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Interpersonal Psychotherapy for Co-occurring Depression and Chronic Pain

Ellen L. Poleshuck[1], **Stephanie A. Gamble**[1], **Natalie Cort**[1], **Debra Hoffman-King**[2], **Beth Cerrito**[1], **Luis A. Rosario-McCabe**[1], and **Donna E. Giles**[3]

[1] University of Rochester School of Medicine, Rochester, NY

[2] Canandaigua Veterans Medical Center, Canandaigua, NY

[3] University of Florida, Gainesville, FL

Abstract

Up to 37% of individuals experience chronic pain during their lifetimes. Approximately one-fourth of primary care patients with chronic pain also meet criteria for major depression. Many of these individuals fail to receive psychotherapy or other treatment for their depression; moreover when they do, physical pain is often not addressed directly. Women, socioeconomically disadvantaged individuals, African Americans and Latinos all report higher rates of pain and depression compared to other groups. This article describes a version of Interpersonal Psychotherapy tailored for patients with comorbid depression and chronic pain, Interpersonal Psychotherapy for Depression and Pain (IPT-P). While IPT-P potentially could be delivered to many different patient populations in a range of clinical settings, this article focuses on its delivery within primary care settings for socioeconomically disadvantaged women. Adaptations include a brief 8-session protocol that incorporates strategies for anticipating barriers to psychotherapy, accepting patients' conceptualization of their difficulties, encouraging patients to consider the impact of their pain on their roles and relationships, emphasizing self-care, incorporating pain management techniques, and flexible scheduling. In addition, IPT-P is designed as an adjunct to usual medical pain treatment, and seeks to engage non-treatment seeking patients in psychotherapy by focusing on accessibility and relevance of the intervention to concerns common among patients with pain. Identifying patients with comorbid depression and chronic pain and offering IPT-P as a treatment option has the potential to improve clinical outcomes for individuals with depression and chronic pain.

Keywords

Psychotherapy; depression; chronic pain; primary care; poverty

INTRODUCTION

Pain and Psychotherapy

Patients with pain and depression have poorer depression and pain treatment outcomes compared to patients with pain or depression alone (Bair, et al., 2004; Poleshuck, et al.,

2009). The biopsychosocial approach (Engel, 1980) suggests it is important to consider the physical symptoms of psychotherapy patients in addition to psychological symptoms and social contexts. Yet outside of multidisciplinary pain clinics, psychologists are often socialized to target mental health symptoms and relationship problems in psychotherapy rather than physical symptoms like pain. By considering patients' physical challenges such as chronic pain in psychotherapy, therapists can engage individuals who understand their difficulties as physical, enhance mental health outcomes, and possibly contribute to improvement of response to medical pain treatments as well.

Chronic pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Merskey & Bogduk, 1994) and is present for a minimum of three or six months, depending on the definition. An average of 65% of people with depression (range 15–100%) also has significant physical pain (Bair, Robinson, Katon, & Kroenke, 2003). Living with chronic pain and depression significantly reduces quality of life and interrupts usual roles and relationships. Depressed patients with pain report difficulties in multiple domains, including general physical function, social support, anxiety, and other comorbid psychopathology (Poleshuck, Giles, & Tu, 2006). The relationships between chronic pain and depression are complex, and research to unravel them is ongoing. While the majority of studies support chronic pain as a cause of depression, there is also evidence for depression as a cause of chronic pain, and for mutually reinforcing relationships between chronic pain and depression; regardless of the cause, once pain and depression are present, both need to be treated (Gatchel, Bo Peng, Peters, Fuchs, & Turk, 2007).

An interpersonal approach to treatment may be a useful option for patients with depression and chronic pain. To date, much of the research on psychotherapy for pain has involved cognitive behavioral therapy. While there is support for the efficacy of cognitive behavioral therapy and behavioral therapy for chronic pain (Astin, Beckner, Soeken, Hochberg, & Berman, 2002; Morley, Eccleston, & Williams, 1999), the findings are inconclusive (Ostelo et al., 2005) and these approaches may not be the best fit for all patients (Vlaeyen & Morley, 2005). One study found that among patients with fibromyalgia, those who were interpersonally distressed had negative pain and depression severity outcomes in response to a traditional multidisciplinary pain treatment program (Turk, Okifuju, Sinclar, & Startz, 1998). Furthermore, women may show specific benefit from a relational approach that emphasizes interpersonal connections and utilizes their natural support systems (Kiecolt-Glaser & Newton, 2001). A greater breadth of evidence-based psychotherapy approaches would allow therapists to select psychotherapy treatments tailored to match the needs of their patients with depression and chronic pain (Roy, 2008; Turk, 2005).

A familiar setting: increasing accessibility

Patients are likely to seek care from their primary care physician's office for both physical and mental health, especially if they are lower income young women (Miranda, Azocar, Komaromy, & Golding, 1998). Anhedonia, low motivation, practical barriers, and physical challenges can coalesce for patients with chronic pain and depression, leading to increased difficulty in following up with mental health referrals. Most patients referred by their primary care physicians to mental health specialty settings do not follow-up (Craven, 2006). Using providers within the primary care setting can improve engagement of patients in treatment as well as feasibility and dissemination of the intervention. A 2006 meta-analysis of 12,355 primary care patients with depression receiving either primary-care-based collaborative care or usual care found that those who received the primary-care-based collaborative care were more improved for depression severity six months later, with evidence for an effect five years later (Gilbody et al., 2006). Physicians, nurses, social workers, and other providers in primary care settings already have established relationships

with patients. By integrating psychotherapy into the primary care setting, it becomes more accessible, less stigmatized, more collaborative with their physical health care, and probably more relevant to the patient with pain.

Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) is an evidence-based time-limited psychotherapy established on the premise that there is a bidirectional relationship between depression and interpersonal difficulties (Stuart & Robertson, 2003; Weissman, Markowitz, & Klerman, 2000). Attachment theory provides the primary theoretical basis for IPT, and suggests that people are distressed when they experience disruptions in their relationships reminiscent of early life attachment disruptions. IPT is based on an expectation that by improving interpersonal relationships and social support, depressive symptoms will improve. The therapist and patient complete an interpersonal inventory to gather information about the patient's key relationships. An interpersonal conceptualization of the patient's difficulties is developed, and patients identify one of four problem areas to focus on with guidance from the therapist. These problem areas include interpersonal dispute, grief and loss, role transitions, and interpersonal sensitivity. The therapist and patient implement specific interpersonal strategies based on their problem area (e.g. interpersonal incident review, use of affect, role play). Patients typically attend 16 therapy sessions weekly, often tapering off the frequency toward the end of treatment to a maintenance schedule. IPT is distinct from Cognitive Behavioral Therapy in its emphasis on improving social support, communication style, and relationships as the primary approach to alleviate depressive symptoms. As a result, the focus of sessions is on modifying how patients approach getting their interpersonal needs met, rather than changing their cognitive styles or behaviors.

Empirical support for the efficacy of IPT is well-established and dates back over thirty years (Klerman, Dimascio, Weissman, Prusoff, & Paykel, 1974; Weissman, 1979). Following the success of early trials, IPT has been helpful for diverse and low-income patient populations (Brown, Schulberg, Sacco, Perel, & Houck, 1999; Rossello & Bernal, 1999; Spinelli & Endicott, 2003) and in a variety of clinical contexts, including medical settings (Grote, Bledsoe, Swartz, & Frank, 2004; Schulberg, et al., 1996; Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001). More recent studies have demonstrated that IPT is effective in treating depression among patients with chronic illnesses, including pain (Karp, et al., 2005), coronary disease (Koszychi, Lafontaine, Frasure-Smith, Swenson, & Lesperance, 2004), HIV+ (Markowitz, et al., 1998), and medically frail older adults (Miller, et al., 1996). IPT has generally required minimal adaptation to fit the needs of different patient populations, and has demonstrated good adherence and treatment satisfaction (Grote, et al., 2004; Koszychi, et al., 2004; Swartz, et al., 2004; Zlotnick, et al., 2001). These studies suggest that IPT is not only feasible, acceptable, and effective for depression, but also helpful to low-income, racially and ethnically diverse patients with physical comorbidities in medical settings.

The indication for IPT for depression in patients with pain is further suggested by how well two of the core problem areas of IPT, role transition and interpersonal dispute, map onto the issues facing these patients. Patients with pain often encounter unwelcome role transitions, such as job loss, disability, and role disruption. These multiple stressors take a toll on relationships with family, friends, and health care professionals, create feelings of guilt and shame, and limit patients' perceived options in dealing with others. Further, due to the invisibility of pain to others, patients with pain often feel isolated and misunderstood, and have difficulty engaging others effectively. IPT allows an opportunity to address feelings of disappointment, rejection, and anger with family, friends, co-workers and health care professionals. Finally, the focus on connections between mood and interpersonal functioning and on taking active steps to improve depression may improve their sense of agency and

their ability to utilize medical care, potentially enhancing generalizability of these skills to other aspects of their lives.

In this paper, the concept of tailoring IPT for individuals with both depression and chronic pain, Interpersonal Treatment for Depression and Pain (IPT-P), is introduced. The rationale for the development of IPT-P has been described. Following is a background on the development of IPT-P, the key elements of the intervention, and a case example to illustrate its application.

BACKGROUND

The University of Rochester Women's Health Practice (WHP) is a large, university-affiliated, hospital-based, urban obstetrics and gynecology clinic. It is a primary resource for physical and mental health care for lower-income, predominantly minority women living in the vicinity of the clinic. WHP provides several specialty clinics, including a weekly chronic pelvic pain clinic. In trying to work with WHP patients with pain, providers frequently expressed concern about how to meet their needs. The patients presented with complex and extensive physical and mental health symptoms, yet seldom reported concerns with depressed mood nor requested mental health treatment. Interpersonal Psychotherapy for Depression and Pain (IPT-P) evolved as a team of clinical psychologists and a women's health nurse practitioner worked together to respond to some of these needs.

KEY ELEMENTS OF INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSION AND PAIN (IPT-P)

Three goals were identified while developing Interpersonal Psychotherapy for Depression and Pain (IPT-P). First, the intervention needs to be relevant to individuals who may not necessarily seek treatment for their depression, and who may not necessarily even identify themselves as depressed. Second, consideration of pain, in addition to depression, is incorporated; more specifically the ways in which pain is associated with depression and interpersonal functioning is discussed. Third, the accessibility of IPT is enhanced. There was particular interest in developing responsiveness to the challenges of socioeconomically disadvantaged patients, since the need is great and the barriers to traditional mental health settings are many.

IPT-P is 8 sessions, modeled after Brief Interpersonal Psychotherapy (IPT-B: Swartz, et al., 2004; Swartz, et al., 2008), and incorporates components of traditional pain management strategies (Table 1). Sessions are held in the primary care clinic if possible. In this way, IPT-P becomes part of their usual health care, a familiar place which is also conducive to emphasizing the mind-body connection of the intervention. The setting can also reduce concerns about going to a mental health clinic, such as finding a new place or being stigmatized. The medical provider is consistently informed about the patient's status and progress in treatment. The clinic offers childcare and evening appointments, and social work and nutrition support is available on-site.

A. Sessions 1–2: Engagement, Conceptualization, and Developing a Plan

Therapist empathy, acceptance, and support of self-efficacy are particularly essential in IPT-P. The IPT technique of clarification is used to understand the implications of the pain, patients' conceptualizations of their difficulties, their hopes for change, and the therapist then works within that framework. At the beginning of treatment, patients are asked to describe their pain in detail, including the duration, location, and severity. Patients are asked how they have tried to cope with their pain (medical and other alternatives) and how successful those approaches have been. Often patients fear that others, including their

physicians, believe their pain is “in their head”, and that if they see a therapist it will be viewed as evidence that their pain does not need to be taken seriously. Asking if anyone has ever challenged whether the pain is “real” provides an opportunity for therapists to emphasize their acceptance of the patient’s pain experience and explore possible fears. Many patients with pain are accustomed to “receiving” care and are not familiar with the active stance required for IPT-P. Educating patients to encourage ownership of their treatment, and communicating clearly about expectations, will help them engage in an active way.

Psychotherapy participation is demanding on patients. In order to succeed at engaging non-treatment seeking patients in psychotherapy for their depression, therapists must address issues of adherence. Patients may be uncertain about whether they need psychotherapy or if it can be helpful to them. The symptoms of depression can impair motivation, energy, and hope, interfering with attendance. Pain flares can make traveling or sitting extremely uncomfortable, pain medications can be sedating, and even if patients push themselves to attend an IPT-P session during a pain flare, it can interfere with their concentration and energy in the session. Further, the process of therapy can be demanding, bringing up uncomfortable feelings or highlighting life struggles. Patients may recognize differences between themselves and the therapist in terms of sex, race, ethnicity, education, or other factors, and wonder if the therapist can truly understand and help. Obstacles such as transportation, other medical and social service appointments, work schedules, sick children, and difficulties coordinating and remembering them all frequently arise. Therapists spend significant time discussing these issues and working with patients to enhance attendance.

The therapist and patient work together at the beginning of treatment to complete the interpersonal inventory, emphasizing current and important relationships, and then identify a problem focus for treatment. It is common for patients to include their health care providers in the interpersonal inventory, and to target improving communication with their health care providers as a goal for treatment. As in Brief IPT (Swartz, et al., 2004; Swartz, et al., 2008), interpersonal sensitivity has been dropped; it refers to an enduring interpersonal style not amenable to significant change in just eight sessions. An additional problem focus was added, *change in healthy self*, based on themes presented in the therapists’ clinical practices. Many patients struggle with the ways in which their chronic pain has changed their ability to function in multiple domains of their lives: work, parenting, sex, taking care of their home, friendships, hobbies, and more.

In IPT-P, pain symptoms are directly considered in the treatment. Psychotherapists cannot treat medical causes of pain and do not aim to eradicate it, but instead try to support the patient in finding ways to enhance adherence with their pain practitioners’ recommendations and improve overall level of functioning. The therapist educates the patient to expect IPT-P to facilitate the improvement of depressive symptoms and functioning, rather than serving as a direct treatment for pain. Patients are guided in selecting a single pain management strategy compiled from the pain literature that fits with their selected interpersonal problem focus and goal for treatment. Examples include identifying and interrupting triggers for pain, pacing the level of activity, mild to moderate exercise, and progressive muscle relaxation. To integrate these strategies into the framework of IPT, the therapist and patient problem-solve how the technique could be successfully implemented within the patients’ social support network (e.g. scheduling regular walks with a friend).

B. Sessions 3–7: Mid-phase of IPT-P

In the mid-phase of treatment, the therapist starts each session by inquiring about the pain and recent doctors’ visits, and assessing how their pain has impacted relationships and depression since the last session. Patients are encouraged to report progress on their

identified treatment goals, as well as impediments to progress that occurred. Challenges to adherence are discussed on an on-going basis. Phone sessions are offered as a back-up to in-person sessions when necessary. This is preferable to a cancelled appointment, and evidence suggests IPT can be administered effectively by phone (Ransom, et al., 2008). While therapists encourage regular and consistent attendance, patients take as long as is necessary to complete their 8 IPT-P sessions. In reality, little is known about the frequency and intensity of treatment required to obtain adequate psychotherapy outcomes (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009).

Identifying and highlighting existing skills and strengths can be instrumental in supporting the patient's sense of competence and agency, and identifying personal resources that can be utilized in a brief intervention. A recurring theme among patients with pain is a tendency to neglect self-care. It is important to educate patients that self-care is an essential aspect of health, and that by neglecting self-care they become more depressed, further depleted and less of a resource for others. Attention to self-care behaviors such as getting sufficient sleep, eating a healthy diet, nurturing previously satisfying relationships, engaging in social activities, church or other religious involvement, hobbies, and pleasant activity scheduling, can all be extremely beneficial. It is also important to explore how the patient can obtain the support necessary from others to implement self-care strategies.

C. Session 8: Concluding IPT-P

In the final session, the therapist emphasizes the patient's efforts, and highlights the gains accomplished no matter how small they may seem to the patient. The intention is that the patient will find IPT-P to be a success experience, allowing psychotherapy to serve as a potential resource in the future. The therapist also assists the patient in beginning to generalize the progress made to other situations in her life. This allows the patient to consolidate new skills and apply them independently in different contexts. Lastly, the therapist reinforces the importance of working collaboratively with her physicians and continuing with her active pain treatment regimen.

During the last session, the therapist encourages the patient to anticipate future difficulties, and to consider how she might use her IPT-P strategies in response. This allows the patient to: 1. recognize that future difficulties will arise; 2. begin to generalize what she has learned through the process of IPT-P; and 3. gain a sense of competence in her ability to respond. It is also important to review how the patient will know if she needs to re-initiate therapy in the future, and what steps she can take to initiate the process. It is not uncommon for patients to feel that there are other ways in which they would like to make progress. A transfer to a new therapist in a traditional mental health setting is a positive treatment outcome. In these cases, the therapist works with the patient and the women's health provider to facilitate the transition to a new therapist.

D. Preliminary Evidence Supports the Use of IPT-P

An uncontrolled pilot study using IPT-P with 17 low-income gynecology patients from the Women's Health Practice was conducted (Poleshuck, Talbot, N.E., Gamble, S, Zlotnick, C., Tu, X, Liu, X, Giles, D.E., in press). All participants met criteria for chronic pelvic pain for a minimum of three months and major depressive disorder on the Structured Clinical Interview for the DSM-IV (First, Spitzer, Gibbon, & Williams, 2001). Depression was measured with the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Hamilton Rating Scale for Depression (Hamilton, 1960). Despite the brief duration and low intensity of the intervention, therapists reported IPT-P fit their patients' needs, patients reported high satisfaction with the intervention, demonstrated relatively good adherence, and reported improvement for their depression severity. While the preliminary

evidence suggests benefits, the study was uncontrolled, conducted with a small and restrictive sample, and cannot generalize to patients with pain conditions other than chronic pelvic pain, to men, to different age groups, individuals of varied socioeconomic status, or to individuals with other chronic health conditions.

CASE EXAMPLE

The case below is based on the experience of one woman who participated in the pilot study. This individual was selected because her treatment was typical of many of the women who participated. Details and identifying information have been changed to protect her confidentiality. Parenthetical notations identify IPT-P strategy used from Table 1.

Ms. P was a 28-year-old African American woman living with her 2 children, ages 6 and 4, and their father, her "on and off" partner of seven years. She reported pain for four years, a diagnosis of endometriosis, and treatment by her physician with laparoscopy and long-term opioids. Ms. P was supported by public assistance and received some financial support from her partner. She reported no previous history of individual psychotherapy, despite repeated referrals.

During a gynecology appointment for pain, Ms. P screened positive for depressive symptoms. She agreed to enroll in the study because she wanted to improve her coping and reduce her anger outbursts. She reported these difficulties were interfering with her relationships with her children and her partner. Ms. P took nearly five months to complete her 8 IPT-P sessions. She consistently attended sessions biweekly for the first 5 sessions. She then had a ruptured ovarian cyst requiring an inpatient admission and causing significant pain exacerbation. She completed session 6 by phone approximately one month after her ruptured cyst, attended session 7 one month later, and her final session 5 weeks after session 7. (J)

Sessions 1–2

During the initial phase of treatment, Ms. P described herself as a very independent person who coped with life's stressors and history of inconsistent family support by managing on her own. When the therapist asked Ms. P to describe her pain and the implications it has for her life, she stated that she felt if it were not for her pain, she would not have any mood or relationship problems (Ai, Aii). Despite the willingness of Ms. P's partner to help, she found it very upsetting to ask, and instead "I try to do everything and suffer meanwhile." Her pattern of trying to manage independently rather than accepting help from her partner exacerbated her pain and depression and often led to conflict and distance between Ms. P and her partner. After completing the interpersonal inventory, the therapist proposed the following:

> "You have been through a lot in life, and have coped by taking care of things on your own as much as possible. It feels safer not to need anyone, and you were proud that you worked hard at your job and took good care of your kids and home. Now that you are living with pain, you are no longer able to manage in the same way. As a result, you continue to try and do everything on your own, push yourself harder than you should, making your pain even worse until you can't function at all. At times you also find yourself taking out your anger and shame on your partner and kids. How does this fit with your experience?" (B,C)

Ms. P agreed with the therapist's conceptualization, and together they discussed ways in which the onset of her pain impacted her mood and relationships. Ms. P and the therapist agreed that change in healthy self captured her problem focus well (C).

Ms. P identified her goal for treatment as "I'm going to have to ask [partner] for help and not feel bad about it." Ms P wanted to decrease her impulsive anger outbursts when interacting with her partner and children. She also decided to limit herself to doing two household tasks during the day, and to ask her partner to take on the responsibility for several specific tasks around house (D).

Sessions 3–7

Through communication analysis, Ms. P became aware that she was more irritable with her partner when she was having significant pain (D). She came to recognize when she was feeling irritable, and found going to her room and writing in her journal about her feelings before talking to him was very helpful in increasing her awareness of her feelings and reducing the anger outbursts (G). After role-playing with her therapist (D), she started talking with her partner about her feelings of shame and anger as they relate to the pain, and reported feeling much more connected to him (G, I). Ms. P also started talking directly with her partner about how her pain was interfering with her ability to accomplish tasks like laundry and grocery shopping, and was pleased to learn he was very responsive to her requests for greater involvement (H, I). She started a recreational activity she found relaxing and enjoyed: crocheting baby blankets (I). This was very satisfying because it allowed her to feel productive and happy when she was resting her body (H).

Session 8

In the final session, Ms. P reported significant improvement in her mood and anger outbursts, and felt she became less distressed by pain flares. She no longer met criteria for major depressive disorder. She reported feeling very activated and confident as a result of her progress, proud of the tasks she was now able to accomplish well, and felt cared about by her partner (K, L). She continued to struggle with moderate levels of pain. Although she reported feeling closer to her partner, she expressed on-going concerns about her pattern of distancing, and felt her history of childhood sexual abuse contributed. Ms. P continued working with her pain physician and accepted a referral facilitated by her therapist to a community mental health center to continue working on these issues.

In summary, IPT-P appears to have been a good match for Ms P's treatment needs and goals. In the initial stages of treatment, the therapist accepted Ms. P's conceptualization of her difficulties (Aii), identified barriers to treatment (Aiii), determined that improving her relationship with her partner was a priority (C), and identified targeted interpersonal strategies that addressed both her pain and depressive symptoms (D). The therapist was flexible with the frequency and format of sessions when Ms P found it difficult to meet consistently (J). Several traditional IPT strategies were used, including clarification, communication analysis, role playing, and problem-solving (D). Self-care tasks and activity pacing were also incorporated to facilitate Ms P's progress toward her interpersonal goal (D). Ms P and the therapist used the final IPT-P session to review progress, identify on-going challenges, and plan for follow-up treatment. (K, L)

IMPLICATIONS

Clinical experience and preliminary findings merit further study of IPT-P as a treatment for patients with chronic pain and depression. Therapists are encouraged to understand the contribution of pain to patients' distress and recognize the ways in which it impacts their mood and relationships. The primary approaches of IPT-P may be helpful when working with patients with pain, regardless of the setting. Framing psychotherapy to be relevant to the patient's conceptualization and priorities may help engagement in treatment. Incorporating pain symptoms as part of the problem formulation may not only be

appropriate, but essential. Last, non-traditional strategies, such as problem-solving directly about treatment barriers and using phone sessions, will likely improve access for patients with depression and pain, especially those who are socioeconomically disadvantaged.

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Biographies

Ellen L. POLESHUCK received her PhD in Clinical Psychology from Kent State University. An Assistant Professor of Psychiatry and Obstetrics and Gynecology at the University of Rochester Medical Center, she serves as director of the Women's Behavioral Health Service. Dr. Poleshuck's research and practice interests include the engagement and treatment of non-treatment seeking, low-income women with depression and pain. Dr. Poleshuck can be contacted by mail: 300 Crittenden Boulevard, University of Rochester Medical Center, Rochester, NY, 14642, or by Ellen_Poleshuck@urmc.rochester.edu.

STEPHANIE GAMBLE received her PhD in Clinical Psychology from the State University of New York at Buffalo. She is an Assistant Professor in the Department of Psychiatry at the University of Rochester Medical Center. Dr. Gamble investigates behavioral interventions for women with co-occurring substance dependence and depression.

NATALIE CORT received her Ph.D. in Clinical Psychology at the University of Rochester. She is currently a Postdoctoral Fellow and Instructor of Psychiatry at the University of Rochester School of Medicine and Dentistry. Dr. Cort is in the process of launching a systematic program of psychotherapy interventions research for women with histories of victimization and Major Depressive Disorder. Dr. Cort's primary research interests include intimate partner violence, Interpersonal Psychotherapy, African American women's mental health experiences, and mental health disparities.

DEBRA HOFFMAN-KING received her PhD (2006) from the University of Rochester. She is a staff psychologist at the Canandaigua Veterans Administration Medical Center. Her main area of professional interest is the treatment of veterans who have experienced military sexual trauma.

BETH CERRITO received her PhD in clinical psychology from the University of Rochester. She is a postdoctoral fellow at the University of Rochester Medical Center. Her areas of professional interest include infertility, pregnancy loss, PCOS management, and providing collaborative care to patients within primary care settings.

LUIS A. ROSARIO-McCABE received his MSN in women's health from the University of Rochester School of Nursing in Rochester, NY. He is a nurse practitioner in the Women's Health Practice at the University of Rochester Medical Center and instructor of clinical nursing at the University of Rochester School of Nursing.

DONNA E. GILES earned her PhD in Psychology from the University of Western Ontario, London, Ontario, Canada. She is Research Professor of Psychiatry at the University of Florida College of Medicine. Dr. Giles has studied factors affecting vulnerability for mood disorders as well as factors influencing the course of major depression.

Table 1

Timeline for completing primary IPT-P tasks

Sessions 1–2	A. Engagement **i.** Elicit pain story **ii.** Accept patient's conceptualization of her difficulties **iii.** Explore and address potential barriers B. Provide psychoeducation regarding associations between relationships, pain, and depression C. Develop conceptualization and identify interpersonal problem focus area D. Select relevant IPT strategies (e.g. clarification, facilitation of affect, communication analysis) and a pain management strategy to be applied with an interpersonal emphasis E. Completing a psychosocial history is NOT conducted due to brevity of treatment
Sessions 3–7	F. Evaluate pain intensity and interference, as well as depression, at beginning of each session G. Explore how any pain changes may be related to changes in depression and relationships H. Assess implementation of IPT-P strategies and progress on interpersonal goals, and respond to challenges that arise I. Reinforce successes and self-care strategies J. Attend to treatment barriers on an on-going basis as indicated
Session 8	K. Review and reinforce useful application of IPT-P strategies and any gains made L. Discuss how IPT-P strategies might be generalized to additional unresolved difficulties M. Anticipate future interpersonal problems that may develop and how they might contribute to pain and depression N. Facilitate referral to community-based psychologist for on-going psychotherapy if indicated