Know

The therapist's work with you will differ according to the stage of the dispute. In a **renegotiation,** the therapist will emphasize learning new ways of communicating so that you and the other person can talk together and reach a solution.

In an **impasse**, the therapist may attempt to bring the issues between parties out into the open. This could result in increased disharmony, at least at first. As disagreements and disputes which have been long suppressed are brought out into the open, you may start arguing again. However, the object is to develop better ways of dealing with the disagreement. This will help you to understand how the differences in expectations between you and the other party in the dispute are related to your symptoms.

In a **dissolution** you will be helped to deal with the guilt associated with the loss of the relationship.

The following are open ended questions for you to think about. Try to write down your response to the questions.

1. Who is the disagreement or dispute with? _____

2. What is the disagreement or dispute about? _____

3. What do you see as your problems? _____

4. What are your wishes in the relationship? _____

5. What does the other person want? _____

6. How have you disappointed each other? _____

7. What are your options? _____

8. Are there any alternatives for you? _____

9. Are there any alternatives for the other person? _____

10. Have you considered these options or discussed them with the other person?

11. How likely is change in the relationship to occur? _____

12. Could you realistically bring about the changes you would like?

13. How would these changes make you and the other person feel?

14. What are the ways you resolve your differences? _____

15. How do you and the other person usually work on the differences?

16. What resources do you have to bring about change? _____

17. Has this dispute happened to you before with others? _____

18. Are there other relationships that are similar to the one that is going on now?

19. Have you told the person directly how you feel? _____

20. If you did, what do you think would happen? _____

21. Could you try? _____

You will be helped to avoid situations that are very painful. You will also be helped to express your wishes directly and to avoid acting impulsively in instances where the outcome is certain to be unpleasant for you. You will be helped to develop a clearer understanding of the nature of the dispute, including the part you may play in it, since there are always two sides to every story. The therapist will also help you to consider the consequences of many different alternatives before you take any action. Most importantly, you will be encouraged to express what you like directly to the other person.

To work out a resolution, the needs and wishes of both you and the other party must be heard. When the dispute is a marital one, it may, at some point, be useful for the partner also to come into treatment. A separate treatment contract for marital therapy might be made in which both the partner and the patient see a therapist together in what is called conjoint marital therapy.

A central theme in many marital disputes is the patient feeling left out and not sharing in activities with the spouse. On the other hand, the patient is making little attempt to get the partner involved and is expecting the partner to know what she/he wants without being told. In these situations, the therapist will help the patient to speak clearly about specific things that the patient wants from the spouse, the things the patient is not getting, and to develop a more direct and satisfactory way of communicating with the partner. Of course, these problems can occur in any close relationship.

The therapist will try to hear how you feel about these things, what you would like and how you would like them, and what is the other person's point of view?

For a homework assignment you may be asked to have a direct discussion with the other person to clarify what you see as the dispute and to listen to the other side. You will be asked to describe how you and the other person in the dispute communicate with each other. Are you reluctant to approach each other? How do you handle differences? Can you handle differences in a non destructive way? You will also learn to see how disputes are connected to your depressive symptoms and how to handle them differently so that they are not self-defeating.

If you and your therapist decide that a discussion with the other person would be beneficial, please answer the following questions after having the discussion.

1. How did you and the other person in the dispute communicate with each other?

   _____

   _____

2. What was the outcome? _____

   _____

3. What do you see as the next step? _____

   _____

Case Example: Role Dispute

Joan is a 42 year old college graduate with three teen-age children. She recently started a new part-time administrative job. Her depression revolved around a role dispute with her husband. She felt that her husband did not help her around the house, criticized her cooking and manner of dress, and generally made her feel terrible. She felt that he should be more attentive to her now that she had resumed working and was helping with the finances, a concern he had expressed to her for several years. He felt that they could not afford to send the children to college on one income and that a disproportionate amount of the burden had fallen on him. She, on the other hand, felt that he did not appreciate the time and energy it took to raise the children, involving the usual duties of feeding, clothing, transporting them, ensuring recreational activities and checking homework assignments. Since all this was basically a full-time job, outside employment would only increase her burden.

Her new part-time job, as she had predicted, made her feel overworked and underappreciated. Although she had relieved the financial pressure by bringing in the extra income, the relationship with her husband deteriorated further. Their sexual relationship essentially came to a halt and they barely spoke to one another. Their marriage was at an impasse. Joan felt sad and listless around the house and argued more with her children. She started to have problems going to sleep and found herself overeating so that she gained eight pounds over the preceding three months. Her husband, who felt strongly about his wife's physical appearance, then criticized her about the extra pounds.

The therapy began with a discussion of her symptoms and their onset. It was clear that the onset was soon after she began working and that the nature of the dispute was in her feeling unappreciated and overworked. She was encouraged to discuss these issues with her husband in order to express her feelings of not being appreciated and also of her wish for his love and attention. This resulted in far better communications between them in which he was able to express some of his own feelings of disappointment in their relationship, as well as his positive feelings about the home and security she had created for him. They planned to have at least two nights a month together just doing something "for fun". Their sexual relationship improved and Joan's depression began to lift.

This page intentionally left blank

CHAPTER 6

Transitions

Definition

Depression associated with transitions occurs when a person has difficulty coping with a change in their life. The change may be obvious, as in the case of divorce and/or becoming a single person, or it may be more subtle, like the loss of freedom following the birth of a child and becoming a parent. Retirement or changes in one's social or work role (especially changes that bring diminished social status) are also often difficult. Moving, changing jobs, leaving home, a change in one's economic status, a change in the family due to illness, e.g., taking on new responsibilities due to the ill health of a spouse or parent, are other examples of life changes or transitions.

The depressions associated with these changes are often related to ideas about what is expected in the new role that you may not have realized. One of the aims of therapy is to understand what the change means to you: what is demanded by the new situation, what is gained and what is lost.

Not all transitions are negative. A sought-after promotion may produce conflicts about responsibility and independence. A person may be more comfortable in a more subordinate position or in a less demanding job, or may feel guilty about having surpassed others. In general, transitions carry the risk of losing familiar friends or close attachments and demand a new set of skills. Role transitions may be more difficult if they are unexpected and undesired and you are unprepared.

Some of the topics that your therapist might discuss to determine whether you are having problems with transition might be: recent change in your life, how these changes affected your life, how you felt about the changes, what people important to you were left behind, who took their place.

Please answer the following questions right in the book to help determine if a transition is related to the onset of your depression. If you are unable to answer a question, just check "Don't Know".

Have there been changes in your life recently?

1. Have you experienced a divorce?

☐ Yes ☐ No ☐ Don't Know

2. Have you experienced a separation from your partner?

☐ Yes ☐ No ☐ Don't Know

3. Are your children leaving home?

☐ Yes ☐ No ☐ Don't Know

4. Has another person moved in with you?

☐ Yes ☐ No ☐ Don't Know

5. Did you recently move?

☐ Yes ☐ No ☐ Don't Know

6. Did you start school?

☐ Yes ☐ No ☐ Don't Know

7. Did you graduate?

☐ Yes ☐ No ☐ Don't Know

8. Did you get a new job?

☐ Yes ☐ No ☐ Don't Know

9. Did you lose your job?

☐ Yes ☐ No ☐ Don't Know

10. Were you promoted?

☐ Yes ☐ No ☐ Don't Know

11. Did you retire?

☐ Yes ☐ No ☐ Don't Know

12. Have you experienced financial problems?

☐ Yes ☐ No ☐ Don't Know

13. Have you recently started living alone?

☐ Yes ☐ No ☐ Don't Know

14. Have you become ill?

☐ Yes ☐ No ☐ Don't Know

15. Have you experienced any other change? (describe) _____

_____

The following are open ended questions for you to think about. Try to write down your response to the questions below. If you have difficulty recalling details, call up an old friend, review the past.

1. How did your life change? _____

_____

_____

2. How did you feel about the change? _____

_____

_____

3. What people were left behind? _____

_____

_____

4. What people took their place? _____

_____

_____

5. What was life like before the change? _____

_____

_____

6. What were the good things? _____

_____

_____

7. What were the bad things? _____

_____

_____

8. What are the good and bad things about the new situation?

_____

_____

_____

For homework, try to arrange to get together with someone who is part of your new life. Describe what it was like.

1. What did you do? _____

_____

_____

2. What did you enjoy? _____

_____

_____

3. What was difficult? _____

_____

_____

4. What else would you like to do? _____

_____

_____

Goals and Strategies

There are five tasks that will be worked on in managing transition problems:

- **Giving up the old role**
- **Expressing your guilt, anger and fears at the loss**
- **Acquiring new skills**
- **Developing new attachments and support groups**
- **Recognizing the positive aspects of the new role**

In a brief treatment, all of these tasks will not be accomplished, but at least there will be a map for what needs to be done and how to go about it. Instead of the transition feeling confusing and dispiriting, you can face it with a sense of direction and a more balanced appreciation of its positive and its painful parts.

The first task in evaluating the old role will come about through an exploration as to what life was like before the transition occurred. What was your old house like, your former job, living with your parents or your former spouse? What was the good, bad? When depressed, you may exaggerate the benefits offered by the old situation while minimizing the negative aspects and the extent to which the previous situation was destructive or unpleasant. For example, a failed, unhappy marriage may be idolized because the new role, that of a divorcee or single parent, is unacceptable. Giving up the old situation may be experienced as a loss and a mourning process may occur. To help facilitate this process it is useful to think about the feelings that the transition evokes such as grief, guilt and disappointment.

New Social Skills

Developing new skills is an important part of the transition recovery process. The therapist is not a vocational counselor who will assist you in getting a different job, but will help you to discover the feelings or beliefs that are hindering you from making full use of your ability to develop new skills, new relationships and new friendships. You may be helped to go through a realistic assessment of your assets and skills for managing the transition. You may talk about practical situations, such as finding an apartment of one's own, learning to get around in a new community, finding a job or meeting new people. The therapist may help you rehearse difficult situations, asking you to imagine the worst thing that could happen and how you might cope with it. This may alleviate unrealistic fears which tend to arise when you are depressed.

Making the transition to the new role, that is the new job, the new apartment, the new home or being a single parent, may also mean developing new friendship patterns or support or developing different relationships with old friends. Since the type of rewards that can be found in the new relationships are unfamiliar, they may seem less desirable at first.

The therapist might give you homework to help facilitate the transition. The homework may include calling your old friends and reviewing past times together. Later you will be encouraged to call one of your new neighbors or work associates and to get together.

Case Example (A): Role Transition

Jodi is a lovely 38 year old woman and mother of two children. Jodi and her family recently moved and she loved the new house. It was her dream: a bedroom for each of the children, an extra bathroom so that she and her husband and the children did not need to fight over the sink in the morning, a sunny breakfast room, a small garden and good schools in the area. Coming from a poor family that lived in a small tenement, she had finally "made it". She and her husband would be able to provide the comfort for their family that neither one of them had while growing up.

They had moved into their new home a year ago. In the beginning there was a big flurry of decorating and getting used to the luxurious new quarters. Over the last few months, the novelty had passed and Jodi started to feel almost desperate, sad, blue and cried often. How could she cry when she should be grateful for such splendor? Jodi felt alone and lonely. The move took her husband over an hour away from his job, the children had to travel by bus to the new school and she didn't know the neighbors. As she was basically a shy person, it was difficult for her to make friends. In her old neighborhood in the city, her husband left for work at 9:00 a.m.; now he left at 7:30 a.m. and he didn't arrive home until sometime after 8:00 p.m. She missed walking down to the local grocery store where everyone knew her and meeting her old friends for coffee and a chat. It was even too hard for her to get to the part-time job that she had had in the city. She would have had to commute, thus the need and expense of buying a second car. Her dream was beginning to collapse yet she didn't feel right about complaining to her husband because, after all, he had done this for her and the family. She should feel grateful. She didn't relate her depression to this move, she just thought she may be overtired from the stress of moving.

A review of her daily activities showed that she had spent long hours by herself in the house. The IPT therapist helped Jodi see that her depression was related to the move. Even though it was a positive move and one she wanted, the loss of her friends and decreased availability of her husband were problems. The therapist helped her see the connection and then find new ways to meet her need for

companionship. She gradually became more active in the new community and was able to discuss her feelings with her husband. While he could not change his work schedule, he was sympathetic to her problems and disclosed that he, too, missed some part of the "old life".

Case Example (B): Role Transition

Phil was a vigorous 67 year old man who ran a small business he and his wife had started when they were first married. Over the years, they had worked together, struggled and finally made it profitable. He looked forward to the days of retirement when he could do those things that had been put on the back burner because of the lack of time and money. He eagerly awaited retirement.

The previous year he sold his store, invested his money and planned how he would spend his time. Things didn't quite work out as he expected. He missed the daily "chit chat" with his customers. He missed the structure of going to work every day and, after a three month vacation, got tired of traveling and wanted to return home. His wife devoted her time to cooking, gardening, the grandchildren and volunteer work at the local hospital; but how would he spend his time? Over the last two months he began having trouble sleeping, lost his old zest and self confidence, and started to lose weight; a physical exam showed him to be in good health. He even wondered what there was to look forward to. At night he took a much larger "nightcap" because of his sleeping problems and even started to drink occasionally during the day.

A review of the timing of the onset of depression and his retirement quickly led to their connection and Phil saw that the symptoms were related to his retirement and not to a general deterioration of his health. He began to discuss his work. He talked about the customers he missed, how he would go for coffee everyday with the store owner next door, his pleasure at seeing a profit at the end of each month. In later sessions he talked about the negative parts of the work, the pressure of making payments, employee conflicts and the demanding market. As their discussions progressed, he began to plan involvement in activities he had missed. He joined a golf club and started to volunteer in a chamber of commerce group, offering technical advice to small business owners in the community. His days became full again and his symptoms resolved.

Case Example (C): Role Transition

Ron is a 45 year old accountant at a major firm in Boston. He had graduated with a degree in accounting and an M.B.A. and joined this company at age 27, gradually working his way up to a managerial position. Over the last six months, his easy going relationship with his boss seemed to deteriorate. Instead of having lunch together or informally going in and out of each other's office, the boss' door remained closed. They rarely had lunch together and during large meetings Ron felt

he was not called on to speak and the meetings became quite formal. He felt that something was going on and he feared losing his job. He also was more irritable and had more problems at work. It was clear that the depressive symptoms began with the changing relationship with his boss.

During the course of the treatment, a dispute with the boss as to promotion and further raises was identified. The company was experiencing financial difficulties and cutbacks were inevitable. His boss was in the process of developing plans for cutbacks and it was difficult for him to maintain a friendly, collegial relationship when he realized that he might need to lay off some of his friends.

During the therapy, the patient was helped to have a discussion with the boss about his own place in the company and what he might expect. The nature of the financial difficulties of the company became apparent and Ron gradually started looking for employment elsewhere. He realized that the dispute had nothing to do with his own performance, but with the nature of the changing economic climate. The company had lost large contracts although they were not contracts with which he had been involved. On the other hand, the consequences might be felt by many people in the office. During the course of the therapy, the patient practiced how he would handle the negotiations with the boss and what they might discuss through role playing. After discussing negotiation strategies with the therapist, the patient would try these strategies out at his office and then would report back on his success or difficulty.

Case Example (D): Role Transition

Beth is a 37 year old mother of one, has been divorced for one year and is delighted the marriage is over. Besides subjecting her to physical violence, her husband neglected her and was involved in an affair. When she was finally able to get the divorce, take her 8 year old to a new apartment and start a job, she felt that her life could begin again.

However, she hadn't anticipated what it would be like to be a single mom; for instance, who would she turn to when her child got a fever? While her husband was never a great support, obviously he was there. Dating again, introducing her child to strange men, handling sex: all were great stresses and sometimes defeats. Having finally escaped an abusive marriage, in her new role as a single mother she faced a life and future that seemed more than she could possibly handle. Also, she had developed typical depressive symptoms over the past few months.

During the course of therapy she first discussed her marriage, the problems and issues which led to the divorce, and also the early years of the marriage, including their good times when their son was first born. She discussed what she missed in the marriage and concluded that it was not her former husband, but the somewhat protected role of being identified as a married woman. She came to

realize that she had been making all the decisions, supporting and taking care of herself and her son for the last seven years. So, in fact, the transition to single parent had been gradual. She arranged for a better afterschool program so that she felt more confident about her son's wellbeing for the 2 hours between the end of his school day and her return from work.

Her major problem in the transition was dealing with new men in her life. She was fearful of making another "mistake", fearful of being alone and had been involved with several inappropriate men, particularly a married man. A bulk of the therapy was a review of the men she had dated, her expectations and disappointments. Her therapist helped her to reduce the pressure she had placed on herself to find another intense relationship immediately and she was encouraged to expand her social life, to include activities she enjoyed. She joined a tennis club and decided to take a 5 day vacation with her son and sister. She seemed more confident about her future and less pressured about "being alone".

This page intentionally left blank

CHAPTER 7

Interpersonal Deficits: Loneliness and Social Isolation

Definition

Interpersonal deficits, meaning loneliness, or social isolation, may be chosen as the focus of treatment if firstly, you have a history of problems finding or sustaining fulfilling interpersonal relationships, and secondly, you described pervasive feelings of loneliness and social isolation not specifically related to some recent transition.

Included are persons who have problems establishing or sustaining intimate relationships, or who have experienced severe disruption of important relationships as children. There are three groups of persons who have problems of this type:

- **Persons who are socially isolated, lacking relationships either with intimate friends or at work, who have long-standing problems in developing close relationships.**

- **Persons who have an adequate number and range of relationships, but find them unfulfilling and have problems sustaining the relationships. These people might have chronic low self-esteem despite appearing to be popular or having success at work.**

- **The chronically depressed person who has lingering symptoms which were untreated or inadequately treated in the past and whose symptoms interfere with relationships.**

Goals and Strategies

The major task in this problem area is to reduce your sense of social isolation by improving your skills in talking to people, by increasing your self-confidence, by strengthening your current relationships and by helping you find new ones. If you do not have important, meaningful relationships in your life, the therapist may focus on your past ones or on your relationship with the therapist. The purpose is to help you understand the problems in your relationships and to begin to practice forming new relationships.

The three tasks that are involved are:

- **To review past significant relationships, both good and bad.**

- **To explore parallel problems in these relationships.**

- **To discuss your feelings, both positive and negative, about the therapist and parallels in other relationships.**

The therapist will want to know about your current friends and family; how often you see them. What do you enjoy? What problems do you have? How can you find friends and activities now that you used to enjoy in the past?

Answer the following questions to help your therapist determine if interpersonal deficits are the problems that seem to be related to the onset of your depression. Complete the questions as best as you can right in the book. If you can't answer a question just check "Don't Know".

1. Do you have any close relationships?

   ☐ Yes ☐ No ☐ Don't Know

   If yes, is it:

   with friend(s)?

   ☐ Yes ☐ No ☐ Don't Know

   with a lover?

   ☐ Yes ☐ No ☐ Don't Know

   with family?

   ☐ Yes ☐ No ☐ Don't Know

2. Do you find it difficult to keep close relationships once you make them?

   ☐ Yes ☐ No ☐ Don't Know

3. Do you enjoy close relationships when you have them?

   ☐ Yes ☐ No ☐ Don't Know

4. Do you have problems making close relationships?

   ☐ Yes ☐ No ☐ Don't Know

5. How often in a month do you see your close friends?

   _____ times per month

6. How often in a month do you see your family?

   _____ times per month

Your relationship with the therapist may provide the most direct evidence of your style of getting along with others. For example, if you are shy and afraid to talk to the therapist, that may reflect how you feel in intimate relationships. Learning to talk openly to the therapist may provide a model for you to follow in developing intimacy in other relationships. If you can begin to talk to the therapist about your feelings, both positive and negative, that may be a useful rehearsal for talking to others about yourself and about them.

The following questions will help you look at your patterns of getting along with others. Try to answer these open ended questions.

1. Describe how you meet people? _____

2. How do you begin conversations? _____

3. Do you have problems knowing what to do in a relationship once you go beyond first meeting the person?

4. What happens when you are with friends? _____

5. What kind of activities do you like to do with friends? _____

6. How does your relationship with friends make you feel? _____

_____

_____

7. Pretend you are in a room full of strangers at a party. Describe what you would do to meet people:

_____

_____

_____

An effort will be made to separate these problems from your current depression. How much of the problem is long standing and how much a reflection of your depression?

Some homework that might help you to work on this problem in between sessions includes assignments to make contact with old friends (or possibly new ones) to seek out social situations. In therapy you will discuss how the contact went, the problems you encountered (or that you might encounter), and how you can handle them. If it is difficult for you to venture out this way, the therapist may invite you to role play difficult situations that you anticipate. For example, the therapist might say, "Let's pretend you are going into a room full of strangers at a party. What might you do to meet people?"

If an old friend was contacted and you arranged to see that person:

1. Describe how it went. _____

_____

_____

2. How did you feel? _____

_____

_____

If you arranged to go to a social situation, a party, a concert, sports, any type of situation with people your age:

1. Describe how it went? _____

_____

_____

2. What did you do to meet people? _____

_____

_____

3. How did you feel? _____

_____

_____

Interpersonal deficits are usually made worse by depression and may also be a reflection of your depression. Depressed patients do not have the energy or confidence to pursue relationships. The goal will be to reduce your social isolation and improve your current relations by improving skills in communicating and increasing your confidence.

Case Example (A): Role Deficits

Diane had never been socially at ease, but with friends she had known for years in high school, living in a dormitory in college and planned school activities, she managed to fit in and make the best of it. Now she was on her own. In the past year she graduated from college, took her first job and her own apartment. She was at a loss. Even though it was a good job and what she had planned and studied for, she could not deal with her discomfort around men. She did not know how to talk to them, how to develop friendships, how to get herself out of relationships which were not comfortable and how to avoid becoming sexually involved with men she hardly knew or liked. Since she graduated and took a new job, she spent most of her time after work in her apartment by herself. Her first attempts to develop friendships were a disaster. She went to a dance and became sexually involved with someone she hardly knew. She describes herself as bored and lonely. She had lost weight, was having trouble sleeping and was missing days at work. Her problem was defined by her therapist as role deficits in social skills.

Therapy began with a detailed discussion of her daily activities - how she spent each day at work, the evenings and the weekends. There was also a review of how her college relationships had developed since she graduated. It was clear that she had a pattern of increasing withdrawal after her first efforts to find friends when she moved to town. She was very shy, she felt unattractive and awkward and did not know how to start up a conversation or how to set boundaries on relationships.

However, on the positive side, she was a reasonably good athlete and had excelled in swimming while in college. She had one "best friend" in college and was encouraged to invite her for a weekend, then to gradually increase her social activities with a trusted friend. Therapy included discussions of these opportunities, her anxieties and role playing with the therapist - planning out the weekend with her friend, approaching people at the swimming club she joined and warding off the premature sexual advances from the men she hardly knew or didn't like.

Case Example (B): Role Deficits

Bill was an attractive 41 year old lawyer. He had a brief marriage in his twenties, a moderately successful career and a series of relationships with women that never lasted more than four to six months. After the initial meeting, dinner, dancing or the movies, he was socially awkward and did not know how to get close. He described himself as sexually disinterested because he hadn't met the "right" woman, but further disclosure showed that he had low self-esteem and felt at a complete loss as to how to get emotionally close. He felt unable to make a woman understand what kind of a person he was, how to talk about himself, or how to have a woman talk about herself. In treatment it was quite clear that he had a great deal of difficulty talking about his feelings. He confided in no-one even though he said he had several close friends. He wanted to get married and have children. He felt that he was getting older, that he was more set in his ways and it was getting more difficult. Over the last several months, with the breakup of his last relationship to Janet (she stopped answering his phone calls), he found himself increasingly depressed.

IPT with this man included practicing relationships (role playing). He was helped to pretend that he was in a relationship with somebody he knew well, practice what he would say and how he might reveal his feelings or get the person to talk about herself. A clear pattern emerged from these practice sessions. He never let the other person finish a sentence, he would jump in lecturing them, closing off further discussion. He came across as judgmental and controlling.

When the therapist pointed this out to him, he said that this was exactly how he would describe his own mother. In fact, last week they had had a major argument. He had told her about his relationship with Janet. His mother's

response was a lecture about his dress, his manners and his work schedule. He became infuriated, they argued and he slammed down the telephone on her. Communication broke off and he could not discuss his disappointment at the breakup of the relationship or his anger at his mother. During IPT he discussed other relationships and how they ended and gradually became aware of his possible contribution.

This page intentionally left blank

CHAPTER 8

Termination

IPT is a time-limited and not an open-ended treatment. At the beginning of treatment you will have an explicit contract as to the frequency and length of the treatment. Your therapist will discuss length of treatment in the first few sessions. Several sessions before the end of this stated time, your therapist will again have an open discussion about the end of the treatment and a review of what has and has not been accomplished. You will be encouraged to discuss your feelings about ending. If the relationship with the therapist has been useful and meaningful, you should anticipate feeling sad and even angry about the ending.

The therapist will emphasize that the goal of the treatment is to treat your depression and to help you deal successfully with life: work, love and outside friendships. The patient-therapist relationship is only meant to enhance your health and confidence on the outside and is not a substitute for real-world relationships.

Most patients have some discomfort with termination. You should anticipate that you will feel the same. If a patient does not want to terminate, there is often a waiting period of several weeks to see if further treatment is really needed. Exceptions to this will be made, of course, if you still have symptoms or have shown little or no improvement in the depression. In these cases, alternative treatments will be discussed including adding or changing medication, a different type of psychotherapy, psychotherapy with a different therapist or a renegotiation of your contract with your current therapist.

Some patients may require longer term treatment and/or maintenance IPT to prevent recurrence. Included are people with a history of recurrent depression who require maintenance treatment, people with long standing problems in relationships, and people who have not responded and are still acutely depressed.

Some patients with recurrent depression (which has resolved during 12-16 weeks of treatment) do well and have a reduction in recurrence with monthly maintenance IPT. If you agree to continue on maintenance treatment, you and your therapist will discuss a new treatment contract. Patients who have long standing problems with relationships and in overall functioning may require more intensive treatment: 2-3 times per week.

Patients who have not responded to IPT with a reduction in symptoms may need an evaluation for medication and/or a different type of psychotherapy. Nearly all depressions respond to treatment so you are wise to consider alternatives if, after 12-16 weeks, you still are not feeling better.

There is a very good chance that you will not be depressed at the end of treatment. If this is the case for you, you should feel good at having accomplished something that probably seemed very unlikely only weeks before. It may take you a while to feel secure that the depression is really gone and won't come back. You should be aware of the symptoms of depression, and of the kinds of interpersonal situations likely to get you depressed again. You should be able to handle them differently when they occur and avoid them, if possible. If your symptoms return, you should know who to contact and you should get help quickly.

In the separate packet of patient assessment forms, you will find duplicates of many of the questions that were included in the chapters. Take some time to redo these forms. After the forms have been completed, discuss them with your therapist. If you still have some symptoms at the end of treatment, your therapist may discuss alternative or continuing (maintenance) treatments with you.

Complete the form on depression to see if any of the symptoms of depression are still there. If you still have 2 or more symptoms, discuss treatment options with your therapist. Also complete the forms on anxiety, alcohol and drugs to see if you have any of these symptoms.

To see how much progress you have made or if you feel new problems have developed, redo the problem area form on grief, disputes, transitions or deficits which you completed at the beginning of treatment.

Discuss the results with your therapist.

We hope that at the end of treatment you are feeling better and are having fewer depressive symptoms. We also hope that you have some understanding of how your symptoms came about and what you can do to avoid them in the future.