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failed—*not* the patient. The therapist gives the patient hope by emphasizing that depression is treatable and many other effective treatments exist, and by encouraging her to explore alternative treatments.

The therapist explores the patient's feelings about the treatment and termination. The therapist acknowledges not only his or her own sadness to be ending their relationship but also happiness about the patient's improvement and confidence that the patient will be able to maintain the progress she made in treatment. Should symptoms recur, the patient has gained tools to manage symptoms of depression on her own. Furthermore, the patient can return to IPT for "booster" sessions as needed.

Using the IPT medical model, the therapist provides psychoeducation about relapse and recurrence of major depression and prepares the patient about potential for relapse. Patients who have experienced one or more episodes of major depression are unfortunately vulnerable to future episodes. The therapist explains this and advises that given the link between stressful life events and mood, the patient can anticipate that she may have difficulty with future, stressful life events. Fortunately, the patient can use the coping skills she gained in treatment to ward off a worsening of symptoms. If the patient has improved in IPT but has either significant residual symptoms or a history of multiple episodes, therapist and patient may contract for continuation or maintenance IPT, which has also demonstrated efficacy in forestalling relapse.

CASE STUDY

The following case demonstrates how a clinician (K. L. B.) implemented IPT for major depression in a 12-week acute treatment and illustrates how one works with the problem area of grief. In IPT, grief (complicated bereavement) is considered as a focal problem area when the onset of depression is related to the death of a significant other and the patient is experiencing an abnormal grief reaction (Weissman et al., 2000). Although cases that focus on the grief problem area usually address complicated bereavement related to the death of a person who has actually lived, the following case involves complicated bereavement related to a stillbirth. Indeed, the IPT problem areas can apply to a wide range of cases. IPT treatment goals and techniques specific to working with the grief problem area are demonstrated.

Background Information

Sara, a 35-year-old, married, childless woman, was referred for treatment of depression following the death of her baby girl *in utero* at 27 weeks' gestation. Her doctor explained that a bacterial infection was the most likely cause of the stillbirth. Sara's chief complaint was: "I feel like I should be over it."

At 27 weeks, after not feeling the baby move for at least several hours, Sara called her doctor, who told her to come to the hospital. The doctor was unable to find a heartbeat and told her that he needed to deliver the fetus. Sara recalled feeling shocked, numb, and unable to cry at first. She was given medication to induce labor and an epidural, and delivered the baby vaginally. Despite efforts to revive her, the baby was pronounced dead shortly after delivery. Sara said that she wanted to hold the baby and was given the baby to hold. She held the baby, who was swaddled in a white-and-pink blanket. She recalled that she and her husband cried uncontrollably while they took turns holding the baby and for a long time after giving the baby back to the doctor. She remembers that the baby was "very cute" and looked like her husband. She was given pictures of the baby and footprints to take home. Sara and her husband decided not to have a funeral or memorial service for the baby.

Sara reported that since the stillbirth 2 months earlier, she had been feeling sad and irritable most of day, nearly every day, and unable to enjoy things she used to enjoy, such as reading fiction, cooking, going to the movies, and exercise. She worked as a nurse on an inpatient medical floor in a New York City hospital, and prior to the stillbirth had very much enjoyed her work. She now felt unable to enjoy her work because of her mood, and she feared having to talk about her loss with coworkers who knew she had been pregnant. She was crying frequently, socially withdrawn, had low energy and difficulty concentrating, experienced decreased appetite, and felt very bad about herself. She denied ever having thoughts of suicide or feeling that life was not worth living.

Sara reported that she tried not to think about the baby's death, but she was frequently bothered by thoughts about the baby, often

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wondering what her life would have been like had she survived. Sara had returned to work 3 weeks after the stillbirth, hoping that it would serve as a distraction and help her "get over" her loss. She reported feeling very angry at and avoiding other pregnant women, including close friends and women with newborns, in addition to other reminders of her pregnancy. She felt angry at having had to go through pregnancy, labor, and delivery without gaining the pleasure of having a child.

Sara was plagued by inappropriate guilt. She felt guilty because she feared that she had done something to cause her loss, despite the doctor telling her that there was nothing she could have done to prevent it. He explained that when bacterial infections cause fetal death, they often cause no symptoms in the mother and go undiagnosed, until they cause serious complications. Nevertheless, Sara felt that she should have known about the infection, and she felt guilty about having waited until age 35 to try to conceive. She described feeling like a failure for having had a stillbirth. Sara felt guilty that she had disappointed and upset her husband by losing the baby, and she did not want to burden him with her feelings about the loss.

Sara had never sought treatment prior to her current evaluation. She described one prior episode of major depression in her late 20s lasting 4–6 weeks, precipitated by a breakup with a boyfriend of several years, but reported feeling much worse since losing the baby. She reported that her mother had been treated for depression with antidepressant medication with good results.

Sara was an attractive woman of average height and weight who looked her stated age. She was casually but neatly dressed in jeans and a large sweater. Sara's movements were slightly slowed; her speech was fluent. Her mood was depressed and her affect, congruent and tearful. She denied current or past suicidal ideation and any history of substance abuse or psychotic symptoms. She denied current or past medical conditions, including thyroid dysfunction. She reported no known prior pregnancies, pregnancy losses, or fertility issues prior to the stillbirth. In fact, she had conceived after just a couple of months of trying to get pregnant.

Sara was good candidate for IPT: She met criteria for major depression and had experienced a recent life event that could be easily linked to the onset of her symptoms. Furthermore, IPT could address the interpersonal problems she was experiencing related to the onset of her symptoms. Sara was also a potential candidate for CBT, pharmacotherapy, or (evidence-based antidepressant) psychotherapy combined with medication. She was uninterested in doing written homework and resistant to taking medication, because she was hoping to conceive again in the near future.

IPT Treatment with Sara

Acute Phase (Sessions 1–3)

Treatment with Sara followed the IPT format for acute treatment. In the first three sessions, the therapist obtained a thorough psychiatric history and set the treatment framework. In the first session, she obtained a chief complaint and a history of Sara's present illness. Using DSM-IV criteria, the therapist determined that Sara met criteria for major depression, recurrent. She administered the HDRS to assess the severity of Sara's symptoms.

The therapist offered Sara empathy for her pregnancy loss, saying: "I am *so* sorry. You've suffered a terrible loss. No wonder you have been feeling so badly and having such a difficult time." The therapist gave Sara her diagnosis of major depression, reviewed her specific symptoms, and gave her the "sick role."

> "The symptoms you've described having in the past couple of months—depressed mood, not being able to enjoy things and your loss of interest in things, feeling very badly about yourself and guilty, your difficulty eating and sleeping, and difficulty concentrating—are all symptoms of major depression. Major depression is an *illness* that is *treatable*. It is *not* your fault that you have been feeling this way."

The therapist explained that Sara's HDRS score of 24 indicated moderately severe depression and that she would readminister the HDRS at regular intervals to monitor Sara's progress. Given the severity of Sara's symptoms, her willingness to participate in psychotherapy, and her reluctance to take medication in anticipation of trying to conceive again, the therapist did not think medication was needed.

The therapist described IPT and the treatment rationale:

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THERAPIST: I am trained in a psychotherapy called interpersonal psychotherapy, which I think could be helpful to you. Interpersonal psychotherapy—often referred to as IPT—is a time-limited treatment that focuses on how recent life events and stresses—such as losing a baby—affect mood, and how mood symptoms make it difficult to current life events and stresses, particularly problems in relationships. Although we will take the first few sessions to review your history, our sessions will focus on the here and now, on your *current* difficulties and relationships, not on the past. Does this make sense to you?

SARA: Yes.

THERAPIST: Often, people respond to treatment with IPT in 12 weekly sessions. I propose that we meet once a week for a 50-minute session for the next 12 weeks. If it's helpful, at the end of the 12 sessions, we can discuss whether it might be useful to have additional sessions to work on issues and maintain your progress. How does that sound to you?

SARA: It sounds good. I hope I can feel better in 12 weeks.

THERAPIST: You *can* feel better in 12 weeks. IPT has been shown in numerous research studies to be effective in treating symptoms like the ones you have described.

After the first session Sara felt somewhat more hopeful but stated that she did not like the idea that she had a diagnosis of major depression. Although she could understand that there was relationship between her stillbirth and her mood, Sara still felt that she should be feeling better after 2 months and did not want to think of herself as depressed, like her mother, and in need of help. Sara stated that she was always the "strong one" and was used to functioning at a very high level. The therapist was not surprised by Sara's initial skepticism, because it can take time for patients to accept the medical model. Furthermore, patients with depression often feel uncomfortable about seeking help, because they fear burdening others. Nevertheless, therapist and patient agreed to work together for 12 weeks, then decide whether further sessions were needed.

In obtaining Sara's psychiatric history, the therapist conducted an *interpersonal inventory*, carefully reviewing Sara's past and current social functioning and close relationships. She started the inventory by asking about Sara's family.

"Where did you grow up? . . . Who was in your family? . . . How would you describe your relationship with your mother? . . . With your brother?"

Sara grew up in Canada with her father and mother, both in their early 60s, and her younger brother, age 33, all of whom still lived near Toronto where she had been raised. She reported that her father had worked a lot while she was growing up, and although she was fond of him, she did not feel so close to him. Sara felt closer to her mother and spoke with her weekly but was easily irritated by her. It bothered Sara that her mother was not assertive and was intermittently depressed. She spoke weekly with her brother, who lived in Canada with his wife and 2-year-old son. She described her relationship with her brother as fairly close. She reported speaking to her brother less often since the stillbirth, because she felt jealous that he had a child. When they did speak, Sara avoided asking about her nephew.

After exploring Sara's relationships with family members, the therapist asked about other important people in her life and asked her about the relationship with her husband. At age 33, Sara met her husband, Steve, who was 1 year her junior. She described Steve as warm and charming, and reported that he took great care of her. She felt she did not "deserve him," because he was "such a good guy." She described her previous boyfriends as less emotionally available and "not very nice." Both Sara and Steve were originally from Canada but met in New York City, when they were introduced by mutual friends. Sara had moved to New York in her early 20s, whereas her husband had moved there 2 years prior to their meeting.

Since the stillbirth, Sara felt distant from Steve and argued with him about "little things." She reported feeling guilty that she had let him down by losing the baby and feared that he blamed her for the baby's death. She did not want to burden him further by sharing her own distress about the loss. She also felt that Steve would not be able to understand her fears about trying to conceive again.

Sara reported having a few close girlfriends who lived in the tristate area and, until the

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pregnancy loss, spoke to them about once per week. She had several friends at work, with whom she chatted almost daily until the loss. She described herself as "independent," "outgoing," and "not one to lean on other people" prior to becoming depressed. She was the one to whom her friends turned when they had problems. Sara said that before the depression, her friends would describe her as hardworking and energetic. Sara reported that she rarely argued with friends because she felt "uncomfortable" with conflict. She avoided confronting friends and coworkers when she disagreed or felt angry with them.

The therapist asked Sara if there was anyone to whom she had turned for comfort after her loss, because it is important to have someone in whom to confide after such a terrible loss or any stressful experience. Sara replied that she had been avoiding her friends and family since the loss. She had felt uncomfortable talking to friends, family, and coworkers about her pregnancy when she was pregnant, because she did not like being the center of attention and felt guilty that she did not enjoy the first trimester of her pregnancy. She felt even more uncomfortable discussing her pregnancy loss. Her parents and in-laws came to see Sara and her husband after the loss, but she felt unable to talk with them about what had happened and how she was feeling. All of her coworkers knew that she had been pregnant, and Sara felt obligated to say something to them about what had happened. The therapist noted that it sounded like Sara could trust no one with her feelings about the stillbirth. Sara did not want to reach out to family or friends, or let them know how bad she felt; she explained: "I don't want to bother people with my problems. I don't want to be weak."

The therapist reframed Sara's difficulty in reaching out to others, using the medical model to explain how depression affects social functioning:

THERAPIST: You are not weak—you are *depressed*—and that's not your fault. People with depression tend to minimize their own needs and avoid seeking help from their friends, as you have been, because they fear being a burden. However, it is not only appropriate to seek support from others but it also can be *really* helpful to get support from others. In fact, support from others has been shown to help in recovery from depression. I appreciate your dilemma. Your depression makes you feel uncomfortable seeking support, yet support from others has been shown to reduce depression and protect people from becoming depressed. Does this make sense to you?

SARA: Yes, but I also don't want to hear what they have to say. It just makes me more upset. They don't understand what I have been through.

THERAPIST: What kinds of things have people said to you?

Sara replied that it bothered her when people said things like "You'll get pregnant again" or "I know someone who also lost a baby." These statements made her feel angry. She felt that others could not understand what she had experienced. One close friend had recently given birth to her first child, and Sara had avoided calling and seeing her. She felt that it was unfair that her friend had a baby when she did not. A coworker had been pregnant at the same time but had a relatively easy pregnancy. Sara felt that her coworker was not sympathetic to her physical discomfort during pregnancy.

By the end of the first phase of treatment, the therapist had connected Sara's major depressive episode to her interpersonal situation in a *formulation* centered on an IPT focal problem area. Sara's chief complaint reflected that she was still grieving the loss of her baby and unable to resume her normal level of functioning. Her situation was a clear example of the grief problem area: Sara was suffering from complicated bereavement. While it is normal to grieve for months after losing a loved one, the severity of Sara's depressive symptoms—especially the excessive guilt, low self-esteem, and social isolation—and her avoidance of thoughts, feelings, and reminders of the baby and the baby's death, reflected an abnormal grief reaction. She had not sought emotional support after the stillbirth and had not really mourned the loss of her baby. In fact, people often develop complicated bereavement when they lack or have not used their social network to help them mourn the loss of their loved one.

The therapist presented this formulation to Sara:

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THERAPIST: From what you are telling me, it's clear that the loss of your baby triggered your current depression. You have suffered a terrible loss and you are having trouble grieving. No wonder you are having such a hard time. This is not your fault. Furthermore, your loss and your depression have affected your relationships with people in your life, like your husband, your friends and coworkers, and you're having difficulty expressing your feelings to them. I suggest that we focus our sessions on handling your grief over this terrible event. Grief is one of the problem areas that IPT has been shown to treat. I suggest we work on helping you to mourn the loss and to improve your relationships that have been affected by your loss. How does this sound to you?

SARA: It sounds good.

With Sara's explicit agreement about the treatment focus, the therapist began the middle phase of treatment.

Middle Phase (Sessions 4–9)

During the middle phase, therapist and patient worked on resolving Sara's interpersonal problem area. In IPT, the strategy for working with grief is to help the patient to tolerate and manage the affect of loss, and to gather social support to help the patient through mourning. In addition, the therapist helps the patient to use existing social supports, to reestablish interests and relationships, and to form new relationships and explore new activities to compensate for the loss (Weissman et al., 2000).

The therapist continued providing psychoeducation about complicated bereavement and how depression affects social functioning, and repeatedly linked Sara's depression to the identified problem area. She began each session with the *opening question:* "How have things been since we last met?" This question elicited affect and a history of Sara's mood and events between sessions, and kept her focused on her current mood and life events.

To facilitate the mourning process, the therapist encouraged Sara to think about the loss. In fact, this process had begun during the initial phase, while the therapist took a history of the events related to the onset of Sara's depression. The therapist asked Sara to describe the events prior, during, and after the baby's death—often a source of patient guilt—and explored Sara's feelings associated with these events. In helping a patient mourn the loss of a loved one, the IPT therapist asks the patient to describe her feelings about the death and about the person who died. The therapist explores what the patient and the deceased did together, what the patient liked and did not like about the person, and what the patient wished they had done together but did not have a chance to do. The therapist asks the patient to describe how the deceased died and how she learned about the death, and explores the patient's related feelings. Given that the Sara's baby died *in utero*, the therapist modified this inquiry somewhat by encouraging Sara to talk about her experience of being pregnant, about the baby, and what she imagined the baby would be like. The therapist asked Sara what she liked about carrying the baby, what she did not like, and what she had hoped to do with the baby.

Sara tearfully described having had mixed feelings about her pregnancy. She reported that she and Steve started trying to conceive 6 months after getting married and, to her surprise, she got pregnant after 2 months. When she discovered she was pregnant, Sara felt really happy, but scared about becoming a parent. She questioned whether she was "ready." Sara reported that she made a great effort to practice good prenatal care: She ate healthy, pregnancy-safe foods, took prenatal vitamins, and started prenatal yoga classes. Practicing good prenatal care made her feel good, "as if I was already a mom taking care of my baby."

Sara quickly began to experience terrible fatigue and unrelenting nausea, which lasted for the first 12 weeks of the pregnancy. She described feeling as if she had been "taken over" by the pregnancy. She complained that she loved to cook but did not want to cook, because she felt so sick. Despite the nausea, she ensured that she was getting the nutrients she needed for the baby. The fatigue and the nausea were so debilitating that Sara could no longer meet the physical demands of her job as a nurse. As a result, she was unable to hide her pregnancy from her coworkers; she told her supervisor, who was happy to accommodate Sara by giving her more administrative responsibilities in lieu of patient care, until she felt better. Sara resented having to give up clinical work with patients, which was the part of her job

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she enjoyed. She felt self-conscious about her symptoms and very guilty that her coworkers had to absorb her patient load, despite their being very supportive. It bothered her that others idealized pregnancy when she found it so unpleasant. At the same time, she felt guilty and selfish that she had complained about the pregnancy: Sara felt that she should have just been grateful she was pregnant.

The therapist empathized with Sara's discomfort during her first trimester and validated her need to complain:

THERAPIST: The first trimester of pregnancy can be really difficult and disruptive. Give yourself a break! It can be hard to appreciate being pregnant when you are feeling so terrible. It sounds like you did appreciate being pregnant—you made a great effort to take care of yourself. You watched your diet carefully and rearranged your work situation.

SARA: I don't know . . . I guess that is true.

When the exhaustion and nausea subsided in her second trimester, Sara began to feel more optimistic and excited about having a child. Seeing sonograms made the baby seem "more real" and helped Sara feel connected to the baby. At Week 16, Sara learned that the baby was a girl. She felt excited and immediately began considering names and envisioning what the baby would look like. Sara imagined that she would look like a combination of herself and her husband, with blue eyes and blond, curly hair. She thought the baby would be a kind person, like her husband. She imagined walking to the park with the baby in a stroller, and playing with her. At Week 20, Sara began to feel the baby move, which she very much enjoyed. When the baby moved, Sara would stop whatever she was doing to watch and feel her abdomen. She described feeling the movements as "some of the happiest moments in my life." Neither she nor her husband had thought of a name for the baby, but referred to her as "Sweetie" *in utero*.

For weeks after the stillbirth, Sara struggled with physical reminders of the baby. After delivering the baby, she had leaky breasts for a few days and vaginal bleeding for several weeks. She reported that she still looked pregnant for weeks after delivering the baby, as her uterus slowly returned to its prepregnancy size. At the time of her initial evaluation, Sara reported that she still had to lose 5 pounds to return to her prepregnancy weight. Sara missed being pregnant and described feeling "empty" and "alone" without the baby inside her. She was eager and ready to be a parent, yet felt scared about conceiving again, because she feared losing another baby.

A couple of weeks after the stillbirth, Sara's doctor determined that an undetected bacterial infection caused the stillbirth. The doctor explained that there was nothing Sara or her husband could have done to prevent the loss, and that this kind of loss was very rare. Despite her doctor's explanation, Sara blamed herself for her baby's death and feared that her husband blamed her too, although he repeatedly denied this. The therapist explored Sara's guilt further:

THERAPIST: What could you have done to prevent your baby's death?

SARA: (*tearfully*) I don't know. . . . I should have been able to do something.

The therapist offered Sara empathy and support, and related her guilt to depression:

THERAPIST: It would be great if there was something you could have done to prevent this tragedy, but there is generally nothing parents can do to prevent a pregnancy loss. It sounds like you did everything you could—you took very good care of yourself. You are struggling with inappropriate and excessive guilt—a symptom of depression. You are blaming yourself for something you didn't do. Perhaps when you find yourself feeling guilty, you can try to label this as a symptom of depression.

SARA: Yes. I guess I can try.

Talking about the pregnancy, the baby, and the baby's death, and exploring related feelings enabled Sara to develop a more balanced and realistic perception of her relationship with the baby and her role in the baby's death. She realized that she had not taken her pregnancy for granted. In fact, she had done everything she could to manage a difficult first trimester and take care of her baby. In addition, her experience with the pregnancy and the baby made Sara realize that, despite her initial anxiety, she was ready and excited to become a parent. By

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the end of the first month of treatment, Sara's mood was somewhat improved and her HDRS score had fallen to 18. She was less self-critical and more hopeful.

An important part of treating grief is facilitating the expression of affect related to the loss of the loved one. The therapist explored Sara's feelings as she spoke about the baby and her loss, giving her time to articulate what she was feeling and to cry. Although IPT therapists generally take an active stance, when facilitating the expression of painful feelings, it is important to allow for silences. By listening silently, the therapist showed that she could tolerate Sara's painful feelings, and that catharsis was an important part of mourning her loss. Sara was able to express feelings that she not only had been avoiding but also feelings of which she had previously been unaware.

Sara had avoided looking at the pictures and footprints of the baby from the hospital, which had been stored in a box under her bed. She and the therapist explored what it would be like for her to look at these items. Sara feared it would be scary, and that she would feel really bad. The therapist gently encouraged Sara to take a risk and look, because it might make her feel better to experience the feelings she had been avoiding:

> "Your feelings are not going to hurt you. You might actually feel better if you allow yourself to let out some of the feelings you have been trying to keep inside. I know I am asking you to take a risk, but you might be pleasantly surprised."

Between sessions, Sara looked at the pictures and the footprints. The therapist asked what it was like for her.

SARA: I cried a lot. She was so cute. It wasn't as hard as I thought it would be. It felt like a release. I was surprised that I felt a little better afterwards.

THERAPIST: I am *so* glad you took a risk and looked. It sounds like it made you feel better.

In fact, every few weeks before the end of treatment, Sara looked at the pictures and the footprints. She explained that the pictures were sort of comforting, because they made her feel a connection to her baby.

In addition to encouraging catharsis, the therapist encouraged Sara to work on her interpersonal interactions, to reconnect with the people in her life, and to consider opportunities to form new relationships and start new activities to compensate for the loss. The therapist explained that people with depression tend to isolate themselves and stop engaging in previously pleasurable activities, both of which can perpetuate depression. Sara reported not wanting to talk to people, because she feared that she would have to talk about the loss, or that things people said would make her feel worse. In fact, as Sara and the therapist discussed, *she* could guide the conversation in a way that made her feel comfortable. They explored and role-played options for maintaining control of such conversations. Furthermore, Sara could tell people what would be helpful to her. The therapist explained:

> "People with depression often have difficulty asserting their needs. If you communicate your needs to others—like your husband, friends, coworkers, and your family—you might improve those relationships *and* your mood. The people in your life may not know what you need. If you tell them, you might not only get support from them, but you might enjoy their company again and feel better."

Using *communication analysis*, the therapist asked Sara to recount arguments and unpleasant interactions with others—what she was feeling during the interaction, what she said or did, and what the other person said or did. They explored what Sara wished other people would say or do, and what *options* she had for asking them to do these things, and *role-played* Sara asking for what she wanted. Sara reported that she hated running into people who knew she had been pregnant but did not know about the stillbirth. In fact, she avoided going places, because she feared having to answer questions about the stillbirth. Sara and the therapist explored these interactions and how Sara could handle them more effectively:

THERAPIST: What kinds of things have people asked, or what are you afraid they will ask?

SARA: People have asked "How's your baby?" or "Weren't you pregnant?"

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THERAPIST: How does that make you feel?

SARA: Awful!

THERAPIST: How do you handle it?

SARA: I don't know. . . . Sometimes I say "It didn't work out" or "My baby died."

THERAPIST: That sounds good. How does it feel for you to say that?

SARA: It feels OK, but then they want to know what happened and say stupid things like "At least you know you can get pregnant" or "You can have another one."

THERAPIST: What would you like them to say or do?

SARA: I would like them to just say "I'm sorry," and not ask any questions. I don't want to talk about what happened.

THERAPIST: How could you convey that?

SARA: I guess I could say, "I'm sorry, but I'd rather not talk about it."

THERAPIST: How does that sound? How did it feel to say that?

SARA: It felt OK. Don't you think that is rude to say that?

THERAPIST: No. You said it politely and it is appropriate for you to assert your needs. It is an uncomfortable situation for both you and the person who asked the question. If you are polite and direct with people, they are likely to understand. But why not try it and see?

Sara reported that she had avoided returning calls from old friends. She explained that she did not feel comfortable seeing her friends who had babies, because it would remind her of the baby she had lost. Sara also did not want to have to talk about the loss. She did not want to tell them how she felt, because she feared hurting their feelings. Sara and the therapist role-played Sara telling her friends about her discomfort and explaining that she did not want to offend them. Role play helped Sara feel prepared and less anxious about going to work, walking around her neighborhood, and talking to old friends. As a result, she gradually starting going out more and began returning phone calls. She returned to the yoga studio, where she had taken prenatal yoga, and started taking regular yoga classes, which helped her mood and provided an opportunity to be among other people. By midtreatment Sara's HDRS had fallen to 13, consistent with mild depression.

Since the stillbirth, Sara had been bickering with her husband Steve "over stupid things" and felt "distant from him." The therapist asked her to describe a recent incident. Sara said that Steve came home from work and told her that his friend's wife had just had a baby. She felt it was insensitive for him to tell her about other people's positive pregnancy experiences. It bothered her that Steve did not seem as uncomfortable as she was with this information, and that he no longer seemed as upset as she about the loss. The interaction made her feel "alone." She had responded to him by saying, "That's nice," then leaving the room and ruminating for the rest of the evening about his insensitivity.

Sara reported that they often had similar interactions. The therapist once again related Sara's difficulty asserting herself with her husband to depression, and noted that keeping her feelings inside might actually be making Sara feel worse. They explored interpersonal options for handling this situation in a way that might make Sara feel better. The therapist also helped Sara to explore what her husband's intentions might have been in the situation she described. She wondered whether he was trying to make her feel better, because his friend's wife had experienced several miscarriages. They role-played Sara telling her husband how she felt. Subsequently, when Sara was able to express her feelings to him, she learned that Steve was, in fact, telling her these stories to give her hope. Furthermore, her husband revealed that he was still upset about the loss of their baby but did not want to upset *her* by sharing his feelings. Sara was relieved that she and Steve were "on the same page" and felt good that she was able to feel close to him again. They subsequently were able to share more of their mixed feelings about the pregnancy experience.

Termination Phase (Sessions 10–12)

During the final sessions the therapist and Sara reviewed the progress Sara had made. She reported that her mood was much improved. Her HDRS was now a 5, consistent with euthymia and remission. Sara's affect was brighter, and she was less preoccupied with the loss of her baby: "I still get upset when I think about my baby, but I don't get as upset. It doesn't ruin my entire day. I am actually able to enjoy things

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again." Furthermore, Sara no longer blamed herself for her baby's death. She felt good about her ability to communicate her feelings more effectively with her husband, friends, and others, and to enjoy socializing and other activities again.

The therapist congratulated Sara on her hard work and achievements, and told her how happy she was that Sara felt so much better. They discussed the potential for relapse and how Sara could maintain her progress. Given Sara's history of depression, the therapist explained that Sara was, unfortunately, vulnerable to future episodes; however, Sara could anticipate that she would be vulnerable in the setting of stressful life events—role disputes, role transitions, deaths—and use the coping skills she had learned during their work together. Sara anticipated starting treatments for her clotting disorder, trying to conceive again, and, she hoped, getting pregnant for a second time—all role transitions. The therapist and Sara explored ways Sara could take care of herself during this potentially stressful time. They discussed Sara's reaching out to others for support, communicating with her husband about how she was feeling, and forgiving herself if she found herself having a hard time.

In the final session, Sara told the therapist that she had reread her diary entries from the days before beginning treatment, and she could not believe how far she had come, that her pregnancy loss had forced her to seek treatment for depression that she now realized had been a lifelong problem; in retrospect, she had suffered numerous episodes of mild to moderate depression. Sara admitted that she was initially very resistant to the medical model. Defining depression as a medical illness ultimately relieved Sara of her shame and guilt about her difficulty in functioning. Furthermore, being able to see depression as a set of discrete symptoms made it seem more manageable. Sara reported that she was getting along better with her mother; now that she understood depression, she felt more sympathy for her mother's struggle with depression. She was grateful for the opportunity to learn coping skills that she felt confident about maintaining. In addition, Sara said that she would not hesitate to seek treatment in the future should she find herself becoming depressed again.

The therapist's frequent encouragement, the time limit, and the brief duration of IPT helped keep Sara motivated. Sara said that she appreciated the opportunity to talk about her feelings about her pregnancy, her baby, and her baby's death, and that she felt the therapist understood and supported her. She recognized that her feelings, while powerful, made sense in context and had subsided with discussion. Sara confessed that she appreciated the therapist's "pushing" her to reconnect with others. She had not thought she could handle being with others but was pleasantly surprised.

Although each patient is unique, Sara's therapy resembled other IPT treatments for major depression and is a good example of working with the problem area of grief. The exploration and normalization of affect, communication analysis, exploration of options, use of role play, encouragement to take social risks, and other techniques employed in Sara's treatment are characteristic of working with interpersonal difficulties related to any of the four IPT problem areas.

COMMON PROBLEMS THAT ARISE DURING TREATMENT

The problems that typically arise during IPT treatment for major depression are (1) those inherent to working with depressed patients and (2) those related to the therapeutic frame. Although these problems are not unique to IPT, how the therapist views and treats these issues distinguishes IPT from other psychotherapies. In keeping with important IPT themes, the therapist attributes problems to depression, and to the patient's difficulties handling interpersonal interactions and communicating effectively outside of the treatment. The therapist continues to maintain an optimistic, supportive, and nonjudgmental stance and avoids transference interpretations.

For example, patients with major depression superimposed on dysthymic disorder ("double depression") and their therapists are often discouraged by the chronicity of their depression. In these cases, the therapist should remain hopeful and optimistic. Some depressed patients feel that their depression is incurable despite reassurances from the therapist. In these cases, the IPT therapist employs the medical model, labeling the hopelessness as a symptom of depression, and emphasizes that patients need not feel hopeless since depression is treatable. Depressed patients often view seeking treatment as a personal failure. The IPT thera-

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