Interpersonal Theory and Music Techniques: A Case Study for a Family With a Depressed Adolescent

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Interpersonal psychotherapy (IPT-A) is a brief, time-limited therapy developed for use with adolescents diagnosed with major depression. IPT-A has been shown to be effective with adolescents in family counseling milieus. Music therapy techniques also have been successfully used to treat adolescent depression. This article provides mental health counselors and family counselors with information about a case study in which these two modalities were successfully integrated. In addition, this article provides explanations of IPT-A treatment protocols and music therapy techniques that might be utilized in a family therapy setting.

Keywords: *adolescent depression; interpersonal theory; music techniques with adolescents*

THE SABASTIANI FAMILY

John Sabastiani, 15 years old, sits sullenly in the farthest corner of the counselor's office. With his leg slung over the arm of the chair in which he is sitting, John positions himself so that he is facing away from the counselor. Although John is wearing earphones, there is no sound emanating from them. John's parents, the Sabastianis, face the counselor on a nearby sofa. Amanda, John's mother, who is immaculately dressed, appears distraught as she nervously drums her fingers on the sofa. John's father, dressed in a business suit, looks more composed. He has a briefcase at his feet. This scene began a week ago when Amanda first called the counselor's office to request an appointment. During the phone call, she told the counselor that John had been getting into trouble "all the time" at school. She also reported that he was being "disrespectful" at home. At the end of the phone call, with an exasperated tone of voice, she confided that John was arrested 4 weeks ago for being at a party where alcohol was being served. John had been drinking and the police found that he showed a blood alcohol level that was twice the amount that is deemed "legally intoxicated." Because of this, John must attend a substance abuse education class and face the possibility of community service. In addition, 2 weeks ago, John's school counselor told Amanda that he believes John is depressed.

At the beginning of the counseling session, Amanda says that she is "at the end of her rope" and does not care what the problem is called. She says, "We just need help!" She states that she and her husband Raul have been having almost daily disagreements about John, especially about ways John should be disciplined. Raul, quiet until now, blurts out, "John is just a kid" and "he will get over this soon." Objecting to Raul's statements, Amanda states that she believes John has not been the same since they moved last year from another city. She says, "I wish that we could just go back to the way we were." John, who has been quiet until now, suddenly explodes at both Amanda and Raul, saying, "No one understands me. You think that you know me so well. No one knows me. Just get me out of here. I don't have any friends here and I am not going to make any. I hate this place, and it's your fault that I am here."

It is obvious as the counseling session progresses that no one in this family group has been effectively communicating with other family members. This lack of communication is not only taking its toll on John. This failure of communication is felt by the entire family. The Sabastianis have formed opinions with little or no information and made alliances based on impressions that are not factual. In essence, no one really understands the other's viewpoints, and at this rate, no one will. This scenario, in many variations, occurs in counselors' offices every day. John is depressed.

John is not unique in displaying symptoms related to adolescent depression. In fact, the incidence of adolescent depression is increasing dramatically according to a report by the National Institutes of Mental Health (NIMH; 2005). At some time, depression affects one in five adolescents between the ages of 12 and 18 (NIMH, 2005). Furthermore, with the rising costs of mental health treatment and the paucity of

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funding available for treatment of adolescent depression, fewer than 5% of all depressed adolescents receive any kind of treatment for their depression. Given that depressed adolescents are more likely to commit suicide, develop substance abuse, and experience stressful life events (Lewinsohn, Duncan, Stanton, & Hautzener, 1986), it is crucial that effective treatment be provided. Furthermore, depression does not go away with age; instead, adolescents who do not receive successful treatment for depression are more likely to experience depression as adults.

Despite the best verbal techniques that the counselor might use, it is likely that more than verbal techniques are needed to help adolescents who are depressed. Typically, depressed adolescents have poor school performance, social isolation, sadness, overreaction to perceived criticism, agitation, substance abuse, and problems with authority (NIMH, 2005). Furthermore, depressed adolescents display more helplessness than depressed adults and experience more despair (Birmaher et al., 1996). Although "belonging" is an important element of development, depressed adolescents have little sense of belonging. Indeed, due to environmental stress related to war, natural disasters, and general stress, the four basic human needs of feeling connected, feeling capable, feeling worthy, and having courage are increasingly being threatened in our society, and concordantly, adolescent's resilience is threatened (Lew, 2002). Thus, depressed adolescents may feel that they can do little to alleviate their symptoms. In reality, they are despairing over their plight. Further complicating their situation, depressed adolescents have short attention spans, limited ability to conceptualize their own mental health needs, and overreactiveness to anything that they might see as critical evaluation by anyone, including family and counselors. Whether purposefully or not, these adolescents have little inherent motivation to help counseling succeed, and more often than not, ultimately, they are proved correct in this self-fulfilling prophecy.

TREATMENT OF ADOLESCENT DEPRESSION

The treatment of adolescent depression has generally involved adapting adult psychotherapy approaches such as Cognitive-Behavioral Therapy, Psychodynamic Approaches, and Behavioral Therapy for depression treatment in adolescents (Gilroy, Carroll, & Murra, 2002; Kutcher & Marton, 1996; Paradise & Kirby, 2005). All of these approaches seek to decrease depressive symptomology and increase psychosocial functioning. However, the results of these studies call into question the transfer of adult psychotherapy approaches with their emphases on decreasing depressive symptomology and increasing psychosocial functioning (Mellin & Beamish, 2002). The results of psychotherapy treatments for depressed adolescents have resulted in a lack of successful direction for family counselors.

INTERPERSONAL PSYCHOTHERAPY AND THE TREATMENT OF ADOLESCENT DEPRESSION

One of the most promising approaches to treatment of adolescent depression is Interpersonal Psychotherapy (IPT-A), which is a brief, time-limited treatment developed for depressed adults. IPT-A has been modified for use with many different populations, including adolescents (Weissman & Markowitz, 1994). Research conducted by Santor and Kusumakar (2001); Mufson, Weissman, Moreau, and Garfinkel (1999); and Mufson, Dorta, Wickramaratne, Nomura, Olfson, and Weissman (2004) indicate that IPT-A was effective in treatment of depressive symptoms in adolescents who were moderately to severely depressed.

The underlying assumption of the IPT-A approach is that one of four problem areas is linked to the development of depression. These problem areas include interpersonal deficits, role transitions, interpersonal role disputes, and grief. Proponents of IPT-A assert that discovering the interpersonal problems contributing to depression and working to alleviate depression are sufficient to effectively treat depression regardless of other factors experienced by the adolescents. In addition, IPT-A addresses issues that are developmentally pertinent to adolescents, including role individuation from parents, romantic relationships, and peer pressure (Mufson, Dorta, Moreau, & Weissman, 2004).

TREATMENT TECHNIQUES OF IPT-A

With regard to treatment techniques, IPT-A is a time-limited therapy that calls for once weekly sessions throughout a 12-week treatment. The goals of this therapy include identification of interpersonal problem areas with which the adolescent is struggling and focusing on the ways that problems are currently influencing their relationships (Mufson, Dorta, Moreau, et al., 2004). There are three treatment phases in IPT-A: initial, middle, and termination phases.

Initial Phase

The initial phase occurs in counseling sessions 1 through 4. In this phase, a diagnostic assessment is conducted, a history of current interpersonal stressors is obtained, goals and techniques of IPT-A are discussed, and treatment contracts are formulated. Because of the high comorbidity of suicide and substance abuse, evaluations of these areas also are conducted. During this phase, parents are educated about their child's diagnosis, general aspects regarding the treatment of depression, the course of depression, and prognosis for depressed adolescents.

In the initial phase, the adolescent is assigned a temporary "sick" role to keep them from withdrawing from supports. The sick role is defined to the depressed adolescent by explaining that he or she has a temporary mental health prob-

lem that might affect his or her ability to participate fully in day-to-day activities. However, the adolescent is encouraged to participate in day-to-day activities because this participation will help speed the alleviating symptoms. The sick role also has the added benefit of assisting parents in understanding depression and possibly preventing them from becoming overly impatient or critical of their child's performance. This phase also includes the development of a treatment contract that addresses techniques that will be used, interpersonal problem areas that are to be addressed, limits of confidentiality, number and timing of sessions, and the role of the parents in the counseling process.

Middle Phase

The middle phase of IPT-A occurs in sessions 5 through 8. During this phase, the counselor and client begin to work directly with previously established goals. In addition, five interpersonal areas are examined during the middle phase of IPT-A. These areas include grief, interpersonal role disputes, role transitions, interpersonal deficits, and single-parent families. The main goal of this phase of therapy is to associate one of the interpersonal problem areas with the depressive symptomology that has been experienced by the adolescent.

Termination Phase

The termination phase occurs during sessions 9 through 12 of the IPT-A process. During this phase, the client is encouraged to separate from the counselor and gain a sense of self-efficacy by practicing coping mechanisms that have been learned during previous counseling sessions. In addition, the client is encouraged to discuss possible areas that could cause future problems and explore problem-solving strategies. Education during this phase includes information regarding symptoms related to depression that might occur in the future, secondary depressive symptoms, areas of conflict that are present in the family, and general family dynamics.

MUSIC IN THE TREATMENT OF ADOLESCENT DEPRESSION

Music listening techniques have been shown to have significant impact on the reduction of depressive symptoms for adolescents. Took and Weiss (1994) studied the influence of heavy metal and rap music on antisocial behaviors and found that adolescents who listened to these types of music were more likely to be arrested for delinquent behaviors than those who listened to music that did not contain violent lyrics. Hendricks, Bradley, Robinson, and Davis (1997) reported that the use of music therapy techniques, including music listening techniques, significantly reduced depression for adolescents between the ages of 12 and 17. Furthermore, music has been used as a form of therapy that enhances expression of feelings, positive associations, and socialization (Gladding, 1999). Hendricks et al. (1997) found that using Cognitive Behavioral therapy in the treatment of adolescent depression was more effective when music therapy techniques were employed.

Music listening techniques have been shown to have significant impact upon the reduction of depressive symptoms for adolescents.

Given the fact that success has been achieved by both IPT-A and music therapy techniques in the treatment of adolescent depression, the authors will illustrate the integration of IPT-A and music therapy in the case of the Sabastiani family. Using the phases in the IPT-A therapy as the centering focus, the authors will illustrate the process of integrating the two approaches.

THE SABASTIANI FAMILY: INITIAL PHASE

During the first week, the counselor explained the basic tenets of the IPT-A approach and explained to the Sabastianis that the general time frame for treatment is 12 weeks. The counselor conducted assessments related to John Sabastiani's psychosocial history and current interpersonal stressors. Although John stated that he really did not have any stressors and really thought that counseling was "bogus," John was nevertheless marginally amenable to the assessment.

In the initial assessment, the counselor talked to John about depression by describing the symptoms of depression. John admitted that he had these symptoms and agreed to be administered a Beck Depression Inventory (BDI). With regard to depression, his score on the BDI placed him as "moderate." After completing the BDI, the BDI was discussed with John and John's responses were noted. In the presence of his family, John agreed that, according to his responses on the BDI, he had some symptoms that needed treatment. He also was told that although he should continue his day-to-day activities, it would be "normal" for him to feel like he did not want to do them. He was encouraged to continue the activities because it would likely increase his recovery. Although John agreed to continue his activities, he was quick to state that he did not want to see a physician for medication, and his parents agreed. The counselor explained that although this was the family's choice, if the symptoms became more pronounced, a medical assessment would be warranted. During this session, John stated that he had used alcohol "a couple of times a month with his new friends, but only at parties." He also stated that he had stopped using alco-

hol because he knew that this would affect his present legal situation. He denied any suicidal ideation.

During the second session, the counselor asked John what John liked to do for fun. John said that he liked to play games on the computer and listen to music. He said that he liked all kinds of music, especially heavy metal. Although his mother stated that this was a major source of John's depression, John disagreed. The counselor asked John if he would agree to bring one song that he liked for the family to listen to in the next session. John, after saying that his parents would not like the music, agreed to bring a song "only this one time."

During the next session, session 3, John brought Guns N' Roses' "Paradise City." As the music played, the counselor made note of the lyrics, which stated raw emotions related to starting over and wishes to be in a place where the "grass is green" rather than in the city where it is "hard to breathe." Suddenly, aspects of John's depression became more evident. It was plain to see that many of John's symptoms centered around "role transitions" as presented in IPT-A. After the song finished, the counselor asked John why he liked this music. He said, "I don't know. I just like it." The counselor asked if Amanda and Raul would like to respond to what they heard in the music. Immediately, Amanda responded and began to tell everyone the reasons John liked the music. The counselor interrupted and asked Amanda what she heard in the music that had personal relevance to herself. Amanda, puzzled, said that she really did not understand what she was being asked. The counselor asked John to play the music again with each parent listening to the music for their own personal meanings. Other techniques to consider in this phase include reframing, my own song, and music collage (see the appendix).

After the second playing of the music, Raul stated that he heard desperation and emotion in the music. He stated that the reason he did not like the music was that it was too "heavy." Raul also stated that his mother did not like the new Italian Rock music that he played as a teenager for the same reasons. Thus began a conversation in which Amanda, Raul, and John began a dialogue about emotion, expression of emotion, and ways that emotion was expressed through music. Raul, somewhat excitedly, asked if he could bring some music to the next session.

A pattern of communication occurred in the Sabastiani family in which music became an important part of family communication during counseling. Indeed, John was listening to hours of music a day, and music was already a part of the family. Now, the family was simply able to integrate this into their daily lives without the compartmentalization that existed prior to John's sharing. Although there were difficult times in family counseling, including the playing of Amanda's Carpenters tapes, which John thought were "geeky," the music techniques allowed the Sabastiani family to embark on a different style of communication, a style that enabled them to be more forthright about their feelings. Now, John not only was less isolated but he was better able to identify feelings related to the family's move to a new city and the subsequent role transitions. He thought that his feelings were unique to him and no one else had any problems adapting to the new surroundings. He was surprised to hear that his mother had a very difficult time in the new community in terms of making friends. He also was shocked to learn that his father had not been invited to any social activities. By the end of the initial phase, the family was better able to cope as a unit with the changes with which they had been presented.

THE SABASTIANI FAMILY: MIDDLE PHASE

It became apparent in the initial phase of therapy that John had problems related to role transitions. To assist in the role transitions, music exercises were given in which John was able to express through recorded music conflicts that he felt in each of various areas. For example, John was experiencing problems that resulted from his perceived loss of a romantic relationship in his former hometown. He said that following his move he had not spoken to his former girlfriend. In the overall situation, John also was experiencing problems related to his general role transitions because he was forced to make new friends, meet new people, adjust to a new school, and generally become accustomed to a new environment—all situations that he disliked. Making matters worse, he felt that he was not "good looking" or a "jock," and he concluded that did not "fit in with the cool people": "I do not even know what it takes to be cool here."

During session 5, John made a collage of recorded music that demonstrated aspects of his former home, school, and friends (see the appendix). In this collage, John combined heavy metal music, country music, and jazz. Raul said that he was surprised to know that John even knew that jazz exists. Through this collage, John demonstrated feelings of ambivalence about his past, including confusion about a romantic relationship, some anger regarding school work and teachers, and happiness regarding friends and neighbors.

John developed a second collage for session 6. In this collage, he demonstrated his present-day situation. For this collage, he included mostly rock and heavy metal with some jazz. He played music that symbolized anger about the move, hope about new friends and relationships, and surprisingly, appreciation to his family for their support and thanks to his school counselor for his "being there during the hard times." John played hard heavy metal music to represent his legal situation. In this session, John also brought some individual songs for his family to hear. During this time, the song selections that John made shifted from the heavy metal that he played in the first phase to softer music with less graphic lyrics. Raul brought a piece of jazz for the family to listen to; he shared that he had enjoyed this music when he was in college, and John was surprised to hear that the jazz sounded just like the "stuff that they play on the radio now."

THE SABASTIANI FAMILY: TERMINATION PHASE

In the termination phase, plans were made for John to actively employ coping mechanisms to deal with his problematic areas related to role identification. In particular, John stated that he wanted to send the music collage that he had made of his former hometown to some of his friends back home so that they could understand him better and he could, in his own words, "say goodbye." In regard to his present situation, he stated that he would get together with some people at school who had similar interests, particularly with regard to music. John stated that he was more likely to listen to violent heavy metal music when he was depressed, and he identified some songs that serve as catalysts for him to want to drink with friends.

Dynamics in the family were discussed. Amanda agreed that she needed to listen to John's feelings and not be so quick to "jump to negative conclusions" about his behaviors. Raul agreed that John did indeed have a condition that needed to be treated and that depression was not simply something that was "part of being a kid." John agreed to another administration of the BDI, and the posttest score on the BDI indicated "No Depression Present." John agreed that if he started feeling depressed again, he would tell his parents. When asked how he would do this, he said that he would get his CD player and start playing "Paradise City" for his mom and dad.

DISCUSSION

There seems to be much that family counselors can gain with respect to finding a way to assist adolescents diagnosed with depression. It is an understatement to say that adolescent depression is increasing rapidly; indeed, it is escalating. Research reported by Lew (2002) clearly pointed out that adolescents do not feel wanted and connected, although in reality this is what they strive for. Other researchers (Birmaher et al., 1996; Lewinsohn, et al., 1986) have pointed to these perceived shortcomings as resulting in an increased incidence of suicide. With the data reported by NIMH indicating that about one in five adolescents are depressed, evidence shows that adolescent depression is a problem of great magnitude.

As we reviewed the literature on working with adolescents who are depressed, it was obvious that there are shortcomings in the literature. That is, most work with depressed adolescents attempted to transfer theory and techniques used with depressed adults to depressed adolescents. We believe that a more comprehensive view of treating adolescent depression is needed. Thus, we integrated information from successful IPT-A techniques and music therapy techniques into our work with depressed adolescents. Based on our feedback from the adolescents, the integration and the two approaches were successful. We received such comments as,"He gets along with us so much better"; "My kid actually talks to me now"; "By using music in therapy, you are just using what my son already uses for his own therapy"; and "He thinks it is cool to go to counseling and listen to music."

The strategic integration of the approaches set forth in this article speaks to the need to adapt counseling strategies to meet the needs of adolescents diagnosed with depression. Family counselors can follow the process set forth in this article and invoke a rationale for integrating other theories and techniques from other models and then modify them accordingly. The point is that family counselors should not assume that because an approach works with adults, it will work with adolescents.

In summary, we have tried to illustrate that adolescent depression is a reality with which families must deal. It is imperative that the families and counselors recognize this group of adolescents as a growing group with a major problem: depression. Although there is no magic formula for counseling depressed adolescents, we believe that the family therapist must reframe the adolescents' experience into a large context and the reframing must include more than "what has worked with depressed adults." From our experience, many depressed adolescents and their families do not want to come to counseling so the family therapist must be able to use techniques (e.g., music) that will appeal to the adolescent. That is, the family therapist must be able to establish a counseling relationship and environment that is received as a positive climate by the adolescent and his or her family. We found the combination of IPT-A and music techniques to provide this climate. We encourage family counselors to continue in therapeutic directions that will create a counseling environment that is enhancing for adolescents to effectively deal with their problems.

APPENDIX

In the following section, we have given you examples of some of the music techniques that we have used while working with families who have depressed adolescents. Each of the techniques should be crafted and implemented for individual family needs; however, these techniques, which have been mentioned in this article, are useful in a variety of situations and may be implemented with little expense. Each of the techniques may be used with families as a whole or individual members of a family.

Music Listening

In music listening, the counselor has one or more family members select a song that has strong personal meaning for them. Together, the counselor and the family listen to the music. After the song is completed, the counselor asks the family questions about the feelings and the thoughts that the song evoked and the way(s) that the feelings and thoughts contribute to present life functioning. For example, a song describing friendship might elicit feelings of comfort and pleasure for the family. The family would then identify ways that these feelings could be helpful in combating stress and anxiety

about friendships or any other applicable situation. This technique gives insight to both the client and family about the family's life situation, history, and functioning.

Reframing

In reframing, the therapist and the family generate new (positive) cognitive understandings or frames of reference for a given situation or experience. For example, a family with an adolescent who is having difficulty in understanding a curfew time might reframe their misunderstanding to focus on the parent's concern for their child's safety. Following the identification of the reframe, the family is then asked to find a piece of written or recorded music that describes some of the feelings that have been identified in the process of the reframe. The family and the therapist then listen to the music. Following this, the family then talks about why they chose the music and what feelings the music evoked.

My Own Song

This technique involves having clients create a short song about something that is bothering them or occurring in their lives. Creating songs increases self-awareness, emotional release, and facilitates problem solving and coping skills.

Music Collage

In music collage, the counselor gives the family access to a tape recorder and asks them to tape enough short (5-20 s) segments of songs that have personal meaning to create a 3- to 5-min music collage. When the collage is finished, the counselor facilitates a discussion of how the music is meaningful and what feelings it evokes. This activity is especially effective with adolescents.

Music and Color

In music and color, the family is asked to listen to a piece of recorded music that they have identified as having personal meaning for him or her. After the music selection has been played, the family is asked to visualize colors that they might have thought about as they listened to the music. After the colors are identified, the family is asked to discuss the colors and explain what the colors might represent.

Television Theme Music

In the television theme music technique, the counselor uses a cassette recorder and records the theme music from several familiar television shows. The counselor then asks the client to identify the shows that are represented by the music and asks him or her to explain which of the shows were favorites or least favorites and why. Further discussion might focus on characters from the television shows with whom the client most closely identifies and what the client feels about these identifications.

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