



Introduction

Where IPSRT Came From

Interpersonal and social rhythm therapy (IPSRT) was conceived in a single day; actually, in a single flash of recognition on July 14, 1990. For the previous 10 years I had been working on a long-term maintenance treatment study testing the prophylactic value of interpersonal psychotherapy for individuals with recurrent unipolar depression. In preparation for the study, I, a committed cognitive therapist, had learned Klerman, Weissman, Rounsaville, and Chevron's (1984) interpersonal psychotherapy (IPT) and had been amazed by the power of this deceptively simple approach to the treatment of depression. There's no zealot like a convert. By 1989 I had become a convert to IPT.

As part of our study, our research group was conducting family psychoeducational workshops in an effort to recruit the family members of our study participants as adjunct members of the treatment team. We believed that if family members truly understood that depression was a real and potentially fatal medical illness, if they could see more clearly how patients suffered, if they understood the purpose of the study we were conducting and how what we learned might eventually benefit their family member, then they could be partners in the treatment and research enterprise. This was a fairly radical idea in psychiatry at the time, but it was just that radical idea that appealed to the members of the National Depressive and Manic-Depressive Association (NDMDA; now the Depression and Bipolar Support Alliance).

On that fateful July 14th, which happened to be my 46th birthday, the NDMDA had invited me to speak at its national convention about family involvement in treatment. Because of the flight schedule, I had to fly into Chicago early in the morning even though my talk wasn't scheduled until after lunch. Like most other clinicians who did little direct work with patients who had bipolar disorder, I had thought that bipolar disorder was a problem solved. It took only 5 hours at the NDMDA convention to see how wrong I was!

I began my day by going to see a performance of a group called the New York Mental Health Players. Their performance consisted of a series of vignettes illustrating problems in the life of patients with bipolar disorder. Following each of these vignettes,

there was an opportunity for audience comment and discussion. What became apparent during that discussion was the extraordinarily high level of stigma associated with bipolar disorder and how much the NDMDA members in the audience had suffered from it. I remember one woman who had been a nurse who reported being fired by her head nurse when she mentioned that she was taking lithium.

Also impressive was the tremendous disparity between the educational attainment of most of the people there that morning and their current employment status. The audience seemed to be filled with PhDs who were now barely getting by as cab drivers, accountants who were working as clerks in discount drug stores, and other highly trained professionals who didn't even have jobs.

I sat down to lunch with several members of the NDMDA in a beautiful setting on the lawn of the Northwestern University campus, but the conversation I heard was in stark contrast to the brightness of that beautiful July day. Members complained of being discouraged by their psychiatrists from participating in activities that were important to them, such as marathon running, rather than being helped to try to manage the complexities of such endeavors while taking lithium. They talked about the poor quality of their treatment and their clinicians' failure to understand that they needed more than just drugs.

As I was about to give my talk, I stopped in the ladies' room, where I overheard a conversation among three member/volunteers who were discussing how effectively the emergency hospitalization protocol for the conference had been working. Although the conference was only in its second day, three conferees, probably overstimulated by the intensity of the experience, had already needed to be hospitalized.

I arrived at the room where my presentation was scheduled to be held with the normal presenter's fantasy (the room will be empty), only to find that not only was every seat in the room taken, but that individuals with bipolar disorder and their family members were lining the back of the auditorium, sitting in the aisles, and even at the base of the stage. Clearly, family involvement in treatment was something these folks wanted to hear about.

During the next hour and a half, I got a crash course in how desperate these patients and their family members were for attention to the psychosocial issues associated with bipolar disorder, how much they longed for accurate information about the disorder, and how critically important family member involvement was to the successful treatment of manic-depressive illness. By the time I left that auditorium, literally every person in the room was on his or her feet. The intensity of feeling surrounding their needs was palpable. I knew that if I didn't exit the auditorium quickly, I would never make my plane home. So, feeling a little like a rock star being pursued by fans to the door of my limousine (absent the paparazzi), I did my very best to answer as many questions as I could while scurrying through the hallways to the car that was waiting for me.

As the door to the limousine closed and I looked back at the dozen or so people who had accompanied me all the way to my car, I knew with absolute certainty that I needed to dedicate the next decade of my life to doing better by these patients and their family members. No sooner were the words formed in my head than I knew exactly what to do: Combine IPT with a social rhythm regulation treatment.

For several years prior, colleagues at the Western Psychiatric Institute and Clinic and in the MacArthur Foundation Research Network on the Psychobiology of Depres-

sion and I had been theorizing about the relationship between *social zeitgebers* (that is, timegivers or timekeepers—think of a metronome) and unipolar disorder. In that moment in the limo I suddenly realized that our theory applied more to bipolar disorder than to unipolar. I also realized that designing a behavioral treatment component to help patients establish and maintain regular social rhythms would not be hard at all, although persuading patients and family members to do it might be a bit of a challenge.

I came home that evening to a huge welcome-the-new-residents party that was taking place in our own backyard. I had only a few seconds to tell my husband and colleague, David Kupfer, about this new idea before needing to play hostess to 18 anxious new residents and their spouses and children. But that night before we went to bed, we sketched out IPSRT on the back of an envelope. All the rest has been elaboration and experience.

The treatment we developed built on the essential components of IPT: taking a history of the patient's illness, educating the patient about the disorder, managing the mood symptoms, learning about the interpersonal realm of the patient's life and its relationship to his or her mood disorder, and intervening to ameliorate existing interpersonal problems and prevent new ones. The major difference between IPSRT and most other modifications of Klerman and colleagues' (1984) original interpersonal psychotherapy is the addition of a large behavior modification component focused on the social rhythms or routines of the patient's life.

My colleagues and I had argued in papers we had published in the late 1980s (Ehlers, Frank, & Kupfer, 1988; Ehlers, Kupfer, Frank, & Monk, 1993) that the major mood disorders (major depression and bipolar disorder) reflected, among other things, a disruption in circadian rhythms, a disturbance in the body's clock. Think about how many of the symptoms of these two disorders are functions that have a regular 24-hour rhythm: sleep (and waking), hunger, energy, ability to concentrate, even mood itself. Furthermore, we said that external social factors, like the time we need to be at work, the time the family normally has dinner, the time a favorite TV show ends, help to set the body's clock. When social factors function in this way, they become social *zeitgebers*. We had also argued that changes or interferences in social routines, which we termed *zeitstörers* (or time disturbers), could disrupt the body's clock and destroy the body's naturally synchronized rhythms. We concluded that, in those who were vulnerable to mood disorders, it was the loss of social *zeitgebers* (timekeepers) or the appearance of *zeitstörers* (disrupters) that led to new illness episodes (depression or mania).

During that flash in the limo, I knew it would be relatively easy to borrow some of the scheduling and monitoring techniques of cognitive therapy and refashion them for the purpose of helping patients to establish and maintain regular social rhythms. I also realized that such efforts would fit very naturally with at least three of the four interpersonal problem areas that form the foundation of the interpersonal work in IPT for unipolar depression: resolving an unresolved grief experience, negotiating a transition in a major life role, and resolving a role dispute with a significant other. Thus, IPSRT became a treatment that seeks to improve on the outcomes that are usually obtained with pharmacotherapy alone for patients suffering from bipolar I disorder by integrating efforts to regularize their social rhythms (in the hope of protecting their circadian systems from disruption) with efforts to improve the quality of their interpersonal relationships and social role functioning. The addition of a new problem area, grief for the lost healthy self, to the four original IPT problem areas is aimed at increasing accep-

tance of the illness and improving treatment adherence in a patient group for which these are both difficult issues.

When we set out to develop a psychotherapeutic intervention that could enhance or complement drug therapy for manic-depressive illness, one of the questions we asked ourselves was, "What kinds of things do first-rate clinicians do with patients who have this disorder in addition to prescribing appropriate medications?" We realized that most expert pharmacotherapists in the area of bipolar disorder always recommended a series of lifestyle changes in addition to careful adherence to the medication regimen they prescribed. Furthermore, we realized that these lifestyle modifications were all consistent with a model of the illness that posits physiological instability as central to the pathology of bipolar I disorder. Thus, our rationale for IPSRT had a foundation in a more general understanding of the pathophysiology of all recurrent mood disorders and in the research literature on recurrent unipolar and bipolar disorder.

In the time since my trip to that NDMDA national convention, with the help of dozens of colleagues and hundreds of patients, IPSRT has evolved from a fledgling idea to a fully elaborated treatment. Yet, as we continue to learn from our patients, IPSRT continues to evolve. As you read this book and use this treatment, you will undoubtedly think of additional ways to help your patients develop and maintain supportive interpersonal relationships and satisfying social roles while leading lives that are characterized by sufficient regularity and routine to reduce the risk of new episodes of illness.



ONE

The Patients

At 18, Jill's future could not have seemed brighter. She had just been accepted into the prestigious college she and her parents had always thought would be perfect for her. She had a large circle of bright and trusted friends, a wonderful boyfriend who would be attending a college nearby, and parents who adored and supported her. True, she had had a few tough semesters in high school, times when her boundless energy and enthusiasm seemed to fail her, when getting out of bed in the morning was just incredibly difficult, when simply deciding whether to wear the white turtleneck or the gray one seemed to take hours, when her usually rapt attention would drift and finishing a paragraph in her history text or a brief poem for English would require that she read and reread and reread again, when nothing seemed like much fun to this usually exuberant young woman. These periods puzzled her parents, but they simply attributed it to adolescent moodiness, especially in light of the fact that when spring came she always seemed to manage to pull herself (and her grades) up by her own bootstraps.

Jill experienced some difficulty in adapting to the natural disorder of college life, especially as compared with the orderly home life she had known: dinners between 6:30 and 7:00, lights out throughout the house by midnight, everyone up and at the breakfast table by 6:45, regular runs with her dad each Saturday at 10:00, and church every Sunday, followed by a big family gathering at her grandmother's. Sensing that she felt better when things were more like they had been at home, after her first year at college, Jill found a roommate who shared her desire for order in the midst of the chaos, who didn't think that pulling all-nighters was cool, and who was willing to hang a Do Not Disturb sign on their door when they wanted to get some sleep.

Graduating as a Phi Beta Kappa, Jill had her choice of graduate programs. She chose one in which she thought she could shine while still having some time to pursue a personal life. Continuing her apparently charmed existence, she left grad school with both a PhD and a Mrs. She and her new husband, also an English professor-in-the-making, were fortunate to find positions in the same Eastern city, and their life seemed set—until the birth of their first child 2 years later. Within 5 days of delivering, Jill turned into someone neither of them knew: sobbing hysterically one moment, grandiose the next, she often made no sense. She was convinced that her little boy had the “mark of Satan” and had no qualms about telling her pediatrician, who had declared the child perfectly fine, that her baby was doomed. Fortunately, the pediatrician recognized her excited, psychotic mixed state as a postpartum psychosis and referred her for psychiat-

ric treatment. Over the objections of her husband, her parents and, of course, Jill herself, the psychopharmacologist to whom she had been referred insisted that Jill be hospitalized involuntarily. Within a few days, with the aid of massive amounts of lithium and a whiff of a typical neuroleptic, Jill appeared much like her old self.

Her psychiatrist tried to explain what the events of the last week meant in terms of long-term prognosis, but “manic–depressive illness” and “bipolar disorder” were not words that Jill or anyone in her family wanted to hear. “No one in our family has ever had anything like this. Manic–depressive illness is a genetic disorder. We get heart disease, but not anything like this.” Nonetheless, her psychiatrist insisted that, given her history of mild seasonal mood swings since adolescence, her history of generally good adjustment and social relations prior to this episode, the appearance of a first episode of psychosis immediately postpartum, and, most important, the fact that she responded quickly and completely to treatment with lithium and a very small dose of antipsychotic medication, all the indicators pointed in the direction of a diagnosis of bipolar disorder.

As the months passed, Jill resumed her teaching, again to high praise. She was caring for her child with great affection and little effort and still found time for a full and rich life with her husband. The whole bizarre episode that followed her son’s birth became a kind of aberration in an otherwise perfect existence, something she and her family just wanted to forget. She kept finding reasons to cancel her appointments with her psychopharmacologist. She had so many more important, more meaningful things to do. Eventually she ran out of lithium . . . and, contrary to her doctor’s dire predictions, nothing seemed to happen.

All went well for the next few years; her child, her career, and her marriage flourished. When Jill’s little boy was 3, her sister-in-law, to whom Jill was very close, became pregnant. Having taken the winter quarter off to write that year, Jill volunteered to go to Seattle to help her care for the new baby. Within days of her arrival she realized what a mistake she had made. There really wasn’t space for her and her son in her brother and sister-in-law’s cramped apartment. Neither of them had ever been big on regular routines, and with the new baby, nothing ever happened on schedule. Jill found it nearly impossible to calm her son, to feed him on anything like a regular basis, or to get any reading done at night when the entire household seemed to be in perpetual motion. And it never stopped raining! So she and that ball of energy that was her son could never escape. Soon she found herself feeling like she had during those awful times in high school. Worst of all, she could never really talk to her husband. Between the 3-hour time difference and the lack of privacy, she felt totally isolated from her “rock,” as she often called him. By the time Jill got back home, she was in a nearly immobilizing depression. Writing was impossible. She couldn’t even read more than a paragraph without losing her train of thought. She dragged herself through her days, barely managing to get something like dinner on the table by the time her husband returned from teaching. In fact, many nights he came home to find her just sitting on the sofa, staring at the TV, surprised that he was home already. Neither Jill nor her husband knew how to explain what was happening, and neither saw any relationship between this immobility and the experience Jill had had right after their son was born.

After much self-torture and recrimination, Jill came to realize that she could not possibly return to the university when the spring quarter began and asked for a temporary leave of absence. She would never go back.

It took almost a year, but finally, Jill’s depression lifted. She, her husband, and her family made a million excuses for what had happened: She had pushed herself too hard too soon, she wasn’t really cut out for the competitive nastiness of academic life, she was too sensitive a soul, she was too devoted to her students and her family and

had too much difficulty putting her own career ahead of their needs and the conflict finally got to her, and so on.

Maybe she would do better in a kinder, less demanding atmosphere and still be able to experience the joy of teaching literature. Without much difficulty, she found a position at a small private girl's high school. The school was thrilled to have someone of her caliber teaching their juniors and seniors, the other teachers were warm and friendly, and the students were any teacher's dream: bright, inquisitive, and always prepared. She made next to nothing, but she was happy: "This will be just fine until my kids are grown. Then I'll go back to the university grind."

With her life more or less back in order, Jill and her husband decided to have another child. The pregnancy went well, she felt fine, and she taught until the week before she delivered their second son, just as her summer vacation was starting. Within a day of her return from the hospital, however, Jill's husband began to see ominous signs of a repeat of their prior postbirth experience. He tried to contact Jill's former psychopharmacologist, but she had moved. He didn't know where to turn. He was afraid to say anything to Jill's parents and just hoped he was being unduly skittish. By the time of her first postpartum visit to the pediatrician, however, there was no denying that she was even more ill than she had been after her first son's birth. And he felt he could count on their pediatrician to confront Jill about it.

This time with the support of her parents, Jill's husband was able to persuade her to go into the hospital voluntarily . . . though just barely. Once she was there, she nearly signed herself out on three occasions before the medications began to take effect. Again, Jill responded well to the combination of lithium and a typical neuroleptic and was home within 10 days.

Unable to deny that there was a pattern to her illness, Jill committed herself to her treatment, going regularly to see her new psychopharmacologist and taking her medicine like clockwork. In the fall she returned to her beloved teaching job and seemed to manage very well for the next several years. Her boys were thriving, but she and her husband really wanted a daughter as well. They consulted her doctor, who felt that with a very slow taper of her lithium—that was all she had taken since her last baby was about 6 weeks old—and reinstatement of her medication a few weeks before delivery, they had a good chance of averting a third postpartum episode.

What he hadn't counted on was that Jill would miscarry in her 5th month. The rapid hormonal shift and the emotional impact of the miscarriage were more than enough to send her into another episode of psychosis and back into the hospital, but this time she did not show her typical quick response to medication. Her doctor tried one thing after another, but nothing seemed to bring her delusions or manic excitement under control. Her husband, who had never before been the focus of her psychotic thinking, was devastated when she accused him of having an affair with one of his colleagues while she was "locked up in this snake pit." He was struggling to manage his teaching and other departmental responsibilities, and their two rambunctious little boys, and get to the hospital to see her every night, so her vicious accusations, loud enough for the whole inpatient unit to hear, put him over the edge. He would go home each night and replay the horror scenes in the hospital in his head and then replay them all day when he should have been writing, or reading students' essays, or playing with his boys.

Finally, Jill's treatment team decided that only electroconvulsive therapy (ECT) held any real promise for bringing her mania under control. Her husband was desperate for anything that would stop the maltreatment from Jill that he experienced each night. Still, there was enough of a thread of a relationship left between them that he was able to convince her that this might be a way out of the hospital. After the first ECT

treatment, he could see a difference. This was going to work. They would return to their happy enough life. The daughter they had dreamed of was unimportant as compared with just getting back to some semblance of normality. And he was right: The ECT did bring Jill's mania completely under control, but she came home a fragile, tentative woman whom he hardly knew. By turns silent and irritable, she was difficult to engage in conversation, let alone in any physical intimacy. They began to fight . . . over everything: the boys, when to have supper, how much time he spent at his office (maybe she still thought he was having an affair), how messy the house was, everything.

As the fall approached, Jill, who had had to take a year's leave from her teaching job, made an appointment to see her department head and make plans for the upcoming term. Only then did he tell Jill that her position had been filled by an excellent substitute whom the school was reluctant to let go. They were terribly sorry. They knew the miscarriage must have been very hard for her. She drove home, not even knowing how she had arrived there, feeling as if her last anchor had been pulled and she was totally adrift. She thought briefly about going to "talk" to someone but, hearing her mother's voice echoing in her head, knew that "we just don't do that in our family. We handle our problems ourselves."

Jill realized that she was much too fragile to manage the stress of teaching in the big public high school where she might have been able to get a position. Instead, she took a job in a children's bookstore near her home. At least they were willing to give her hours that would allow her to get home before her boys, get dinner ready, begin to take care of the house like she used to. But none of it seemed to matter. Her husband remained distant, they fought all the time, her boys were out of control, the household was in chaos. One night her husband just didn't come home. In some ways, it was a relief.

The next day he came to the bookstore and asked if she could take a coffee break. At the coffee shop, he told her he had been out walking the campus all night, trying to figure out a way to tell her that he just needed a peaceful place to go home to. She and the boys would never have to worry, he would always take care of them, but he needed to move out. The "rock" needed some time to regroup.

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At the point that Jill appeared for treatment with IPSRT, she and her husband had been separated for more than 3 years and their divorce was imminent. She had not worked since the day her husband came to the bookstore. She kept telling herself she'd go back, but she never did. Finally, the bookstore closed and she couldn't think of any place that would want her. She was barely getting by financially, but knew her soon-to-be ex could not afford more on his university salary. Her parents couldn't (or wouldn't) help. They really didn't understand why she wasn't still at her own university job. Her children were beginning to have problems in school, and she was at a loss to know what to do about it. Summers were worse. All three of them would wander aimlessly through the days, never going to bed at a reasonable time, getting up whenever they felt like it. Finally, she decided that she just wasn't going to go through another school year with them like the last one. She needed some help getting her life together. She couldn't remember the last time she had spent any time, or wanted to spend any time, with a friend. She wasn't exactly depressed, but she had never really snapped back after her last hospitalization. It seemed as though the doctor could never get her meds quite right . . . and every time she started to feel something like her old energy and enthusiasm come back, they would both panic and agree that she needed more. What had happened to that brilliant future that seemed so assured just a dozen or so summers ago?

Jill's history is typical of those who suffer from manic–depressive illness in many respects and, unfortunately, especially typical of those patients who never receive any sort of psychosocial treatment or psychoeducation. Her early life was characterized by great energy, intellectual promise, and good social relationships. The quality of her early upbringing, including a warm and supportive family that led an orderly existence, kept her protected from most manifestations of mood disorder, with the exception of some relatively mild and brief episodes of seasonal depression that went essentially unrecognized. Her own maturity, good sense, and wisdom about what she needed to function well (a regular routine, sufficient sleep, structure, etc.) protected her during college, graduate school, and the early years of her marital and professional life. In Jill's case, it took the massive hormonal and circadian challenge of parturition to bring about the expression of her bipolar illness. Once she became ill, some of the very things that had protected her earlier—the absence of any apparent mood disorder in her immediate family, the basic rigidity of her parents, her naiveté as well as that of her parents and husband about psychiatric illness—eventually proved to be her downfall. Had she (and they) received more in the way of psychoeducation about mood disorder, both her subsequent manias and her severe depression might have been averted. She had had the good fortune of responding well to an initial treatment regimen that was relatively uncomplicated and kept her symptoms under good control. However, at the beginning neither she nor her family had really understood or accepted the lifelong nature of her illness and its propensity to recur. Had she received psychotherapy focused on the management of her illness and her interpersonal life in the context of that illness, she might not have made the trip to Seattle or been so puzzled by what was happening to her marriage. But, here, even her psychopharmacologist failed to see what was needed. In the absence of any kind of psychosocial intervention, many of those who suffer from bipolar disorder find themselves on the deteriorative course that characterized Jill's life, a course from which it can be very difficult to recover.

Still, Jill brought many strengths to her IPSRT treatment. Perhaps most important, she was highly motivated to change the direction of her life. In addition, she was intelligent, verbal, and reasonably insightful. Although not the person she had been a decade earlier, she retained many of the social skills she had had as a young woman. Finally, because her illness did not begin until she was an adult, she had an idea of what it meant to be fully functional even though it had been many years since she was able to do so.

Jill's IPSRT therapist began by taking a history of her bipolar illness, going all the way back to her seasonal mood changes in high school. Together they created a timeline in which her episodes, her treatments, and any life circumstances that seemed to be associated with the onset of symptoms were represented, along with her work and marital status. Her therapist pointed out how important challenges to her circadian system and changes in her hormonal state seemed to be connected to the onsets of her episodes. He also pointed out how much better she seemed to function when she was in a regular routine. He queried her about the various medications she had taken over the course of her illness, trying to understand what had worked best for her. He then completed what we call the "interpersonal inventory," an informal review of all the relationships that were currently important to Jill and all the relationships that had been important to her in the past. He discovered how socially isolated this once well-integrated woman had become. In taking the illness history and the interpersonal inventory he was also able to see the clear decline in her work functioning. At their fourth

session, he discussed the IPSRT problem areas with Jill and together they agreed that first she needed to grieve for her lost healthy self and former life as a functioning professional and wife. They talked about the fact that she really had not fully made the transition to being single or to being a single parent and decided that this would be a later focus of their work. First, though, they needed to concentrate on getting Jill and her boys into some sort of regular routine. Fortunately, Jill's therapist didn't need to do much to convince her that she would feel better if she were on a regular schedule. That was something she knew already. He gave her the Social Rhythm Metric to complete before their next session. When she returned the following week, he could see that the time at which she was getting up in the mornings varied by as much as 3 hours a day. Knowing that a person's "good morning time" tends to set the body's clock, he concentrated on having Jill get up at a regular time each day. Because it was summer and the boys didn't need to be at school, he chose 9:00 A.M. as the target, thinking that later in the summer he could help Jill work her way toward an earlier wake-up time. He also suggested that she focus on making a real breakfast for herself and the boys and eating breakfast as a family each morning, thinking that that would be good for Jill's self-esteem, further help to set her clock, and bring a bit of needed stability to the boys' lives. At each visit, he praised her progress and encouraged her to stick with what was a difficult challenge for her. He inquired regularly about her symptoms and about her response to the new medications his colleague had prescribed, including any side effects she might be experiencing. Once she was on a modestly regular schedule, he began to help her grieve for the young professor of such high promise and for all that she had hoped to become. He gently helped her to see how her once supportive parents had subsequently failed her by mostly denying her illness. He asked Jill if she thought it might ever be useful for the four of them to meet together, and when she tentatively said yes, he tucked away the idea of a conjoint psychoeducational session as something he would attempt to schedule in a month or two when Jill was feeling stronger. He took a more careful history of the marriage and what its loss had meant to her. He tried to understand what kind of life Jill wanted now and how much of what she wanted she might be capable of having. Very, very gradually over the ensuing months Jill came to accept her illness as a challenge she might be able to master and her life as a single mother as one that might offer satisfactions. When the therapist did attempt the conjoint educational session with her parents, he realized that they were just too uptight, angry, and disappointed to be able to be a support to Jill without entering into treatment themselves, something he thought it unlikely they would ever do. After that, Jill's therapist helped her to reconnect with other, less judgmental sources of support and to garner some new ones. He kept his expectations for her modest and tried to convey those modest expectations to Jill. By Halloween, Jill was able to host a small neighborhood party for her boys' friends and some of their parents. Her boys were enormously pleased, and Jill was pleased with herself, perhaps for the first time in years. Whether she would ever be able to go back to working was a question they left open, for now focusing just on keeping Jill's mood stable, her routines regular, and her boys' functioning at home and at school on a steady course of improvement.

In some ways, Tad was more fortunate than Jill, even though the beginnings of their stories sound similar. At 18, Tad's future also seemed incredibly bright. A gifted artist from the time he was a little boy, he had been accepted to one of the foremost fine arts colleges in the nation. He was going to have an opportunity to study painting with a man whose work was world renowned, despite the fact that Tad had grown up in a tiny town in Alabama, had never been in a real museum, and had never seen a great painting except in the art books his mother had borrowed from the library where she worked. His interests had made him an outcast as early as junior high, but knowing

that he would finally get to do what he had dreamed of doing for as long as he could remember eclipsed all the suffering he had experienced in high school. And there had been quite a lot: months when he was so sad he could hardly speak, moments when, out of the blue, he was consumed with heart-stopping anxiety so terrifying he was certain he was going to die, days when he was so irritable that even his sainted mother lost her seemingly endless patience with him and he felt utterly abandoned in the world.

At college he found not one, not two, but dozens of soul mates, people who seemed to care just as intensely as he did and were willing to talk about their passions from the minute classes ended until the sun came up the next morning. And then there were the museums! Just a subway ride away, there was a veritable feast for the eyes, the intellect. Whenever he wanted, he could take off for an hour and see a real Picasso, or Rembrandt, or van Gogh, and unlike the way he was in high school, he seemed to have boundless energy. Indeed, within a few weeks he found he really didn't need to sleep. He could spend all afternoon in the museums and almost all night talking with his classmates, and when he finally made his way back to his room, he still had energy enough to do his homework and finish his projects—brilliantly! The wildest, most original ideas kept coming to him, day after day, week after week. The sunshine on the minerals in the cement of the sidewalk appeared to him like van Gogh's starry nights. As he walked back to his dorm just before dawn, the shadows of the twisted old trees on the campus had all the weight and intensity of one Michelangelo's dying slaves. He had never experienced anything like it! When it came time to plan his first-semester final project, he was a bit secretive with his advisor, who, because Tad's work to date had been so exceptional, decided to just wait and see what this brilliant young kid came up with. To his advisor's horror, what Tad presented as his project was a complex and visually stunning installation, which he had completed in a single night in the men's gymnasium, made entirely of women's underwear, stolen one piece at a time from the drawers of his dorm mates. The text he wrote to accompany his exhibition was completely incomprehensible, like something written by a madman. Neither his advisor nor the administration nor the women from whom he had taken the underwear were the least amused. When interviewed the following day by the dean, it was immediately apparent that this was not just some drug-induced joke. Tad was a seriously ill young man.

Immediately referred for treatment of his mania by the school administration, Tad presented numerous challenges to his IPSRT treatment team. Naturally, he at first denied that there was anything wrong with him or that he had any need for treatment. Once the team was able to begin treatment in earnest, his mania proved very hard to control pharmacologically, and, although he was chronologically 18, his social development was found to be more like that of a 14-year-old. He was alone in a big city with no real support system other than his treatment team. Sending him back to the dormitory, where overstimulation and easy access to drugs had already proven to be a major problem, was not an option. Together with Tad, his treatment team worked out a housing and scholastic plan that would eventually allow him to reenter school on a part-time and, later, full-time basis. In the interim, he would enter an assisted-living facility where medications were dosed by the staff and take a part-time job as a clerk at a 7-Eleven.

It took two more severe episodes of mania, hours of psychotherapy, and the unwavering support and encouragement of his treatment team, but Tad finally accepted the need for ongoing pharmacotherapy. Unfortunately, the only medications that controlled his symptoms made Tad's hands tremble so that he had to give up his dream of becoming a painter. However, like Matisse, he learned (with his advisor's encouragement and support) to work in other media when he could no longer create in the way

that was most natural to him. It took 6 years, but Tad did finish school and, during that time, matured about twice 6 years. Much of his psychotherapy focused on grieving for all the dreams he had once had—of doing great work, of traveling and studying abroad, of making full use of his gifts—and on doing all he could to keep his symptoms under control. This included keeping to a very regular schedule, getting sufficient sleep, avoiding excessive stimulation, and being sure to get adequate sleep in the social context of fine arts studies (where routine is anathema). By the time Tad was ready to graduate, he had come to accept the numerous limitations his illness placed on him. Rather than remain in a city that always threatened to tempt him with overstimulation and easy access to drugs, he opted to return to the town where he had grown up. Back in Alabama, he knew he could count on the support of his mother and sister should he become ill again. Still a gifted artist and irrepressible art enthusiast, he accepted a position as an elementary art teacher in the same school where his mother serves as librarian (and close observer of any changes in his moods). He adores the children he works with, and they adore him and his enthusiasm. His family doctor prescribes his medications, and both he and his doctor remain in occasional touch with the treatment team that put him on the road to a stable and satisfying life.

Tad's story is a good illustration of what can happen when a very needy, but entirely likable, young patient with bipolar disorder has the good fortune to encounter a skilled and dedicated treatment team early in the course of his illness. From the outset, his team members understood that despite his enormous size (6'3" and over 200 pounds), social grace, and intellectual gifts, he was really a scared little boy alone in a huge city with no skills or other supports to combat his illness. They interpreted his initial denial of his illness and nonadherence to treatment as perfectly normal . . . and told him so. They stuck with him through a series of hospitalizations for mania (when he often treated them despicably) and through the difficult, drawn-out depressions and the suicide threats that followed each of these episodes. By telephone and during his mother's occasional visits, they worked closely with his family members to educate them about what was happening to their beloved Tad, what his illness would mean for both his short-term and long-term plans, and why the medications that made his long-dreamed-of career impossible were necessary for his survival. At each step along the way, they helped him to grieve for what he was losing and congratulated him on what he was accomplishing. To this day, despite the fact that he has not seen the members of his treatment team face-to-face for almost a decade, their approval of his life choices and their interest in his accomplishments remain an important source of pride.

Although Jill and Tad entered treatment at very different stages in their battle with bipolar illness, IPSRT proved to be an appropriate intervention for both of them. In Jill's case it helped her climb out of what seemed to be a morass of symptoms, stress, and unmanageable responsibilities to live a life of dignity, albeit not the life she had foreseen for herself at age 22, but one of which she could be justifiably proud and which provided her children with the stability they needed. In Tad's case, IPSRT was able to set him on a life course that was consistent with the perils his disorder presented if he failed to respect the limitations that it set for him. He, too, found a life of dignity and deep satisfactions, although not those he had anticipated when he first became ill.

Interpersonal and social rhythm therapy (IPSRT) was developed with the late adolescent and adult patient with bipolar I disorder in mind. It has been tested in a randomized clinical trial that included only individuals over the age of 18 with a diagnosis

of bipolar I disorder who had experienced at least two past episodes of mania and/or depression. The anecdotal evidence gained from our own pilot studies and from our experience in training therapists in the conduct of IPSRT suggests that it is also an appropriate intervention in younger patients, in individuals who are experiencing only their first or second episode of bipolar depression or mania, and in individuals with bipolar II disorder.

In characterizing the patient for whom the treatment is intended, we refer the reader to the descriptions of manic episode, major depressive episode, and bipolar I disorder provided in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 2000, pp. 350–355) and to the extensive description of the disorder provided in Goodwin and Jamison's classic 1990 volume, *Manic Depressive Illness*. Briefly, the essential feature of bipolar I disorder is the lifetime experience of an episode of mania. Episodes of depression are usually present in the history as well, but are not a requirement for the official DSM-IV diagnosis. In contrast, the diagnosis of bipolar II disorder requires that the individual have a history of both hypomanic and depressive episodes. Formal diagnostic considerations aside, IPSRT is almost certainly appropriate for any patient with clearly defined and impairing episodes of high and low mood (as opposed to fleeting shifts in mood) that are accompanied by the cognitive and neurovegetative changes associated with mania/hypomania and depression. With respect to mania/hypomania, these changes include inflated self-esteem and grandiose thinking (often reaching delusional levels in mania), reduced need for sleep, increased energy, sexual interest and activity, rapid speech and thought, and increased involvement in pleasurable activities without regard for the consequences such activities might have. With respect to depression, such changes include loss of interest in usually pleasurable activities; decreased energy; increased or decreased sleep, appetite, and weight; difficulty in thinking, concentrating, remembering, or making decisions; reduced self-esteem; and thoughts of death or suicide.

Although the epidemiological data suggest that bipolar I disorder (which has a lifetime prevalence of about 1% in most industrialized societies in which it has been studied) is equally likely to afflict men and women, our experience and that of our colleagues is that about two thirds of those who seek voluntary treatment for this condition are female. The female-to-male ratio is probably even higher for bipolar II disorder. Both classic manic-depressive illness (bipolar I) and its more attenuated forms (bipolar II, bipolar disorder not otherwise specified [NOS], and cyclothymia) tend to begin in the late teens or early 20s, although patients may suffer for many years or even decades before an appropriate diagnosis is made. Especially if the manias are nonpsychotic, not terribly destructive, or even, in some ways, functional, the bipolar aspect of the illness may be missed unless a very careful history is taken. A group of almost 3,000 individuals participating in a bipolar disorder patient registry that we maintain at the University of Pittsburgh reports that it took, on average, 10 years from their first episode of illness to the time they received a correct diagnosis from a professional (Kupfer, Frank, Grochocinski, Cluss, et al., 2002).

Perhaps more important to the introductory discussion in this chapter is the *nature* of the depressive or manic/hypomanic illness at the time IPSRT is being initiated. As becomes obvious in subsequent chapters, this is an intervention that requires considerable effort and, particularly, effort at change on the patient's part. Thus, IPSRT is intended for individuals whose clinical condition is such that major psychotic symptoms

have receded or are absent. Although IPSRT can be started either in the hospital or on an outpatient basis, our experience with this treatment has been almost exclusively with individuals who have already been discharged from the hospital or were not hospitalized in the first place. Because written homework is required, a moderate level of literacy is necessary for participation in IPSRT, at least as it was originally conceptualized. Most of this homework relates to the completion of the Social Rhythm Metric (SRM; Monk, Flaherty, Frank, Hoskinson, & Kupfer, 1990; Monk, Kupfer, Frank, & Ritenour, 1991), a self-monitoring form, originally 17 items in length, for recording the time at which and with whom a series of daily activities are completed. We have recently created a simpler and shorter, five-item version of this self-monitoring device (Monk, Frank, Potts, & Kupfer, 2002) that could almost certainly be adapted to the needs of individuals with very limited literacy. Copies of both versions of the SRM appear in the Appendices (short version, Appendix 1; long version, Appendix 3).

Although both of the case examples at the beginning of this chapter describe individuals of above average intelligence and talent who had high educational attainment, we have engaged individuals of much lower intelligence levels and much lower educational attainment in IPSRT. Even though it is true that the population of individuals who have suffered from bipolar disorder does include some of the world's most gifted persons, there are also many ordinary citizens who must cope with this condition, and IPSRT appears to be able to help them do that.

As noted earlier, IPSRT was developed for use with "adult" patients with manic-depressive illness. The youngest individuals we have treated with IPSRT were 18 years of age at the time they entered treatment. IPSRT, however, could almost certainly be applied to relatively mature late adolescents, especially those whose families can be engaged as "coaches" for the changes the patient is being asked to make. At the upper end of the age spectrum, the oldest patients we have treated with IPSRT to date are those in their 60s. However, we are beginning to try to understand how IPSRT functions in the relatively small population of individuals with classical manic-depressive illness who continue to suffer into their 70s, 80s, and beyond.

Interpersonal and social rhythm therapy was developed with primarily Anglo and African American patients in mind. We have used it with good success with small numbers of patients of Asian, East Indian and Middle Eastern backgrounds, but have essentially no experience in using it with individuals of Hispanic origin. It is clear, however, that interpersonal therapy and the interpersonal aspects of IPSRT are, by their very nature, adaptable to virtually any cultural or subcultural background. In IPT and IPSRT the interpersonal problem areas to be addressed are always conceptualized within the context of the subject's own values with respect to interpersonal roles and relationships. Likewise, the social routines aspect of the treatment makes no particular judgment as to when specific daily routines should occur, but simply emphasizes the importance of regularity of routines in the lives of those who suffer from manic-depressive illness. If breakfast is not taken until after morning prayers are said, or the large meal is eaten at midday, or there is a period of sleep following the midday meal as essential parts of a cultural routine, the treatment is easily able to accommodate these cultural preferences. Thus, in theory at least, IPSRT should be adaptable to a multiplicity of ethnic groups and subcultures.

The chapters that follow describe something about the theories of etiology of bipolar disorder and bipolar episodes and the other treatments that have been shown to be

effective in this condition that follow from these theories. We describe our own theoretical stance in detail because it provides the basic rationale for IPSRT. Then we take you through the various elements of assessment and treatment that constitute IPSRT. We also describe other useful interventions that work well as adjuncts to IPSRT and offer some thoughts about the therapeutic relationship in IPSRT and what to do when the treatment does not seem to be helpful. Finally, we discuss the issue of termination or transition to more limited contact with the patient.

An essential foundation for IPSRT is familiarity with Klerman and colleagues' interpersonal psychotherapy (IPT) for unipolar disorder (Klerman et al., 1984; Weissman, Markowitz, & Klerman, 2000). If you are contemplating using IPSRT yourself, you would do well to read one of these two books describing IPT. Although it is very helpful to obtain supervision from an experienced IPT or IPSRT clinician, in many places it may be difficult to find such a person. In the absence of the availability of such supervision, we recommend finding a colleague who shares your interest in practical, present-focused treatments and asking him or her to read through this book, begin to apply IPSRT in his or her practice, and then, using audiotapes of treatment sessions, engage in informal peer supervision with you.