Treatment of Chronic Depression With a 12-Week Program of Interpersonal Psychotherapy

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Recent changes in the finance and delivery of health care have increased the interest in time-limited, empirically tested psychotherapy programs. However, clinicians often are concerned that these short-term approaches will not be appropriate for patients with long-standing or multiple problems. We present a case of a middle-aged woman with a chronic mood disorder and multiple psychosocial and economic problems who was treated with a 12-week program of interpersonal psychotherapy. This case illustrates the changes that can occur with time-limited treatment.

Interpersonal psychotherapy is a time-limited psychotherapeutic approach that has shown efficacy in the treatment of several psychiatric disorders, including major depression and dysthymia, in several controlled trials (1–4). It rests upon the premise that major depression, regardless of etiology, is initiated and maintained within an interpersonal context (5). The goal of interpersonal psychotherapy is to achieve symptomatic relief for depression by addressing current interpersonal problems associated with the onset of the depression. It does not seek to attribute interpersonal problems to underlying personality characteristics or unconscious motivations. Rather, interpersonal psychotherapy works under the assumption that little can really be said about the patient’s personality until the depression is alleviated.

From the technical point of view, sessions are viewed as an opportunity to examine the interpersonal relationships of the patient, link them to the changes in mood, and discuss possible alternatives to the patient’s behavior patterns. The therapist helps the patient devise new strategies to use in similar situations and coaches the patient on how to implement them. The therapist may even engage in role playing to give the patient an opportunity to rehearse these strategies. In contrast to brief therapies of analytic orientation, transference plays a much smaller role. In interpersonal psychotherapy, the therapist is aware of the development of transference and countertransference in the treatment relationship but typically avoids focusing on them and rarely uses transference as a therapeutic tool.

Consistent with the emphasis on the relationship of interpersonal problems and mood symptoms, the focus in interpersonal psychotherapy is the “here and now” of the life of the patient outside the session rather than the process of the session and its relationship with the patient’s past.

Case Presentation

Ms. A was a 38-year-old Caucasian woman who was married and had three daughters aged 2, 7, and 15. At the time of treatment, she was living with her husband and children in New York City and was receiving public assistance.

Ms. A was referred to our clinic by her 15-year-old daughter’s therapist, who thought Ms. A might be depressed. Ms. A reported having felt depressed for the past 4 years, having little interest or pleasure in doing things, and experiencing feelings of worthlessness. She reported fatigue and low energy; she had to push herself to take care of household chores. She felt guilty about not doing enough for her children and making poor life choices and often felt helpless and lonely. Ms. A denied recurrent thoughts of death and had no history of suicide attempts. She reported chronic overeating and oversleeping and was morbidly obese. She felt unattractive particularly because of her weight problem and felt easily criticized or rejected by others. Her baseline score on the 17-item Hamilton Rating Scale for Depression was 25, indicating depression of moderate severity. According to Ms. A, she had not experienced substantial changes in the severity of her symptoms throughout this episode before coming to treatment.

She was assessed with the Structured Clinical Interview for DSM-IV Axis I Disorders (6); she did not meet criteria for another psychiatric disorder.

The onset of the depressive episode coincided with the worsening of her difficulties with her husband. Ms. A was dissatisfied with the limited role that she and her children seemed to play in her husband’s life, even though at the same time he expected them to be always available and ready to please him.

Ms. A’s first episode of major depression was at age 28. This happened immediately after she had found out that her husband had a second wife and two children in another country. While Ms. A had three daughters, she knew that her husband would always favor the other wife because one of these other children was a son. Initially, Ms. A considered divorcing her husband. However, she decided that the pain of losing him for a few months every year was less than the pain of losing him totally, so she slowly grew used to the situation. She saw a psychiatrist for the first 3 months after the onset of her depressive symptoms but stopped the treatment for financial...
reasons. This episode slowly remitted over 2 years. She consulted a psychologist at a university clinic about her depressive symptoms 4 years ago, shortly after the onset of the current episode, but discontinued therapy after two sessions because of "lack of progress." She denied any lifetime alcohol or substance use or any other psychiatric disorders.

Consistent with prior reports of a higher risk for depression in the offspring of mothers with a history of major depression (7), Ms. A's 15-year-old daughter was also depressed. The daughter had been in treatment for depression when Ms. A was referred to our clinic, although session attendance had been sporadic. There was no other documented family history of psychiatric disorders.

In developing a plan with this patient, the therapist had to consider a daunting array of symptoms and interpersonal problems: a demeaning and troubled relationship with the husband, a child's depression, unemployment, low household income, few friends, morbid obesity, and chronically low self-esteem, among other issues. One might question whether it was even feasible to treat this woman with a 12-week, short-term therapy program. Interpersonal psychotherapy proposes that it is possible to treat an episode of depression by narrowing the focus to one or two problems. The explicit expectation is that the patient will be able to manage the other problems better once mood is improved.

Ms. A requested to be treated with psychotherapy and was scheduled to receive 12 sessions of weekly interpersonal psychotherapy. After much difficulty negotiating a mutually convenient time, the first 45-minute session was scheduled. Two hours before the appointment, Ms. A canceled because she was unable to find a baby-sitter for her 2-year-old daughter. The appointment was rescheduled, and Ms. A's 15-year-old daughter agreed to baby-sit for her two sisters at the clinic. Ten minutes into the session, the 2-year-old insisted on entering the room, and the session had to be interrupted for 10 minutes until she agreed to go back with her sisters. After the second appointment was rescheduled (and missed) three consecutive times, the therapist suggested that the therapy be done over the phone; the duration and periodicity of the sessions were preserved. After this, no session was rescheduled or missed. Ms. A was never late for her phone sessions, although on occasion the sessions were briefly interrupted by the children coming into the room to ask her a question. The possibility of returning to in-person visits or coordinating them with the child's visit was discussed twice more during the treatment, but Ms. A stated that she could not afford to pay for a baby-sitter to look after her children during the visits.

This patient's difficulties in getting to the clinic were seen as a reflection of her life situation and her limited social and economic support. It is consistent with interpersonal psychotherapy's pragmatic approach to focus on how to get the therapy done rather than to interpret its snags and pitfalls. Likewise, if a patient were to come late to sessions, the interpersonal psychotherapy therapist would "blame" the depression, reinforce the importance of coming on time, and perhaps even reschedule the session for another day rather than interpret the possible resistance. A recent open trial has suggested that interpersonal psychotherapy may be effectively conducted by telephone (5).

It is important to note that providing therapy over the telephone poses several additional challenges to the therapist and the patient. Because communication is limited to verbalizations and audible expressions of emotions, important nonverbal communication such as facial expressions or shifting of posture is missing. Thus, it is more difficult for both the patient and the therapist to assess the emotional state of the other individual and, on a related note, to create an atmosphere of trust. It is also easy for the therapist and the patient to get distracted while on the telephone (e.g., checking e-mail), which may further decrease the intensity of the treatment.

Because there is very limited systematic information on therapy provided over the phone, there are no clear guidelines about when this might be indicated or how its outcome may differ from more traditional, in-person therapy. However, in deciding whether to conduct therapy over the phone, the therapist should consider the reasons for not coming and whether these may reflect lack of motivation on the part of the patient. In other cases, interest in receiving therapy over the phone may in fact reflect strong motivation, such as in the case of some physically disabled patients or single parents with young children. In this case, the therapist considered that the patient had legitimate obstacles to coming to therapy and thus agreed to conduct it over the phone.

The first three sessions were devoted to reviewing symptoms, obtaining an interpersonal inventory, understanding current relationships, explaining the medical model of depression and the role of interpersonal relationships in the onset and course of depression, and formulating the focus of the therapy.

Ms. A was born and raised in New York City, the only daughter of an Irish-American family. She lived with her parents until marriage. She described her father as a caring person who always had difficulty expressing his love. Her mother frequently devalued Ms. A's social and intellectual capabilities, criticizing her friends and telling her that she would never be able to go to college.

Before her marriage, Ms. A's longest relationship had been with a man of the same age whom she had dated for 4 years. The relationship ended when they both realized that the passion had progressively disappeared. Ms. A met her husband at a party and fell in love with him immediately. She stated that the passion had grown more intense throughout the years and that the sexual aspects played a very important role in their relationship. Ms. A held several administrative jobs until her first pregnancy, when she quit. After that, Ms. A became progressively focused on her new family at the expense of other social contacts. She had intermittently considered returning to work or opening a business but was systematically discouraged by her husband, who insisted it would detract from the care of the children.

The first three sessions of interpersonal psychotherapy constitute the evaluation phase. The therapist assesses the presenting disorder and evaluates the patient's current
and past interpersonal relationships, looking for patterns relevant to current relationships. In this case, the patient's relationship with her parents was noteworthy for the absence of superficial support and lack of warmth from the father and an undercurrent of criticism from the mother. Examining the interactions of these relationships may elucidate the patient's current behavior, expectations, and obstacles to changing her relationship with her husband. For example, fear of rejection was seen as a potential obstacle that could prevent the patient from resolving the dispute with her husband.

In the final phase of the evaluation, the therapist identifies for the patient the name of his or her illness and provides the patient with the sick role—alleviating the responsibility and sense of guilt for being depressed. The interpersonal problem is then formulated into one of four categories in relation to the onset of symptoms: 1) grief (e.g., death of a loved one), 2) role transition (e.g., marriage, graduation), 3) role dispute, or 4) interpersonal deficits.

Because the onset of the first episode of depression and the subsequent course was clearly related to marital difficulties, this case was understood as a role dispute. Ms. A's attempts to become more independent were incorporated into the therapy by formulating a secondary focus on role transition. This formulation, refined through the course of treatment, helped Ms. A and the therapist translate the difficulties in the relationship into specific, achievable goals of the therapy.

When Ms. A started treatment, her stated goal was to be able to tolerate her marital situation without suffering. This seemed an unrealistic objective to the therapist, who worked with Ms. A to develop alternative goals. The therapist repeatedly raised the possibility of reconsidering the marital arrangement, but Ms. A made it very clear that leaving her husband was not an alternative she was willing to entertain. After much discussion, Ms. A and her therapist agreed to work on identifying positive aspects of the relationship with the husband that she would like to promote and aspects that she saw as sources of pain and wanted to change. Throughout the sessions, it became evident that the way she felt in his company, their sexual relationship, and their history together were aspects of the relationship that she cherished and wanted to preserve. Her emotional and economic dependency on her husband, and feeling humiliated at times by him, were aspects she wanted to change. A great deal of time in the sessions was spent obtaining the details of how specific situations developed, how she felt in those situations, and what could be alternative, more adaptive behaviors in response to such situations. References to similar situations in the recent past were discussed, but attempts at reconstructing the childhood roots or intrapsychic conflicts underlying those behaviors were discouraged.

It is not uncommon for depressed patients to accept too much responsibility for a problem that really involves two people. This patient hoped therapy would help her learn to better adapt to a bad situation. Because our society strongly rejects bigamy, the therapist initially suggested a discussion on how to change that situation. However, the patient insisted that she did not wish to consider leaving her husband. The therapist then decided to avoid making judgments about explicit reasons or interpreting subconscious motivations for her lifestyle choice and helped the patient explore ways of initiating change in the relationship to make it less distressing and more satisfying. Pragmatically, interpersonal psychotherapy usually does not provide sufficient time to confront problems that the patient does not recognize as such. Rather, the therapist works with the patient to select a problem area that makes sense to the patient. Even when interpersonal psychotherapy cannot alter the nature of the problem, it may help by changing the patient's feelings about the problem and thus its impact on symptoms. Often the mere process of working on the problem, analyzing the options, and actively selecting a course of action provides the patient with a sense of control, which neutralizes his or her depressive feelings of powerlessness.

On several occasions during the treatment, the therapist felt uncomfortable with Ms. A's helplessness and was tempted to shortcut the therapeutic process by immediately offering a solution to the patient's problems. However, the therapist was aware that he did not have "the right answer" to those problems and that he had limited knowledge of the culture of Ms. A and her husband. He was also careful to avoid substituting Ms. A's dependency on her husband with a dependency on the therapist himself. Thus, he encouraged Ms. A to discuss her situation and possible solutions with her close friends, who would be better judges of her cultural norms and provide ongoing support should she decide to deviate from those norms. She would also see them as peers, making it easier for her to disagree with them than it would be to disregard the therapist's advice. Increased contact with her friends would also improve her interpersonal relationships, increase her independence and self-esteem, and strengthen a social network on which to rely upon termination of therapy.

Because the emphasis of interpersonal psychotherapy is on the "here and now" and on problem solving, there is a risk that therapists may be overactive and try to impose their own point of view instead of creating a space in which feelings can be expressed and alternative courses of action discussed. In this case, helplessness, a classic symptom of depression, led the therapist to undervalue the patient's ability to find a solution to her problems and to feel that he alone was responsible for the outcome of the case. By being aware of the feelings elicited by the patient, the therapist avoided the temptation of presenting himself as holding the key to the patient's problems or presenting the therapy session as the only place where her problems could be discussed. Thus, the therapist explored other possible sources of interpersonal support and satisfaction that could influence the mood of the patient and avoid excessive dependence on the therapist.

As the treatment developed, Ms. A focused on three specific goals to help resolve the role dispute:

1) Renegotiation with her husband about their differences of opinion without giving in to his point of view but also without allowing the situation to become an ar-
gument. Ms. A identified a pattern in which minimal disagreements would very quickly impair their ability to listen to each other and would degenerate into verbally abusive arguments that made her feel unappreciated and disrespected and lowered her self-esteem. Areas of dispute included how much time they should spend together as a family and how to allocate their scarce economic resources.

2) Weight loss. Ms. A stated that her husband enjoyed overweight women. However, she also believed that encouraging her to stay overweight served the additional purpose of limiting her ability to appear attractive to other men, thus allowing her husband to take her for granted emotionally and sexually.

3) Work on obtaining a government-guaranteed loan to start a small clothing business. Ms. A had some experience in that specific type of business and was able to enroll the help of her former boss to advise her on how to set up the new store. She also found agencies that could help her make a business plan and other people who would provide accounting and other services for small fees to beginning small companies.

Formulation of these goals helped Ms. A focus her energies, test her assumptions about her ability to make changes in her environment and her life, and measure her progress in the therapy. As Ms. A realized how much control she really had over her life, her self-esteem improved, her mood lifted, and she felt much more energetic.

The goals of treatment in role disputes are to help identify the dispute and to make choices about how to address the dispute. The direct approach to the role dispute relies on careful tracking of the sequence of interactions. In this way the patient can make changes in his or her own behavior and expectations that may lead to decreased conflict.

The first goal focused on the patient's communication. The patient was accustomed to tolerating her husband's lack of attention and worried that bringing up her feelings would lead to fights between them, resulting in her eventually receiving even less attention from him. The therapist examined this assumption and helped her explore ways of saying how she felt. The implicit hope in this process is that the partner will meet the patient halfway and that the patient's change will be a catalyst for change in the couple. If both people are motivated, this work is often best accomplished in conjoint sessions. In this case, the husband was able to hear the patient's concerns more willingly than she expected. However, he did not alter his behavior in any significant way. Despite this frustration, the patient still felt relief in expressing how she felt and empowered by the knowledge that she had choices.

The therapy also sought to address the role dispute indirectly by helping the patient draw on other relationships and activities to neutralize the negative valence of the problematic relationship. To this end, two additional goals were identified: taking steps to start a business and losing weight. The patient said that her husband was pleased with her being overweight and commented about how he found heavy women attractive. The patient recognized that this was not in her own interest and resolved to try to lose weight. Similarly, the patient became aware that her distress around her husband was worsened by her financial dependency and limited social contacts. The therapist helped her recognize how this situation satisfied his expectations but frustrated her own. She sought to modify her role in the family by establishing her own source of income. It was anticipated that her increase in independence would also facilitate a renegotiation toward a more satisfying relationship with her husband.

An implicit goal in interpersonal psychotherapy, regardless of the problem area selected, is to demonstrate the link between the interpersonal problem and change in symptoms. Since the patient had already connected the dispute with her husband to her depression, it was left to demonstrate that the converse was also true. When she took a positive step, such as expressing her feelings to her husband more openly, the therapist asked about the changes in her mood. Improvements in mood were explicitly linked to changes in the problem area. In addition, the patient was congratulated by the therapist on her progress, encouraged to seek new opportunities to apply her newly learned skills, and coached on how to further improve her performance in future situations.

The therapy progressed smoothly from the third through the eighth session. Increasingly, Ms. A was able to select the appropriate incidents for discussion during the session, consider alternative ways of handling difficult situations, and work toward achieving her stated goals. It became evident that she spent substantial amounts of time thinking about her difficulties outside the sessions and was progressively able to learn how to solve most of them without the help of the therapist. During the seventh session, the therapist announced he would be taking a 2-week vacation after the 10th session. During the ninth session, 2 weeks after that announcement was made, Ms. A reported that her husband would be returning to his native country for 5 months. The husband would be leaving the day after the therapist returned from vacation. Ms. A felt abandoned by her man, who was going back to his country to visit his other wife and children. The therapist, after exploring these feelings, encouraged her to find ways to cope with his absence, including relying on her friends for companionship and emotional support.

Upon the therapist's return from vacation, Ms. A stated that she was upset and a little down, but she was clearly not depressed. She scored a 6 on the Hamilton depression scale administered at the last session. Ms. A requested a referral to continue working "on issues." However, she had difficulty articulating those issues. Given the acute stressor of her husband's departure and her history of recurrent major depression, it was agreed to extend the treatment for two additional sessions. Ms. A continued to be euthymic and to work on her goals after the two extra sessions.

In interpersonal psychotherapy, it is accepted that problems are not typically resolved at the end of therapy. Rather, interpersonal psychotherapy begins a process of change that it is hoped will continue after the therapy ends. The termination phase in interpersonal psychotherapy seeks to review and consolidate gains and deal with feelings related to termination. Although feelings of sad-
ness and loss around therapy ending are discussed, the therapist does not seek to belabor this point. As during the rest of the treatment, the therapist avoids centering the discussion on transferential material and focuses on the here and now of the relationships outside the session.

Since the goal of interpersonal psychotherapy is to help the patient cope well without therapy, termination provides an opportunity to internalize strategies. In this case, the fact that the husband left during the therapy was presented as a positive opportunity to tackle this experience with the help of the therapist. The patient was then able to take on a new perspective and feel less helpless in coping with this event. Had the departure not yet occurred, the therapist may have attempted to rehearse this scenario and explore ways of coping were this to happen.

Three months after the end of the treatment, Ms. A was contacted by phone by the therapist as part of the clinic procedure. Although many of her chronic problems remained, Ms. A reported feeling considerably better than before treatment. She had lost 20 lb since her last treatment session, had continued to be euthymic, and communication with her husband had substantially improved. However, progress with the start of her business was lagging. She was informed that should she become depressed again, she could contact the clinic for a new evaluation and another course of treatment or a referral.

Conclusions

Over the last few years, short-term psychotherapy has become increasingly popular among clinicians. Potential factors that may have contributed to this popularity include proven efficacy, existence of treatment manuals for the therapeutic approaches, and decreased economic burden for the patient. Time-limited therapy is often reserved for individuals with high prior psychosocial functioning. As this case exemplified, short-term therapy can also benefit patients with long-standing problems, even in the presence of limited psychosocial support.

Use of medication was considered throughout the treatment. However, the patient's psychological mindedness, her expressed preference to be treated with psychotherapy, her early and good response to treatment, moderate severity of her depression, and the absence of suicidal ideation made her a good candidate for psychotherapeutic treatment alone.

The patient did not solve all of her problems during the course of this treatment. However, her main goals of improving her mood and her relationship with her husband were achieved, and she felt prepared to face new challenges. In addition, during the course of treatment, the 15-year-old daughter became more compliant with her own treatment, and her depression also improved. Whether these improvements were related is unknown. Ongoing studies at several institutions are currently investigating this important area of research.

It is possible, although far from certain, that this patient will need further treatment for depression in the future. Short-term therapy favors new time-limited treatment courses in these situations. If the patient's preferences or situation change, other therapeutic alternatives may need to be considered.

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