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9 A CASE STUDY FOR THE NEW IPT THERAPIST

Marie Crowe and Sue Luty

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Background. X was a 42-year-old divorced female with a son aged 25. She heard about the study from a friend and self referred, aware that she had depressive symptoms. The diagnosis of major depressive disorder of moderate severity was made on the initial assessment interview by an experienced psychiatrist.

X's depression had occurred in the context of her mother's death from cancer three years previously, followed by the death of her father one year later. Major family conflict had then developed as her three half-siblings from her father's first marriage contested the will with her and her other three biological siblings. The patient lived alone in her own home and found her supports came from younger adults, many of whom were her son's friends. She had an active sporting life and worked with elderly people which she enjoyed and regarded as low stress. However, the lack of a supportive partner/intimate relationship was difficult for her.

X had no previously diagnosed episodes of depression but had been "down" during her violent marital relationship which had ended 15 years previously. All her intimate relationships since the divorce from her husband were "difficult," and she described herself as a person who was well liked by friends but was "not good at choosing men." X was brought up in a blended family with constant conflict between the two sets of half-siblings. Her father was a heavy drinker, and she had only recently begun to have a positive relationship with him. At the age of 16, she became pregnant and left home to marry the father of her child. She had always been close to her mother.

Symptomatically at the commencement of psychotherapy, she described low mood, loss of enjoyment, insomnia, loss of appetite, and described life as being "crappy; what's the point of going on?"

The psychotherapist and patient identified interpersonal role disputes as a focus. This involved relating X's symptoms to the dispute, determining the stage of the dispute and how it was perpetuated, understanding how nonreciprocal role expectations related to the dispute and exploring parallels in other relations.

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Psychotherapeutic Interventions

From the transcripts of the sessions, there was an analysis of the psychotherapeutic interventions utilized by the psychotherapist which involved identifying and tracking the nature of the interventions used, when they were used, and their effect on the patient.

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This was then compared to Weissman's (2000, p. 25) description of the specific focus for interpersonal disputes:

- Seeking information on different levels
- Exploring parallels in other relationships
- Exploring relationship patterns
- Exploring the communication patterns that [the] patient draws on

Weissman has identified that although the techniques used in IPT are common to other psychodynamic psychotherapies, there are differences in how they are used. In IPT the techniques are used to treat a depressive episode rather than to increase insight. "Each technique is used in a specific sequence and with varying frequency, depending on the characteristics of the patient and the particular interpersonal problem the patient describes." The following are the psychotherapist's interventions that were identified by analyzing the transcripts of the sessions with X.

Seeking Information. During the beginning phase, the psychotherapist was setting the scene for the process of psychotherapy and conducting the interpersonal inventory.

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- What is he like as a person?
- How often do you see him?
- What kind of things do you do together?
- Do you ever clash at all?
- Would you want the relationship to be different?

The information sought in this beginning phase enabled the therapist to formulate an interpersonal inventory that identified who was significant in the patient's life and any relationship issues that the patient found unsatisfactory.

Exploring Parallels in Other Relationships. The psychotherapist helped the patient to identify parallels between what she was currently experiencing and what had happened in past relationships:

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- Has that happened to you in the past?
- Is that something you have done before?
- I guess you have learned this way of dealing with things.
- Your tendency has been to rush and fix things—"well, I will do it if no one else will."

The therapist also linked how the patient was currently responding to relationship issues and the way she had dealt with them in the past:

- Remember with your mom dying, things just took over and you didn't have time to really grieve.
- Did it bring up issues for you, about the losses before? Are there similarities to your mom?

The therapist explored what the patient had learned in past relationships that worked well for her and suggested that she identify the successful aspects so she could apply them to her current situation:

- You might be able to draw on things you have achieved in the past on what it was that worked.
- You have been able to see the elements that made it something you enjoyed and maybe you can create that again in a different way.

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Most of these interventions occurred in the early middle sessions and appeared less often towards the end of the sessions.

Exploring Relationship Patterns. In the middle sessions, the therapist began to explore the patterns that the patient was describing in her relationships:

- It seems that there is a type of role that you have gotten yourself into.
- I guess that demonstrates that you chose a backward step because you knew there would be conflict.

The therapist moved from exploration to naming some of the patterns that were emerging:

- What do you think leads you to not being able to be assertive?
- Looking at different decisions, it might have been that you were trying to be all things to all people.
- It has been easier for you to sort of focus on other people rather than on yourself.

This shifted from exploration to suggesting how the patient might make some changes to the patterns:

- You have learned how not to compromise when probably what you need to do is practice compromise.
- We have already talked about you being in the caring role; maybe it is not what you want to do . . . you have overly stressed yourself and put yourself in situations of multi-tasking, but the future could be "let me do what I want to do," "let me do what I enjoy," or "I could be doing something that I feel much more motivated to do."

Another aspect of this phase involved the therapist suggesting how the patient might make changes:

- I guess this is a crucial thing about expectations in relationships, about being clear about what you want and what he wants.
- Perhaps you need to be clear about what you want for yourself, and that would make a difference.
- It is about looking after you, not other people, so that you can work through issues.

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These interventions enabled both the therapist and the patient to identify repetitive experiences and patterns that were occurring in the patient's relationships.

Exploring Communication Patterns. This psychotherapeutic intervention involved clarifying how the patient communicated her feelings and wishes:

- How do you give him the message?
- Is that giving him the message that you don't actually want to see him?
- Is she [his wife] aware that you feel awful?

It also involved identifying problems in the patient's communication style:

- I guess sometimes you don't really talk about how badly you feel about yourself.
- What do you think leads you to not being able to be assertive?
- So that is a kind of giving excuses sort of thing.

The therapist encouraged the patient to try different ways of communicating by exploring it from the other person's perspective:

- What does she [his wife] need to be able to do to forgive you, do you think? What would you expect in that situation?

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As the patient began to practice the changes in communication style, the therapist provided her with feedback:

- So you were direct with him, you were honest.
- So you stuck to your guns?
- Have you talked to her about it? What have you done about it?
- I guess you are still not saying I am not interested, I would like to be friends but that's all.

Other Interventions. Although the therapist utilized techniques specific to IPT, other techniques were also applied, but within an IPT context.

Signaling What Is Significant. One of the strategies that the therapist utilized in early sessions was to signal to the patient when she brought up an issue significant to the IPT process:

- That was an important thing to know about.
- It's good to voice that and just being aware of why.

Providing Support. Another strategy that was important in developing a therapeutic relationship involved providing the patient with acknowledgement of what she was experiencing and providing support for how she was managing:

- I see you have already made some fast steps . . . you have come to some decisions just by exploring them and thinking about them more in terms of "how helpful is this?"
- And you have been changing; you have been making some quite significant decisions which wouldn't have been easy.

Exploring Affect. Throughout the sessions the therapist drew connections between how the patient was feeling and how she expressed her feelings to others:

- What about the fact that you have been hurt; what about dealing with that a little bit; do you see what I mean?
- And how did you feel when that happened?

Exploring Options. The therapist encouraged the patient to explore the options she had in dealing with issues in her relationships:

- What were your choices; did you choose to retaliate or withdraw?
- It is a choice that you have got—you can either go and tolerate it or not go.
- What other choices do you have?

Problem-Solving. Throughout the middle phases in the IPT process, significant attention was given to approaching issues using problem-solving techniques:

- Let's look at what is going to be good for you and what is not, because that might help clarify the goal or what the need is.
- That's the same kind of thing with life decisions; you kind of narrow it down and start testing the waters, and if doesn't work, it doesn't work.

Drawing Analogy. A technique the therapist used which engaged the patient was that of making an analogy:

- When you say you are not sure [about what to do], it's like saying, I'm not sure about that color; what will I do? I will try that color, let's have a look, let's just see. Maybe I made the wrong decision or maybe I could go with that.

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Challenging. The therapist also gently challenged some of the beliefs that underpinned the patient's decisions and challenged her to practice some new strategies:

- Is it really selfish? Following something you want to do, why should that be selfish just because other people say it is?
- I wonder if you can go away with a sense of testing the waters?

Weissman and colleagues suggest that the general goals of treatment in interpersonal role disputes are to help the patient first identify the dispute, then make choices about a plan of action, and finally modify maladaptive communication patterns or reassess expectations, or both, for a satisfactory resolution of the interpersonal dispute. Improvements may take the form of a change in the expectations and behavior of the patient and/or the other person; changed and more accepting patient attitudes with or without attempts to satisfy needs outside the relationship; or a satisfactory dissolution of the relationship.

The general IPT treatment strategy with interpersonal disputes is to help the patient understand how nonreciprocal role expectations relate to the dispute and begin steps that will bring about resolution of disputes and role negotiations. This involves movement from exploration to action.

The aim is to help patients recognize their complex, mixed feelings of anger, fear, and sadness, and devise strategies for managing them. Depressed patients typically have difficulty in asserting their needs and in appropriately expressing anger in interpersonal situations.

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The Patient's Response to IPT

The following section presents the themes that emerged from the transcripts as the patient dealt with her mood and her relationships with others.

Struggling. The patient described her relationships with family members and friends and also identified a pattern of avoidance when faced with conflicts—"I do try to avoid as much as I can to do with them." She also expressed some uncertainty about relationship expectations—"I don't know what I expect from my friends; I don't know if what I expect is realistic." She described how she learned avoidance as a child:

> Most of our childhood was just spent trying to not be seen essentially, all we heard was a lot of yelling . . . all we heard was lots of yelling and screaming and the less you were noticed the better.

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The patient also revealed a number of significant losses that she had experienced over the previous two years, including the death of both parents and of a close friend, and how she had not allowed herself to fully experience her grief.

> I tell you at that stage I still hadn't grieved for mum, death was fine, I don't know to be honest, I didn't really feel much, I wasn't feeling anything.

It also became apparent that she often took on most of the responsibilities in her relations with others and that she managed any interpersonal disputes either by avoidance or placating.

> At the time, I thought keeping everything smooth was fine, I mean not just for me but for everyone, doing what I thought was best for all of us.

However when she entered psychotherapy she was feeling overwhelmed by the responsibilities she had taken on.

> Before, I always managed to survive but just recently I stopped [being able to survive], it is such a struggle.

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The patient had been able to identify that her struggle with depression was associated with her pattern of 1) avoiding conflict and a role where she became the pacifier, and 2) her feelings of grief that she suppressed rather than feel overwhelmed by.

Deconstructing. During this phase of the psychotherapy, the patient identified a theme of selflessness that influenced her decision-making in regard to relationships.

> A lot of the things I have chosen to do is because I don't want to be selfish.

She identified a fear of being regarded as selfish underpinning many of her decisions and that many of her decisions were influenced by her attempt to not appear selfish.

> I think a lot of things I do and why I make a lot of decisions is to oppose that I am just being selfish, but it doesn't make me any happier.

The patient made the connection that although she had strived not to be selfish, it had not made her happy. She was able to identify what had made her happy and the elements which were most satisfying.

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> I liked being free . . . it is a feeling where you have got to rely on yourself and it is just you against everything, just you with nature, and it is a great feeling. You have to rely on your own know-how, your own skill, strength.

The patient identified self-reliance as a significant experience that brought her happiness but which was currently absent in her life, a life that involved many relationships in which she felt responsible for others. She also accepted the therapist's challenge to think about selfishness differently.

> I think maybe I have done my time and maybe I am allowed to . . . be selfish.

As a result of beginning to see some patterns in her relationships, the patient then expressed trepidation about becoming involved in a new relationship.

> I am scared of the whole thing about relationships, because there seems to be a pattern, you have to do what other people want you to do, otherwise they don't work.

Her uncertainty about relationships related to the role of pacification she had adopted.

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> Make it smooth, try and smooth it over, be the mediator, make the peace, do what ever they want to keep it quiet.

She described the struggle she had been having as feeling overwhelmed and not in control of what had been happening to her.

> Sometimes it is very hard to keep on that Pollyanna kind of thing when things are just constantly happening and to me it just sometimes you know, you are just starting to feel good and something else pops up, something else trips you up.

The patient had been able to deconstruct her experiences in relationships with others and identified the particular aspects that were causing her problems: her judgments about selfishness, her need to feel self-reliant, and a need to feel more in control of her life.

Connecting. This next phase in the improvement trajectory occurred as the patient began to make connections for herself between her mood and what had been happening in her relationships. The first connection she made was about her need to trust herself more.

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> Maybe if I can't trust myself I can't trust other people.

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After exploring what had been happening she realized that not all aspects of her life were bad.

I say, look our lives aren't really that bad when you look at the good things.

She also realized that she had not always been as passive as she had perceived herself.

A lot of them have been kind of a non-decision, I have to admit, but that is a decision in itself.

The patient made some connections between the role she had been assuming in relationships and her mood.

I thought keeping everything smooth was fine, I mean not just for me but for everyone, doing what I thought was best for all of us . . . I was thinking what's the point and then I thought things have got to change, they've certainly got to change.

At this point in the psychotherapy, she began to realize that things were not as hopeless as she thought and that change was possible.

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I guess it is actually determination; you have just got to keep plugging on and on and on and maybe have a bit of optimism.

She had made a connection between her mood and her role in relationships, which enabled her to consider other possibilities. She described the process of change as a process of remediation but recognized that it was not going to be easy.

This is like my remedial life lessons . . . but it is so hard, it's actually really hard to do.

She reminded herself of the importance of attending to her own needs which she had not considered important before.

The thing that keeps ringing through is unless you are true to yourself, you know, life ain't going to work. Now it is ringing through, it didn't ring through before; I didn't even hear anything before.

In response to the therapist's identification of the achievements she had made, the patient realized that she had made progress and that she wanted to make further progress.

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Pat on the back, yeah, yeah, sometimes if I get time I can sit and think OK yeah little changes, not major ones, and I can see them, I mean other people might not but I can see them. Maybe just wanting a change is good . . . yeah I am getting it, I am sure I am getting there. I wasn't so certain this week, but I still want to get there which is good. I still take little steps, but it just means trusting myself which is the hard one.

The significant themes that emerged through this phase of the patient's improvement were related to the connections she made about the roles she had been assuming in relationships and how she could make changes.

Practicing. This next phase involved putting into action what she had learned from the connections she had made about her lack of assertiveness and her over-responsible role in relationships.

I actually just said no, look I can't cope, I can't do it, I have other things to do; she was really nice, so that was alright.

She began to set boundaries around her role.

It's their problem. It's not my problem.

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She realized what she had been gaining from putting other's needs before her own.

> I mean it is lovely that they all love you and want you there and need to see you but it is kind of like a bit here bit there, bit there—you are just pulled in millions of directions. But I survived that too.

With the realization of the trap she had set for herself in wanting to be wanted, by placing her own needs as subordinate, she was able to identify that she needed to communicate what she wanted in a more direct manner.

> I am just going to have to be more honest with him and say definitely not. It is throwing me out; I really don't need to worry about having a relationship . . . I just didn't really know whether I wanted to be myself at that stage.

As she began to practice different roles and different methods of communicating, the patient became clearer about what it was that she needed.

> I just want time to be me.

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The positive experience of being more assertive and being more direct enabled the patient to make a clear statement about what it was she needed.

Reconstructing. The final phase of the improvement trajectory involved the patient being able to articulate a reconstructed sense of self. She gave herself permission to accept her feelings as important and described herself in a more positive manner.

> Maybe it is just kind of a reaffirmation of the fact that it is OK to feel how I am feeling and um you know, I am not such a drop kick after all.

She realized that she needed to refocus her energy on herself and her own needs rather than expending it on meeting others' needs.

> I was just thinking instead of giving all these other people my energy I could actually focus on myself.

She also described an occasion when she was tempted to revert to an old relationship pattern and how she resisted this because of the progress she had made.

> At one stage I thought it would actually be nice to go and get a big hug from [male friend] and have sex and lie in his arms and just cuddle and I thought no, no, NO, NO . . . this is a nice temporary measure and I thought yeah this is OK.

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Towards the final IPT sessions, the patient identified a significant improvement in mood and how this has not resulted in a major life reconstruction but rather a reconstruction in the way she perceived herself and the changes she had made.

> I feel better, I was just thinking today, the situation hasn't changed, I just don't feel as bad about it . . . I know that I am just feeling OK, it is feeling good, I am feeling like a person, I mean there are still things I need to think about like work and how I feel about that . . . but basically as a human being I am feeling OK, and it doesn't mean my life has changed that much, I mean I am still in the same position but it feels OK.

The improvement in mood that was facilitated by the IPT process had enabled the patient to have a more hopeful view of her future.

> Now that I am feeling better I might actually be able to see where the opportunities are, whereas I was just so wound up, I just couldn't see anything. I just couldn't see a damn thing, I needed a guide dog.

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The patient employed the metaphor of a guide dog to describe how she had experienced the IPT sessions. It had enabled her to make sense of her mood, connect it to her pattern of interpersonal relationships, and change some of her roles and communication styles.

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DISCUSSION

This case study of the patient's improvement can be validated by plotting her mood based on self-reported BDI-II scores. (See Figure 1.) From this figure, it can be seen that the patient was experiencing severe depressive symptoms at the commencement of IPT (BDI-II range: severe 29–63, moderate 20–28, mild 14–19, minimal 0–13). Her symptoms improved at a consistent rate until she rated them as mild at the end of her 12 sessions of IPT. During the 3-month follow-up, the symptoms were in the non-depressed range. This is consistent with the process of recovery in IPT observed by Weissman and colleagues. It is of interest that there was a marked improvement in mood during the second week of IPT and then the process of improvement was more gradual over the following weeks.

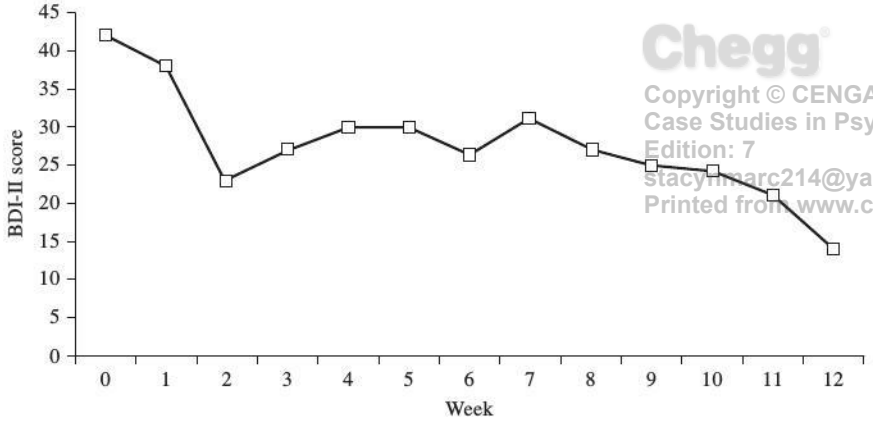

Figure 1. BDI-II Totals Over Weeks Of Therapy

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The Process of Change

At the commencement of IPT, this patient rated her depressive symptoms as severe. Her symptoms occurred in an interpersonal context; she was engaged in relationships that were both contributing to and being affected by her mood. The role she had adopted in her relationships, that of a pacifier, involved her taking responsibility for others. She described learning this behavior as a child as a way of protecting herself in family conflicts, and it could be regarded as a motivating influence for her to learn to suppress her feelings. A deconstruction of what it meant to be "selfish" enabled the patient to make connections between trusting herself and trusting others—and between her pacifier role and the need to be "true" to herself. After making these connections she was able to practice different communication strategies which enabled her to be more direct and assertive. In the final sessions, it was evident that she had developed confidence in these new practices and in herself.

The IPT enabled the patient to make a shift from regarding herself and her situation as hopeless to "feeling like a person" and seeing opportunities in her future. She described the content of her IPT sessions as "remedial life lessons" and the process like having "a guide dog," enabling her to make significant changes which she attributed to seeing things more clearly.

This case study provides details about the process of IPT which is helpful for therapists working with IPT or training to become an IPT therapist. Further in-depth validation or replication of the process of change in IPT will enable a more comprehensive understanding of the factors that influence a positive response to the psychotherapeutic process.

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Editors' Introduction

With family therapy there is the same dilemma we faced with behavior therapy: Dozens of good teaching cases are available, but it is virtually impossible to select a single case that will adequately illustrate the multiple and variegated techniques used by most family therapists. Ultimately we elected to use a strategic therapy case to serve as an exemplar of family therapy.

We feel fortunate to have been able to locate the following case by Peggy Papp. It demonstrates the effective treatment of the family of a young anorectic woman and demonstrates the use of a "Greek Chorus"—a group of observing therapists who remain behind a one-way mirror. The Greek Chorus is always available to consult with the therapist, and the group will periodically make recommendations about treatment. Family therapists, more than any other group, have used such procedures to good advantage. Would you feel comfortable having your own work scrutinized this closely?

The case describes the treatment of a young woman with anorexia nervosa. The longer this life-threatening disorder remains untreated, the more intractable it becomes. How would this client have been treated differently if seen by a psychoanalyst, a behavior therapist, or someone practicing rational emotive behavior therapy? Would a person-centered therapist, committed to authenticity in the therapeutic relationship, feel comfortable with the manipulation inherent in the use of paradoxical intention? How do you feel about this therapeutic tactic? How do the values of a therapist affect decisions about which tools in the psychotherapist's armamentarium are appropriate in any given case?

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