Applying Interpersonal Psychotherapy to Bereavement-Related Depression Following Loss of a Spouse in Late Life

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The efficacy of interpersonal psychotherapy (IPT) as a treatment for outpatients with major depression has been documented in several controlled trials. Recently, IPT has been adapted specifically for depression in late life. The authors report on their experience in applying IPT to geriatric patients whose depression is temporally linked to the loss of their spouses. Detailed treatment techniques are illustrated with case vignettes. Preliminary treatment outcomes are presented for 6 subjects who showed a mean change on the 17-item Hamilton Rating Scale for Depression from 18.5 ± 2.3 SD to 7.2 ± 4.6 after an average of 17 weekly IPT sessions. IPT appears to be an effective short-term treatment for bereavement-related depression in elderly subjects.

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> Grief is not a disease, but it can develop into one.
>
> —George Engel

The known consequences of bereavement include increased rates of depressive and anxiety disorders; increased consumption of alcohol, tobacco, and tranquilizers; exacerbation of existing medical illness; diminished immune competence; and premature mortality from increased rates of suicide, accidents, cirrhosis, and cardiovascular disease.[1–10] A year or more after widowhood, a 10% to 20% rate of major depression was noted by Clayton and Darvish,[11] translating into an annual incidence of 80,000 to 160,000

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cases of bereavement-related depression. Recently, Zisook and Schucter[12] reported rates of major depression in 350 widows and widowers as 24% at 2 months, 23% at 7 months, and 16% at 13 months after their loss, compared with a 4% rate of depression in 126 age-matched subjects whose spouses were still living.

We have recently reported a large decline in Hamilton Rating Scale for Depression (Ham-D) ratings in elderly subjects with bereavement-related major depression who were treated with the antidepressant nortriptyline.[13,14] However, these same patients showed only a small decline in grief intensity as measured by the Texas Inventory of Grief.[15] These data suggest that although the somatic or vegetative symptoms of bereavement-related depression may benefit from treatment with antidepressant medication, such treatment makes little change in the psychological distress associated specifically with the loss of a spouse. This finding argues for a psychotherapeutic component to the management of bereavement-related major depression.

This report will outline our efforts in applying the principles of interpersonal psychotherapy (IPT) to elderly, depressed, spousally bereaved patients in a research setting. These efforts draw on our previous adaptation of IPT for the treatment of major depression in late life: IPT/LL.[16] Illustrative case examples will be provided, as well as specific techniques relevant to this population. Response data obtained through independent raters will be presented in 5 cases.

Interpersonal psychotherapy[17] is an interpersonally focused, present-oriented approach to the treatment of affective disorder. It has been established as an effective acute, continuation, and maintenance strategy with unipolar depressed patients. It was developed by Klerman et al.[17] as what would today be considered a continuation therapy. Subsequently, two large trials[18,19] have demonstrated its efficacy as an acute treatment, and Frank et al.[20] have now shown IPT's prophylactic efficacy in preventing recurrence of major depression in a 3-year maintenance trial.

The use of IPT with depressed older patients has been specifically addressed by Sholomskas et al.[21] and more recently by Frank et al.,[16] who are currently using it in a long-term maintenance trial of therapies in late-life depression.[22]

It should be acknowledged that most patients who lose a spouse in late life will be female and that the loss often occurs in the context of other stressors associated with this life stage. Medical, sensory, or ambulatory disability, financial strain, adjustment to retirement, and loneliness are a few of the elements that set the stage for our patients' reactions to their loss.

IPT Specificity for Grief

In the second edition of the classic text *Grief Counseling and Grief Therapy*, Worden[23] outlines four tasks of mourning: 1) accept the reality of the loss; 2) work through the pain of grief; 3) adjust to an environment in which the deceased is missing; and 4) emotionally relocate the deceased and move on with life. Klerman et al.[17] define consistent goals and strategies for using IPT to treat unresolved grief as follows:

> The two goals of the treatment for depressions that center on grief are 1) to facilitate the mourning process, and 2) to help the patient reestablish interests and relationships that can substitute for what has been lost. The therapist's major tasks are to help patients assess the significance of the loss realistically and emancipate themselves from a crippling attachment to the dead person, thus becoming free to cultivate new interests and form satisfying new relationships. The therapist adopts and utilizes strategies and techniques that help the patient bring into focus memories of the lost person and emotions related to the patient's experiences with the lost person. (pp. 97–98)

GRIEF AS A FOCUS PROBLEM AREA IN IPT

Once the IPT patient has been educated about the nature of depressive illness, the next step in treatment, regardless of the problem area on which the therapist expects to focus, is the completion of the interpersonal inventory. A thorough interpersonal inventory is essential to assess the quality of earlier relationships as well as the availability of current relationships and supports that may facilitate the last phase of the mourning process (reintegration). In addition to the interpersonal inventory, we have found the following series of questions to be helpful with spousally bereaved older patients to ensure a complete understanding of potential areas of conflict or of points where a patient may have become stuck or bogged down:

1. How much support did the deceased provide in social matters? Practical matters such as paying bills?
2. How much adjustment is required to manage the patient's current lifestyle without his or her spouse? Must a home be sold? Will income drop?
3. What proportion of activity was independent versus joint? Did the patient have hobbies or independent activities in place that will provide a ready-made support system, or did the couple do virtually everything together?
4. What was the manner of death? A chronic illness allows more time for adjustment than an acute illness or accident. Was there difficulty acknowledging or accepting that the spouse was dying? Suicide obviously requires extensive exploration.
5. If the spouse had a chronic illness, how much caregiving burden did the patient shoulder? Was there a great financial burden from medical care? Do many large bills remain to be paid? What changes in the patient's customary lifestyle were required to accommodate the spouse's illness prior to death? Was the death a welcomed end to suffering?
6. What was the history of their marriage? With the IPT therapist recognizing a tendency to idealize a lost mate, specific questions will allow for useful inferences. How were decisions and responsibilities shared? Were there difficult times in the marriage? Were there any periods of separation during the marriage? Was the marriage, in fact, a severe burden? Does the patient experience relief on some level that, through death, the relationship finally ended?
7. Were there contingency discussions with the spouse in the event that one or another partner died first? Were wills and other legal matters handled jointly? Were there areas of disagreement? Were money matters discussed, with plans in place to adequately support the remaining partner? Were funeral plans discussed? Were they implemented as agreed?
8. How frequently has the patient had thoughts about beginning a new romantic relationship? Had this possibility ever been discussed with the patient's spouse? Does the patient feel that a period of waiting is "proper?" Were there other relationships during the marriage that are producing guilty ruminations now?
9. Where are the patient's children living? What is the quality of those relationships? Are there grandchildren, and how often is contact made? The nuclear family has become widely dispersed, with children moving away to find jobs. Thus, although children may mean well, their practical availability may be an issue. Have there been discussions about moving closer to children? What other sources of support are available?
10. What other losses has the patient sustained, and what were his or her reac-

tions to those losses? Particular attention is focused on any losses in early life, with early parental loss clearly associated with increased risk for depression in adulthood.[24]

11. Has the surviving spouse been able to dispose of personal items of the deceased, particularly clothing? In our experience in our pilot study, this act is a powerful metaphor; it is indicative of true movement or, if the process is protracted, of fixation. Leaving the bedroom "just as it was" is common for parents of a lost child but can also be seen with loss of a spouse. The therapist's direct inquiry along these lines can provide valuable indirect clues about the patient's struggle to "hold on at all costs" as opposed to "letting go" in a measured way that allows for emotional growth.

    Some patients may benefit, however, from their IPT therapist's acknowledging that "a timeless attachment" to the deceased (as described by Bowlby[25] and Parker et al.[26]) may be best for them. Bereavement therapists should not be trapped into expecting all patients to "get over it" and "move on." Many patients, particularly the "old-old" (80 years or older), may be at a stage in their lives where it is best for them to consolidate their memories and draw on them for sustenance throughout their remaining years.

12. If patients have difficulty getting in touch with their feelings, have they considered writing a farewell letter to the deceased? Leick and Davidsen-Nielsen[2] encourage extensive letter writing. Although "homework" is not a focus of IPT in general, we have found that its use is justified because it helps patients reach deeper levels of feeling and promotes progress. Similarly, reviewing photographs or other memorabilia may provide further stimulus to deepen levels of feeling.

EXPLORING MARITAL QUALITY

To expand further on the marital history, the IPT therapist must realize that the quality of the marriage has been shown to affect the process of bereavement. Futterman et al.[27] found that bereaved older persons rated their marriages more positively than nonbereaved older persons, suggesting an idealizing bias. These authors further noted that bereaved depressed older patients viewed their marriages more positively than did depressed older patients who were not bereaved.

Bowlby's[25] attachment theory postulates that the quality of early-life parental attachments sets the stage for all future affectional bonding. Secure attachments in early life promote a positive self-image and the realization that other satisfying affectional bonding is possible. In contrast, impaired attachments in early life (resulting from neglectful, ambivalent, indifferent, or abusive parenting) can lead to lifelong difficulty in forming satisfying interpersonal relationships. Therefore, according to attachment theory, an individual's choice of mate and the degree of satisfaction obtainable in the marital relationship have roots traceable to the quality of affectional bonding in early life.

Erikson[28] similarly outlines the critical importance of early relationships in the initial two stages of his development model: basic trust, as versus mistrust (engendering hope), and autonomy, as versus shame and doubt (engendering will). In their 15 years of grief therapy experience, Leick and Davidsen-Nielsen[2] have noted that those patients who had difficulty with attachments tended to have more protracted grief reactions. It was harder for them to say goodbye and to welcome new contacts as well as to make use of the healing power of a supportive network.

Parker et al.[26] recently reviewed the literature that examines the links between patients' perceptions of the quality of parenting they received and their social bonds in

adulthood (the concept of "continuity"). Parker et al. point out that exceptions exist that run counter to expectations of continuity theory; for example, adversity in childhood is not always associated with an impaired ability in adulthood to form stable, satisfying relationships. That is, a "pervasive negative bias" can be corrected if a secure attachment is made at a later point in life. It is this last point that forms a link with grief work: therapists need to recognize that the lost spouse may have played the role of correcting that "pervasive negative bias."

Parker et al.[26] report that ample evidence exists to conclude that

1. Negative parent-child bonding may dispose people to judge social bonding in adulthood negatively, either directly or by shaping mental models.
2. Those who had extreme deficits in early parental care appear more likely to associate with an uncaring partner (if a relationship is established at all).
3. Initial vulnerability associated with less extreme difficulties in early parental care apparently can be modified by later relational experiences with intimate partners and significant others.

Horowitz et al.[29] have written about the related concept of a profound loss reactivating previously latent, negative self-images that had been counterbalanced or compensated for by the living spouse. Patients with histories of deficient early parenting should be seen as being at greater risk for the establishment of a dysfunctional marriage or for experiencing the loss of the negative-bias-correcting spouse more acutely than those who had adequate parenting.

MANAGING NEGATIVE OR AMBIVALENT EMOTIONS

A common reason for inhibited completion of the mourning process is ambivalence, anger, or rage (often at being left behind) toward the deceased, God, or fate; these emotions may be intolerable to admit and thus may be beyond the patient's awareness. When the IPT therapist has reached an appreciation of these common feelings from the interpersonal inventory and the patient's own understanding of his or her difficulty in dealing with the spouse's death, the therapist will ask if the patient agrees to work toward a greater understanding of the underpinnings of the continued grief and depression. Having obtained permission to focus on grief, the therapist will often need to make some effort to educate the patient about common patterns of adjustment to loss. The therapist may remind the patient that all significant relationships are characterized by some mixed feelings and that the agreed-upon task is to learn as much as possible about both sides of those mixed feelings—negative as well as positive aspects. Careful empathic review of the events surrounding the death and the subsequent necessary adjustments will provide an invitation to renew the unfinished mourning process in a safe environment.

When patients make references to how difficult their lives have become since their spouses died, the IPT therapist attempts to empathize with their difficulty and encourages them to talk about the personal problems that arose in response to their loss. The therapist might say, "Having just heard about all the difficulties you've had adjusting to your loss, I wonder if it sometimes seems unfair to you that you now have all these extra responsibilities?" The therapist might further say, "In my experience, it's not uncommon for people to feel some annoyance or anger toward the deceased as the negative part of those mixed feelings we talked about earlier." Similarly, Leick and Davidsen-Nielsen[2] use the invitation, "...and what *don't* you miss?" after patiently listening to all the positive attributes the survivor ascribes to the deceased. With gentle persistence, the IPT therapist will clarify, interpret, and sometimes confront the patient with the evidence already assembled from the patient's verbaliza-

tions to suggest that further inquiry along these lines is indicated, at the same time educating him or her about common feelings many people harbor in the grief process. This approach provides reassurance and legitimizes the state of mixed feelings as appropriate under the current circumstances. The experience of relief or unburdening after a session along these lines often instills hope in the patient that he or she can use the therapist's expertise to help "get through" the grief and the accompanying depression.

Case 1: Coming to Terms With Ambivalent or Negative Affect. Mrs. H. was referred because of uncontrollable crying spells and inability to concentrate at work. Her husband had died suddenly of a heart attack 6 months earlier. She had been previously divorced and had enjoyed her second marriage for 12 years. She spent the first sessions talking about her embarrassment at being unable to control her emotions and how much she had enjoyed her lost love, especially compared with her first husband.

The first task of therapy was to give her permission to grieve, to allow herself to feel whatever was there at the moment. Some time was also spent in early sessions on practical matters such as encouraging her to respectfully decline invitations she was not up to and realistically appraising alternative ways to better handle her emotional outbursts at work.

After several sessions of idealizing the patient's dead husband, the question "Where is the ambivalence?" arose in the mind of the therapist. Why is this patient unable to move forward? Gradually, a theme began to emerge concerning her husband's unwillingness to get adequate medical examinations. She felt that if she had been successful maybe his death could have been prevented. She admitted feeling enraged at the thought that he might have concealed knowledge of medical illness with which he did not want to burden her. Finally, she also came to acknowledge angry feelings that he might still be here (for her) if he had heeded her advice to get medical evaluation. These thoughts were quickly followed by guilty ruminations for thinking so selfishly.

A parallel development was a decline in her husband's sexual potency in the months before his death. She described a mutually satisfying sex life and said that both were dismayed about recent difficulties. She was very careful to downplay the loss of erectile function (and of missing her own sexual pleasure) to avoid making him feel insecure. They had discussed the possibility of "getting it checked" medically but had never done so. The patient described considerable unburdening relief at the opportunity to discuss these issues in detail, particularly her guilty ruminations about having selfishly encouraged medical evaluation for a sexual problem when, in retrospect, he really needed medical help to save his life. Out of "respect" for her dead husband she had been unable to discuss all these ramifications with well-meaning friends and family.

Mrs. H. progressed, with continual clarification and confrontation of these themes, to the point of accepting plans to travel with family, and she got through the death anniversary with less stress than expected. She was no longer crying at work nor thinking constantly about her late husband, and she agreed that it was time to terminate treatment.

Comment: This case vignette is a good example of the idealizing posture that bereaved depressed patients bring to the initial sessions. It is this posture that protects them from the negative or ambivalent affects they find painful to acknowledge. The IPT therapist's job is, first, to understand this common phenomenon, anticipate its occurrence, and look for evidence to support its presence from the patient's own verbalizations, then to reflect it back to the patient in a therapeutic manner, at the same time educating the patient that his or her experience is well within the range of the "normal."

Although conflict over expressing ambivalent or negative affect is common in the authors' experience, it is by no means universal, and IPT therapists are cautioned against overzealous interpretations along these lines.

Case 2: Struggling to Do the Right Thing. Mr. G., a construction worker, presented with a 30-pound weight loss, anergia, anhedonia, and passive suicidal ideation. He reported severe grief reactions after his mother, father, and father-in-

law died. He described his wife of 43 years as "my best friend, lover, and wife." She had died a lingering death after many years of illness, the last 4 of which required her to be bedridden with 24-hour care. Despite her decline in weight to 76 pounds, he had not allowed himself to anticipate her death. Since her death, he had been spending his time attending Mass, praying, and visiting her grave daily.

The most striking aspect of his early sessions was sexual preoccupation and inappropriate flirtatiousness with female staff members. When finally confronted with the interpretation that his overzealous advances must be hiding a great deal of pain, Mr. G. became tearful and discussed how much he missed female companionship; however, he felt greatly conflicted about Catholic religious prohibitions against sex outside of marriage. After this confrontation, his flirting toned down considerably. He was painfully aware of his loneliness and emptiness. He said he wouldn't be able to get his wife "out of his system" until another woman came along, but he felt awkward because he had not dated in 43 years. He talked at length about his ambivalence about forming new relationships, saying that he missed his wife's openness and trust and doubted that he could replace her. He said he didn't want to hurt anyone he dated by breaking up with them, but he alternatively described a wish to find a new relationship he could "nail down" and count on.

Mr. G. described a parallel overactivity in hobbies and sport activities, which he said was necessary to reach a level of exhaustion that would allow him to sleep at night.

After his eighth session, he reported that he had put away some of his wife's reminders and had begun redecorating his house in a more "manly" decor. He had his first date and talked of his struggle with the realization that his experience was bound to be new and different. He continued his ambivalent struggle with sexual activity. Mr. G. reported on his progress in therapy, saying: "I've come through some bad months; I never thought I'd make it." He described reducing his cemetery visits to once a week, has joined a square dance group, and looks upon dating as a challenge.

Comment: Leick and Davidsen-Nielsen[2] rightly point out that feelings of guilt and shame that follow steps of progress in forming new relationships can be truly paralyzing, as if any progress would be betraying the deceased. Mr. G., torn by conflict over forming new relationships since his wife's death, showed his defenses in his flirtatiousness and his immersion in activities that left him exhausted. His IPT therapist helped him to deal with both sides of this underlying conflict and to work through it, enabling him to relocate his deceased wife emotionally and begin dating.

INCOMPLETE MOURNING

Grief work can reach a plateau, only to be reactivated by subsequent events. The following vignette illustrates.

Case 3: Incomplete Mourning. Mr. P. lost his wife in a 2-year battle with breast cancer. Almost immediately after her death, he was called to active duty in the Persian Gulf, where he served for 6 months until he reached the mandatory retirement age. He became depressed 14 months after his wife's death when he began dating a woman 17 years his junior.

His initial complaints were poor sleep, poor motivation, and preoccupation with themes of death—for example, feeling that he had now outlived the 10-year guarantee on his cardiac bypass surgery (two friends who also had undergone bypass surgery had died in the previous 6 months). He did not want help from any medication because he felt he had to "do this himself."

Mr. P. described feeling guilty about "having fun" with his new lady friend, feeling that it wasn't fair that it couldn't be his wife. He acknowledged that he had never had the opportunity to grieve for his late wife and felt that it was now unfair to burden his new friend with his grief. He was obsessed with the thought that he might mistakenly refer to his new friend by his wife's name.

Mr. P. felt that he had a good marriage and that he had "been there" for his wife throughout her decline and death. He expressed gratitude for the opportunity to discuss his feelings and reported feeling and sleeping better after several sessions.

A tragic coincidence occurred during the

therapy: his mother was diagnosed with breast cancer and was near death on the 2-year anniversary of his wife's death. Upon exploration, Mr. P. did not feel that he had a good relationship with his mother, summing his feelings for her as "respect" for "raising her kids alone." As his mother's condition deteriorated he was able to make time for her without resentment or guilt feelings.

After his mother's death, Mr. P. dealt with her estate and felt satisfaction in his ability to "be there" for her even though his mother had not been there for him during his wife's battle with cancer. He was able to find satisfaction in the knowledge that he attended without reservation to his mother as well as his wife on their deathbeds.

Comment: The first task of IPT with Mr. P. was to provide a safe forum in which he could restart the mourning process interrupted by his military service. The inhibition he felt in his new relationship was not going to be resolved until he finished the process of emotionally relocating his wife to a place he could accept. His IPT therapist was able to allow him to explore all the feelings he was experiencing without the "unfair" burdening of his new friend. His mother's illness caused him to review realistically his relationship with her as well as revisit his role as caregiver for both his mother and his wife. Ultimately, Mr. P. was able to acknowledge that he had been there for them both and could now let them rest and move on to new relationships. Leick and Davidsen-Nielsen[2] describe the readiness to love again as being prepared to live through the grief of a new loss.

OTHER PROBLEM AREAS

Although grief is the most common of the four problem areas that we focused on in our experience with bereaved older persons, each of the other three IPT problem areas (role transition, interpersonal conflict, and interpersonal deficits) has come to bear on the management of grief reactions. Exploration of the patient's immediate reactions and feelings about the death is clearly required; however, it is also the case that role transitions are often dictated by changing circumstances after the death of a spouse; interpersonal conflicts may exacerbate remaining family relationships; and interpersonal deficits may strongly influence the way a patient goes through the grieving process. The following cases illustrate these problem areas.

Case 4: Role Transitions. Mrs. P.'s husband had died 4 months earlier of liver cancer. She was brought to treatment by her adult children with whom she had been living sequentially, exhausting and frustrating each one in turn. They described her as weepy, clinging, and unwilling to be left alone even for short periods.

In private, her children described their late father as an abusive alcoholic, and they collectively expressed their amazement that their mother had stayed with him. At the initial evaluation, the patient was severely depressed and required 3 weeks of hospitalization that included treatment with antidepressant medication. The hospitalization brought considerable relief to the children, who were very willing to be supportive but had been overwhelmed by her dependency needs.

When the psychotherapy resumed on an outpatient basis, the greatest feeling of loss that Mrs. P. expressed was for the past obligatory attendance by grown children at Sunday dinners at her home and her loss of status as the "hub" of family activity. It was as if she were willing to overlook or tolerate her husband's abusiveness as long as she could counterbalance it with satisfaction from the maternal role, in which everyone came home to her. One daughter, in particular, revealed her own struggles in her psychotherapy and Children of Alcoholics support groups to break from what she termed an "enmeshed, dysfunctional family."

Therapy with this patient was clearly focused on role transition. Many sessions were spent exploring the differences between her wishes and more realistic expectations concerning her grown children's aspirations and their allegiance to her. She was gently challenged to take more responsibility for her own needs and to learn better ways to cope with their independent activities. She somewhat idealized her late husband but referred far less often to him than

to the loss of her previous lifestyle.

After 3 months of steady progress, Mrs. P. moved to an apartment building and successfully spread her dependency needs over a wider area by "looking in on other widows" in her building and joining a local senior center, where she served food to less able members. Her family continued to be involved and supportive at a level with which they were more comfortable.

Comment: As the above case illustrates, patients with strong dependent traits who were heavily invested in the support their spouses provided will have a much more difficult time adjusting to the loss and establishing new roles for themselves. Traits of excessive dependency can also precipitate interpersonal conflict among family members.

Case 5: No More Time for Experimentation. Mrs. T.'s husband died suddenly following a one-week illness. She presented herself for therapy 12 months later, during the month that would have marked her 50th wedding anniversary.

Mrs. T. described feeling guilty because somehow she should have known that her husband was sick, even though no clues were available to her. She acknowledged that her marriage "was not great" in the later years. Upon further exploration, her therapist heard her describe her husband as "crabby, negative, and always angry." Mrs. T. described spending the bulk of their marriage tolerating her husband's moods but found it increasingly difficult to do so in the later years. She described changing her style from the accommodating soother she usually was to one who became "just as crabby as he was," even though it seemed out of character for her. She now felt guilty, as if her change in behavior toward her husband had been an experiment that ended disastrously without giving her any opportunity to reconsider. On another theme, Mrs. T. recalled conversations with her husband about his preference that he "go first" and admitted angry feelings toward him for successfully "willing it to happen."

After Mrs. T. had had ample opportunity to express her negative feelings as well as how much she missed his company, her attempts to grapple with the role changes in her life came to the forefront. She described how strange it felt doing things alone rather than as a couple. For example, now she had to park the car herself, initiate social contacts, and go alone to the country club socials they had attended so often together. She referred to a list she was keeping of these "alone firsts." Mrs. T. was acutely aware of missing the hundreds of daily physical touches from her mate, not the least of which was sleeping together.

Not all of her changed roles were unpleasant, however. She realized, for example, that she no longer had to be one of the first to leave parties as her husband had always demanded. She could now make decisions with only one set of preferences to consider.

Mrs. T.'s social network was extensive, and she was able to draw on it for considerable support. For example, she organized a slumber party with a cohort of grade school friends who had kept up with each other. The pangs of regret that the party had to end the next day and her friends return to their individual lives portended similar difficulties with approaching termination. Her therapist noted a change in style to a more isolated, protective stance. This defensive posture was short-lived, however, and Mrs. T. was able to terminate successfully and has shown considerable independent capability.

Comment: Mrs. T. clearly felt her husband's death was untimely. He died after a short illness, he died first (as he said he'd prefer), and he died in the midst of her experiment of changing her approach toward him. Their life together was quite involved socially, and this required great changes on her part after his death. Mrs. T. felt the loss of proximity to her husband even more profoundly. In IPT she was able to explore all these issues and was able to use the resource of her social network to help fill the void she felt. Predictably, she quickly came to value the relationship with her IPT therapist, and the prospect of termination was, at first, a difficult one. The feelings of need that arose in the context of termination were taken up and worked through over several sessions, and Mrs. T. was able to make this transition successfully as well.

Leick and Davidsen-Nielsen[2] emphasize

that learning new skills is a prominent component of grief work, as illustrated in the case of Mrs. T. Talking about intense emotion can also be a new skill, especially when coupled with the experience of unburdening relief.

Using the social network can also be a new skill for the bereaved. Leick and Davidsen-Nielsen[2] suggest asking, "Can you ask your friend/confidant (network) not to try to comfort you but just to be with you while you talk about how you feel, to tolerate your tears?"

Feeling like a "self" rather than "half a dyad" is another required skill demonstrated by Mrs. T. when she realized she could now decide for herself when to leave social functions.

TERMINATION ISSUES IN IPT GRIEF WORK

In *Interpersonal Psychotherapy of Depression*, Klerman et al.[17] suggest the following in the final three or four sessions to facilitate the termination process: 1) explicit discussion of the end of treatment; 2) acknowledgment of the end of treatment as a time of potential grieving; and 3) movement toward the patient's recognition of his or her independent competence.

For patients who come to therapy for help with spousal loss, the IPT therapist must pay careful attention to the possibility that the patient will experience the termination of the psychotherapy as an additional loss. Much has been written about termination in short-term therapies being easier to negotiate than in longer term therapy because less time has elapsed during which dependency can develop. Furthermore, in IPT, transference interpretations are specifically avoided in order to keep the patients' conflicts focused on significant figures in their everyday lives (which also serves to discourage dependence on the therapist). Nevertheless, IPT therapists should anticipate greater difficulty with termination for patients who became depressed in the context of a loss than for patients with a primary focus on role transition or interpersonal conflict.

From our experience, we suggest the following specific techniques for termination:

1. From the beginning, clearly state the range of the anticipated length of therapy, generally 16–20 weeks, with frequent reminders of the approaching date of termination.
2. Frankly discuss the possibility of a temporary resurgence of symptoms near the time of termination; that is, make full use of an educational approach as well as a therapeutic one.
3. Focus on exploring alternative coping strategies (such as specific plans to combat loneliness). Begin well ahead of termination to allow some experimentation on the patient's part, with review and possible revision of those plans in subsequent sessions.
4. Encourage new relationships.

Except for patients who remain severely symptomatic, Klerman et al.[17] recommend telling patients who report a high level of discomfort with the prospect of termination that a minimum 4- to 8-week waiting period is required before beginning further treatment of a different type. This conveys a clear message that *this* therapy will be completed, that the therapist is confidant of the patient's ability to function outside of therapy, and that before further treatment is started the patient should first make a reasonable trial on his or her own.

Termination issues in short-term psychotherapy have been discussed in further detail by other authors.[30–32]

PRELIMINARY RESPONSE DATA

We conducted a preliminary study of IPT efficacy in the treatment of depressed bereaved spouses in late life. In the study, 3 male and 3 female patients, mean age 68 (range

64–73) were engaged in IPT after meeting Research Diagnostic Criteria for major or minor depression. Subjects entered treatment an average of 26 weeks (range 11–56) after the loss of their spouses. Mean age was 69.2 ± 6.0 SD, and subjects had been married an average of 42 years (range 25–49). Independent raters obtained pre/post Ham-D scores of 18.5 ± 2.3/7.2 ± 4.6; Global Assessment Scale[33] scores of 62.5 ± 4.3/78.3 ± 9; and Texas Revised Inventory of Grief scores of 49.3 ± 9.6/39.2 ± 14.9 after a mean of 17 weekly IPT sessions.

These preliminary data suggest that IPT is an effective treatment for bereavement-related depression in the elderly. We are currently comparing the efficacy of IPT, nortriptyline, and combination therapy in this population under randomized double-blind placebo-controlled conditions.

DISCUSSION

Interpersonal psychotherapy was specifically designed as a short-term psychotherapy for depression, focusing on four major areas: grief, role transition, interpersonal conflict, and interpersonal deficit. The foci of grief and role transition are particularly germane to the bereaved depressed patient. The foci of interpersonal conflict and interpersonal deficits may also require attention in the bereavement setting. Surviving relationships may become unbalanced by the loss, and patients with interpersonal deficits (greater degrees of character pathology) may be at greater risk for inhibited or prolonged grief.

IPT focuses on interpersonal themes, it incorporates an educational approach, and it can be used in conjunction with psychotropic medication. The principles of IPT can be taught to a variety of mental health professionals (psychiatrists, psychologists, social workers, psychiatric nurses), making it a practical treatment for bereavement-related depression.

When comparing IPT with other therapies for bereavement, IPT does appear to offer key elements common to all grief therapies. These are defined by Raphael[34] in her excellent review as 1) establishing a relationship with the bereaved, 2) exploring the loss, 3) reviewing the lost relationship, 4) exploring background issues, 5) providing support, and 6) achieving goals (recovery).

Behavioral therapy, cognitive therapy, and brief relational/insight psychotherapy have been compared for the treatment of depression in older persons (not necessarily secondary to bereavement). Results of the study by Gallagher and Thompson[35] showed a slightly better outcome for the cognitive and behavioral groups than for the relational/insight group, although small numbers and differential dropout rates make the comparisons less than clear. Gallagher and Thompson argue that a focus on goals as well as skill training is essential to effective psychotherapies for depression. Although IPT developed out of the psychodynamic model, it is strongly goal oriented and focused on interpersonal themes. Specific homework assignments are not employed in IPT, although patients are encouraged to improve communication skills, to consider the pursuit of effective coping strategies, and to discuss the implications of such changes at subsequent therapy sessions.

Horowitz et al.[36] undertook a detailed study of dispositional and process variables in 52 bereaved patients treated with psychodynamic psychotherapy. A few points from this complex study merit mention in the context of IPT. Horowitz et al. found that even patients ordinarily considered to be relatively poor candidates for brief therapy because of low motivation or low developmental level could still be engaged in treatment by an active, supportive therapist. Patients with low motivation had better outcomes regarding termination issues when matched with highly active therapists. Conversely, highly motivated patients had better outcomes when their therapists took a less active stance in the termination phase. In general, however, Horowitz et al. found that more exploratory

actions by the therapist worked best for highly motivated or organized patients and less well for less motivated or less organized patients. Supportive actions were indicated for the latter group.

IPT is consistent with both active and supportive therapist approaches and can accommodate both high and low levels of patient motivation and organization. IPT seeks to establish a positive working alliance quickly and to agree to a focus early on. The attitude of the therapist is supportive, educating, and active. Those patients capable of or motivated for more in-depth exploration are encouraged by the IPT therapist to undertake it; however, in our experience, patients with less exploratory desire can still benefit from the supportive, educational, active stance of the IPT therapist.

Psychodynamic psychotherapy and IPT have common historical roots; however, IPT discourages transference interpretations or extensive exploration of early life experiences while encouraging a focus on interpersonal themes. This difference perhaps decreases the intensity of patient-therapist termination issues and allows IPT to be used effectively by less experienced therapists.

Group therapy for the bereaved has been studied by several authors.[37–42] Vachon et al.,[37] for example, assigned widows randomly to a control group or an intervention group (widow-to-widow program) and found that the intervention group resisted the emotional deterioration that was noted in the control group after postbereavement support waned. Even though the control group had caught up to the intervention group at 12 months, the intervention group was clearly ahead in the resocialization process. Similarly, Lieberman and Videka-Sherman,[38] comparing self-help group participants and a normative sample of widows, concluded that the interventions were truly therapeutic and that improvement could not be accounted for simply by the passage of time. Subjects in both of these studies were recruited by a mailed solicitation, however, and this method may have selected a help-seeking subgroup.

Marmar et al.[40] compared mutual self-help group therapy with brief dynamic psychotherapy (12 weekly individual sessions with experienced psychodynamic psychotherapists, focused on conflicts with the late spouse that might impede mourning). Although both groups experienced reduction in symptoms of depression and anxiety, Marmar et al. found a larger dropout rate in participants of group therapy compared with individual therapy.

Mutual self-help groups provide consensual validation, a forum to express difficult affects, peer support, and facilitation of problem solving. These groups are beneficial to many widows and widowers, particularly those with more outgoing or help-seeking interpersonal styles or those with less severe depression. Those with more severe depression, more complicated interpersonal difficulties, or a reluctance to join a group may require a more tailored individual psychotherapeutic approach.[40]

Given the depth and breadth of individual differences among widows and widowers, it is not surprising that a variety of approaches are potentially beneficial. IPT is one approach that can provide a workable forum to address systematically bereavement-related depression and that can be taught to a variety of mental health practitioners.

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REFERENCES

1. Zisook S (ed): Biopsychosocial Aspects of Bereavement (Progress in Psychiatry Series, vol 8). Washington, DC, American Psychiatric Press, 1987
2. Leick N, Davidsen-Nielsen M: Healing pain: attachment, loss, and grief therapy. London and New York, Tavistock/Routledge, 1991
3. Valanis B, Yeaworth RC, Mullis MR: Alcohol use among bereaved and nonbereaved older persons. Journal of Gerontological Nursing 1987; 13:26–32
4. Calabrese JE, Kling MA, Gold PW: Alteration in immunocompetence during stress, bereavement, and depression: focus of neuroendocrine regulation. Am J Psychiatry 1987; 144:1123–1134
5. Stroebe MS, Stroebe W, Hanson RO (eds): Handbook of Bereavement Theory, Research and Intervention. Cambridge, England, Cambridge University Press, 1993
6. Gallagher DE, Thompson LW, Peterson JA: Psychosocial factors affecting adaptation to bereavement in the elderly. Int J Aging Hum Dev 1981–82; 14:79–95
7. Parkes CM, Benjamin B, Fitzgerald RG: Broken heart: a statistical study of increased mortality among widowers. British Medical Journal 1969; 1:740–743
8. Parkes CM: Risk factors in bereavement: implications for the prevention and treatment of pathologic grief. Psychiatric Annals 1990; 20:308–313
9. Jacobs S, Kim K: Psychiatric complications of bereavement. Psychiatric Annals 1990; 20:314–317
10. Jacobs S, Ostfeld A: An epidemiological review of the mortality of bereavement. Psychosom Med 1977; 39:344–357
11. Clayton PJ, Darvish JS: Course of depressive symptoms following the stress of bereavement, in Stress and Mental Disorder, edited by Barrett JE. New York, Raven, 1979, pp 121–136
12. Zisook S, Schucter SR: Depression through the first year after the death of a spouse. Am J Psychiatry 1991; 148:1346–1352
13. Pasternak RE, Reynolds CF, Schlernitzauer M, et al: Acute open-trial nortriptyline therapy of bereavement-related depression in late life. J Clin Psychiatry 1991; 52:307–310
14. Hamilton MA: Development of a rating scale for primary depressive illness. British Journal of Social and Clinical Psychology 1967; 6:278–296
15. Faschingbauer TR, DeVaul RA, Zisook S: Development of the Texas Inventory of Grief. Am J Psychiatry 1977; 134:696–698
16. Frank E, Frank N, Cornes C, et al: Interpersonal psychotherapy in the treatment of late-life depression, in New Applications of Interpersonal Psychotherapy, edited by Weissman M, Klerman GL. Washington, DC, American Psychiatric Press, 1993, pp 169–175
17. Klerman GL, Weissman MM, Rounsaville BJ, et al: Interpersonal Psychotherapy of Depression. New York, Basic Books, 1984
18. Elkin I, Shea MT, Watkins JT, et al: National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. Arch Gen Psychiatry 1982; 46:971–982
19. Weissman MM, Klerman GL, Prusoff BA, et al: Depressed outpatients: results one year after treatment with drugs and/or interpersonal psychotherapy. Arch Gen Psychiatry 1981; 38:51–55
20. Frank E, Kupfer DJ, Perel JM, et al: Three-year outcomes for maintenance therapies in recurrent depression. Arch Gen Psychiatry 1990; 47:1093–1099
21. Sholomskas AJ, Chevron ES, Prusoff BA, et al: Short-term interpersonal therapy (IPT) with the depressed elderly: case reports and discussion. Am J Psychother 1983; 37:552–566
22. Reynolds CF, Frank E, Perel JM, et al: Combined pharmacotherapy and psychotherapy in the acute and continuation treatment of elderly patients with recurrent major depression: a preliminary report. Am J Psychiatry 1992; 149:1687–1692
23. Worden JW: Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner, 2nd edition. New York, Springer, 1991
24. Lloyd C: Life events and depressive disorders reviewed. Arch Gen Psychiatry 1980; 37:529–535
25. Bowlby J: The making and breaking of affectional bonds. Br J Psychiatry 1977; 130:201–209
26. Parker GB, Barrett EA, Hickie IB: From nurture to network: examining links between perceptions of parenting received in childhood and social bonds in adulthood. Am J Psychiatry 1992; 149:877–885
27. Futterman A, Gallagher D, Thompson LW: Retrospective assessment of marital adjustment and depression during the first 2 years of spousal bereavement. Pathology and Aging 1990; 5:277–283
28. Erikson EH: Childhood and Society. New York, WW Norton, 1968
29. Horowitz MJ, Wilner N, Marmar C, et al: Pathological grief and the activation of latent self-images. Am J Psychiatry 1980; 137:1157–1162
30. Malan DH: The Frontier of Brief Psychotherapy. New York, Plenum, 1976
31. Sifneos PE: Short-Term Psychotherapy: Evaluation and Technique. New York, Plenum, 1979
32. Strupp HH, Binder JL: Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy. New York, Basic Books, 1984
33. Endicott J, Spitzer RL, Fleiss JL, et al: The Global Assessment Scale: a procedure for measuring overall severity of psychiatric disturbance. Arch Gen Psychiatry 1976; 33:766–771
34. Raphael B: Preventive intervention with the recently bereaved. Arch Gen Psychiatry 1977; 34:1450–1454
35. Gallagher DE, Thompson LW: Treatment of major depressive disorder in older adult outpatients with brief psychotherapies 1982; 19:482–490
36. Horowitz MJ, Marmar C, Weiss DS, et al: Brief psycho-

therapy of bereavement reactions. Arch Gen Psychiatry 1984; 41:438–448
37. Vachon MLS, Lyall WAL, Rogers J, et al: A controlled study of self-help intervention for widows. Am J Psychiatry 1980; 137:1380–1384
38. Lieberman MA, Videka-Sherman L: The impact of self-help groups on the mental health of widows and widowers. Am J Orthopsychiatry 1986; 56:435–449
39. Lieberman M, Yalom I: Brief group psychotherapy for the spousally bereaved: a controlled study. Int J Group Psychother 1992; 42:117–132
40. Marmar CR, Horowitz MJ, Weiss DS, et al: A controlled trial of brief psychotherapy and mutual-help group treatment of conjugal bereavement. Am J Psychiatry 1988; 145:203–209
41. Yalom ID, Vinogradov S: Bereavement groups: techniques and themes 1988; 38:419–446
42. Lieberman MA: Group properties and outcomes: a study of group norms in self-help groups for widows and widowers. Int J Group Psychother 1989; 39:191–208