1 Depression: An Interpersonal Problem

In this chapter, we define the different types of depression and guide you in understanding your own experience of depression. We talk about the prevalence of depression and look at its possible causes, including our focus in this book: interpersonal behaviors.

WHAT IS DEPRESSION?

Let's begin by developing a clearer understanding of what depression is. The current diagnostic scheme used by the vast majority of mental health professionals, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), describes several forms of depression. We focus on two of those, major depression and dysthymia, as well as one form that is not yet in the DSM, double depression. While bipolar disorders include other forms of depression, we will not emphasize them here.

Major Depression

Major depression is a condition that persists, causes distress or impairment, and involves certain symptom patterns. We address each of these three in turn.

First, major depression is relatively persistent. By definition, the symptoms that constitute major depression must be present more days than not for at least two weeks. Major depression is generally a chronic condition. Its course is both *episodic* (intermittent) and recurrent. As you may have experienced, the disorder comes and goes. At times, it is in full swing, with numerous and severe symptoms; at other times, it is mild or moderate, with symptoms present but less noticeable; at still other times, it is absent, with symptoms in full remission.

Second, the symptoms of major depression cause significant distress and impairment. That is, they are disturbing, unpleasant, or painful. The symptoms may also hinder your ability to effectively function at work, school, or in other settings.

Third, major depression includes a majority of the following symptoms:

- sadness
- loss of capacity for pleasure *(anhedonia)*
- low energy
- suicidal thoughts or behaviors
- difficulty falling asleep, staying asleep, or getting up in the morning
- changes in appetite, gaining or losing weight without trying
- *psychomotor disturbance* (slowing or agitation)
- difficulty concentrating
- feelings of guilt or worthlessness

Dysthymia

Another form of depression, *dysthymia,* is more constant and chronic than major depression. Dysthymia may be viewed as a low-grade, persistent version of major depression. It is defined as a depressed mood that has persisted for most of the day for more days than not over the course of at least two years. In addition to depressed mood, at least two of the following symptoms must be present for a diagnosis of dysthymia:

- low energy
- difficulty falling asleep, staying asleep, or getting up in the morning
- changes in appetite, gaining or losing weight without trying
- difficulty concentrating
- low self-esteem

- feelings of hopelessness

While diagnostic criteria state that symptoms must be present for at least two years, the reality is that quite a few people experience the symptoms of dysthymia for many years. Because dysthymia can last so long, you can come to view the symptoms as a normal part of your personality. Be assured that they are not.

Double Depression

A third form of depression, *double depression,* involves major depression superimposed on dysthymia. For example, consider a woman who has had depressed mood more days than not for around four years, accompanied by energy and concentration problems. On the basis of these symptoms and their duration, we can conclude that she has dysthymia. Suddenly, her symptoms become much more severe and expand to include sleep and appetite disturbance, suicidal thoughts, and restlessness. In this case, a major depression has developed on top of the dysthymia.

Double depression is not a formal term in the DSM, but is worth noting for a couple of reasons. First, it entails both severe symptoms (major depression) and chronic symptoms (dysthymia). Consequently, it is a quite debilitating form of depression. Second, research suggests that people with double depression may respond to treatment more slowly than those with major depression or dysthymia alone, although this isn't always the case (Amore and Jori 2001).

UNDERSTANDING YOUR DEPRESSION

As you can see, depression is characterized by a range of symptoms, in contrast to the common misperception that depression simply refers to feeling sad or blue. In fact, the experience of depression is quite varied—well over two hundred different combinations of symptoms all satisfy the current definition of major depression (Buchwald and Rudick-Davis 1993). In this section, you have the opportunity to examine the depressive symptoms you may be experiencing. While we encourage you to seek formal evaluation from a mental health professional rather than attempting to diagnose yourself, the self-assessments in this chapter may help you better understand the nature, severity, and duration of your symptoms.

Your Depression Symptoms

Let's begin by taking a look at your symptoms.

EXERCISE 1.1: Assessing the Symptoms of Your Depression

This exercise will help you identify which—and how many—symptoms you are currently experiencing. Below is a list of the nine symptom criteria used to establish a diagnosis of major depression, as well as a description of each symptom. Check the appropriate box if you experience a particular symptom more days than not. Next, add up the total number of checked boxes and enter your score at the bottom.

Check if present more days than not

1. Depressed mood or sadness ☐
   You may feel sad or like you have the blues.

2. Loss of interest or inability to experience pleasure ☐
   Things that were fun or interesting in the past no longer seem pleasurable, and you may even have stopped doing them altogether.

3. Changes in appetite or weight ☐
   You may have noticed a relatively sudden increase or decrease in your appetite. Similarly, you may lost or gained weight even though you were not actively trying to do so.

4. Sleep disturbance ☐
   You might have difficulty falling asleep or staying asleep, or you might wake up in the middle of the night or unusually early in the morning and not be able to fall asleep again. Or you may sleep more than you used to and have more difficulty than usual getting out of bed in the morning.

5. Restlessness or sluggishness ☐
   You may feel on edge, fidgety, or unable to sit still. Or you may feel slowed down or lethargic—so much so that your arms and legs feel heavy and difficult to move.

6. Fatigue or loss of energy ☐
   You may have frequent feelings of tiredness and lack of energy.

7. Feelings of worthlessness or guilt ☐
   You may have low self-esteem, such that you feel of no value. You may also have excessive feelings of guilt, beyond what most people would experience in response to negative events.

8. Difficulty concentrating or making decisions ☐
It may feel hard to focus on tasks at hand and concentrate without your mind drifting to other topics (often sad topics). It may also be hard to make even minor decisions, such as what clothes to wear or what to eat for dinner.

9. Thoughts of death or suicide ☐
You may think a lot about death in general or have thoughts about what it would be like to die, who would come to your funeral, and so on. You may even wish that you were dead or think of ending your life.

Total score (number of checked boxes): _____

If your total score is less than three, then you are not currently experiencing an episode of major depression or dysthymia. Your depressive symptoms, if any, are considered *subsyndromal,* or minor, because you do not meet the diagnostic criteria for a depressive disorder.

If your total score is five or greater, and you checked box one or box two (or both), then you are experiencing symptoms that are consistent with major depression. If your total score is between three and five, and you checked "depressed mood or sadness" but not "thoughts of death or suicide," then you are experiencing symptoms consistent with dysthymia.

Your Depression over Time

Remember that your combination of symptoms is only one component to understanding the scope of your depression. The duration of your symptoms must also be considered. Depression is often a chronic condition, and there are three aspects of your experience of depression over time: episode duration, recurrence, and relapse.

EPISODE DURATION

Episode duration has to do with the fact that depression lasts so long. On average, major depression lasts around eight months in adults and may last even longer in youth (American Psychiatric Association 1994). These long episodes involve prolonged experience of the most acute, painful, and debilitating aspects of depression.

It is worth dwelling on this point. There are other acutely painful conditions (for example, stomach flu), but there are few that are acutely painful for such a long period of time. The stomach flu typically goes away in three days or so. Several months is the average episode length; if you experience longer than average episodes, you may face years of suffering and impairment.

The story with dysthymia is equally astounding. What dysthymia lacks in acute pain (remember that it's a low-grade form of depression) it makes up for in sheer length of episodes. The average length of dysthymic episodes is around a decade, and it is relatively common for people in their forties and older to report decades-long dysthymias. For example, a woman in her fifties who has experienced persistent, low-grade depressive symptoms since her teens has had a forty-year episode.

Clearly, episode length or duration is important in how you experience depression over time. Once depression finally does go away, it tends to return. The two other important aspects of the timeline of depression have to do with its return.

RECURRENCE

Recurrence is defined as the return of clinical depression following a symptom-free period. Someone who recovers fully from a past depression but then experiences another episode of depression can be said to have experienced a recurrence. Recurrence, too, is important in that it can affect substantial portions of your life.

RELAPSE

There are times when people get somewhat better from a past depression, but some depressive symptoms remain nonetheless. Someone who partially recovers from a past depression but then experiences another depression is said to have experienced a relapse. *Relapse* is the resumption of symptoms in the vulnerable time frame just following remission of a depressive episode. Like recurrence and episode duration, relapse conveys the chronic nature of depression.

There is an important distinction among episode duration, recurrence, and relapse. If you are experiencing a long-lasting episode, depressive symptoms are an obvious part of the clinical picture. So, too, with relapse: you have partially recovered, but depressive symptoms remain. In both of these cases, depressive symptoms are part of the picture. Depression recurrence, however, is different. By definition, recurrence includes a period of time when you have fully recovered and do not meet the diagnostic criteria for major depression. The importance of this distinction to you is that the absence of symptoms right now does not necessarily mean you can't become depressed again in the future. In fact, we believe that there is a good chance you will continue to be at risk for depression until you change your patterns of interacting with other people.

As an aside, we realize that you may be feeling demoralized now that you've read about how chronic depression can be and how it tends to recur. Indeed, this is a sobering aspect of depression and is not to be taken lightly. But we encourage you to hang in there and stick with the material outlined in this book, because depression does not have to consume vast portions of your life. By using the strategies present in this book, you can significantly reduce and even put an end to long-standing bouts of depression.

Let's take a look at how chronic, or long-standing, your depression is.

EXERCISE 1.2: Assessing the Duration of Your Depression

For how long have the symptoms you checked in exercise 1.1 been present?

- ☐ A day or two
- ☐ Several days, but less than two weeks
- ☐ A few weeks (at least two)
- ☐ Several months
- ☐ Several years (two or more)
- ☐ As long as you can remember

Diagnostic *Criteria*

Now that you have examined the severity and duration of your symptoms, let's return to the issue of diagnostic criteria.

MAJOR DEPRESSION

If you checked at least five symptoms in exercise 1.1, including "depressed mood or sadness," "loss of interest or inability to experience pleasure," or both, and they have been present more days than not for at least two weeks, then you may be experiencing a major depressive episode. If your symptoms have been present for less than two weeks, then you do not yet meet diagnostic criteria for major depression, although you might soon if your symptoms persist.

DYSTHYMIA

If you checked between three and five symptoms in exercise 1.1 and your symptoms have been present for two years or longer, then you are likely experiencing dysthymia. Recall that this is a more chronic, low-grade form of depression.

DOUBLE DEPRESSION

If you checked at least five current symptoms and you have experienced low-grade symptoms for two years or more, then you may be experiencing double depression. Remember that double depression doesn't mean that you are twice as depressed as others; rather, it indicates major depression on top of ongoing dysthymia. This form of depression is both severe and chronic, and it may respond more slowly to treatment. We don't mean to discourage you if you have these symptoms. Instead, we mention this to let you know that it may take a little extra time, work, and practice to improve your depression.

MINOR DEPRESSION

Even if you don't meet the diagnostic criteria for major depression, dysthymia, or double depression (perhaps you don't have a sufficient number of symptoms or the symptoms don't last long enough), but you do experience some symptoms, we still encourage you to learn the strategies outlined in this book. We make this recommendation because research demonstrates that people with minor depression have similar problems in interpersonal functioning (Lewinsohn et al. 2000).

Comparing Courses and Severity Levels

Figure 1.1 is a sample representation of the typical number of symptoms and duration of major depression, dysthymia, double depression, and minor depression over a two-year period. Note that this graph is just an example, so the course of your symptoms likely differs somewhat from any of the four courses showed here. As you can see in the graph, the different types of depression have different courses over time and different levels of severity. We list some of their features below.

Major depression has an episodic course, going from *subclinical* levels (less than five symptoms) up to between five and eight depressive symptoms, then returning to subclinical levels. This all occurs within the two-year period, and the major depressive episode lasts for less than one year.

Dysthymia has a stable course, marked by the presence of three or four depressive symptoms that change very little during the two-year period.

Double depression has an episodic course, but at least three depressive symptoms are always present during the two years. For some of the time, the symptom level reaches the range of major depression (that is, more than five symptoms).

Minor depression can be somewhat episodic, but there are never five or more symptoms present for two weeks or more.

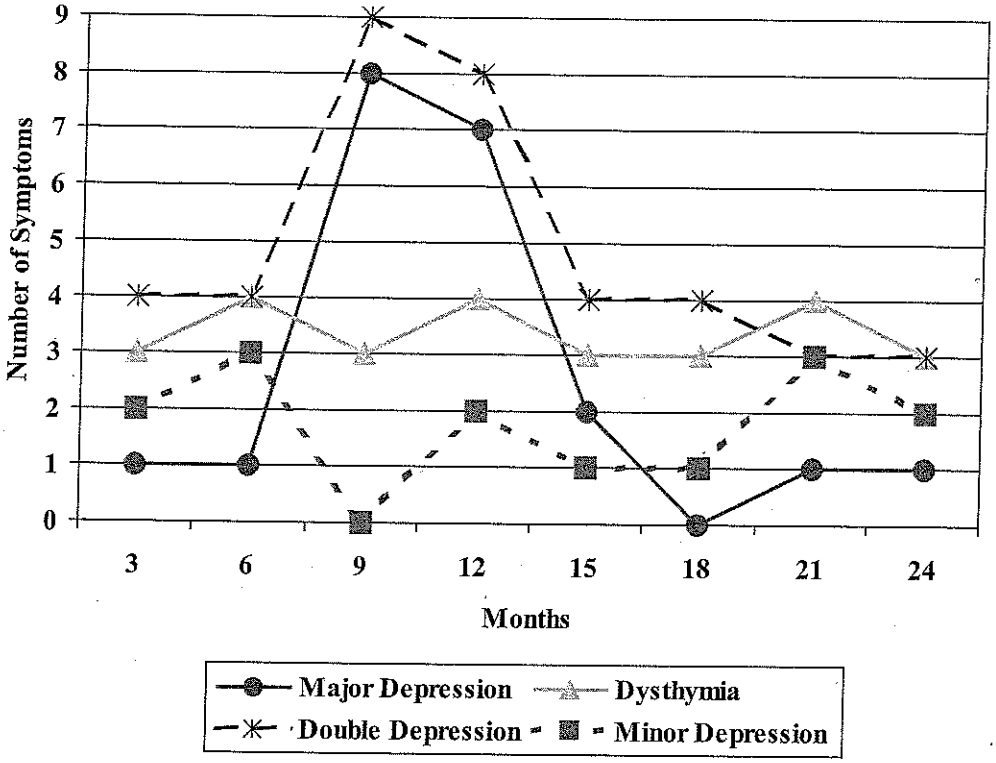
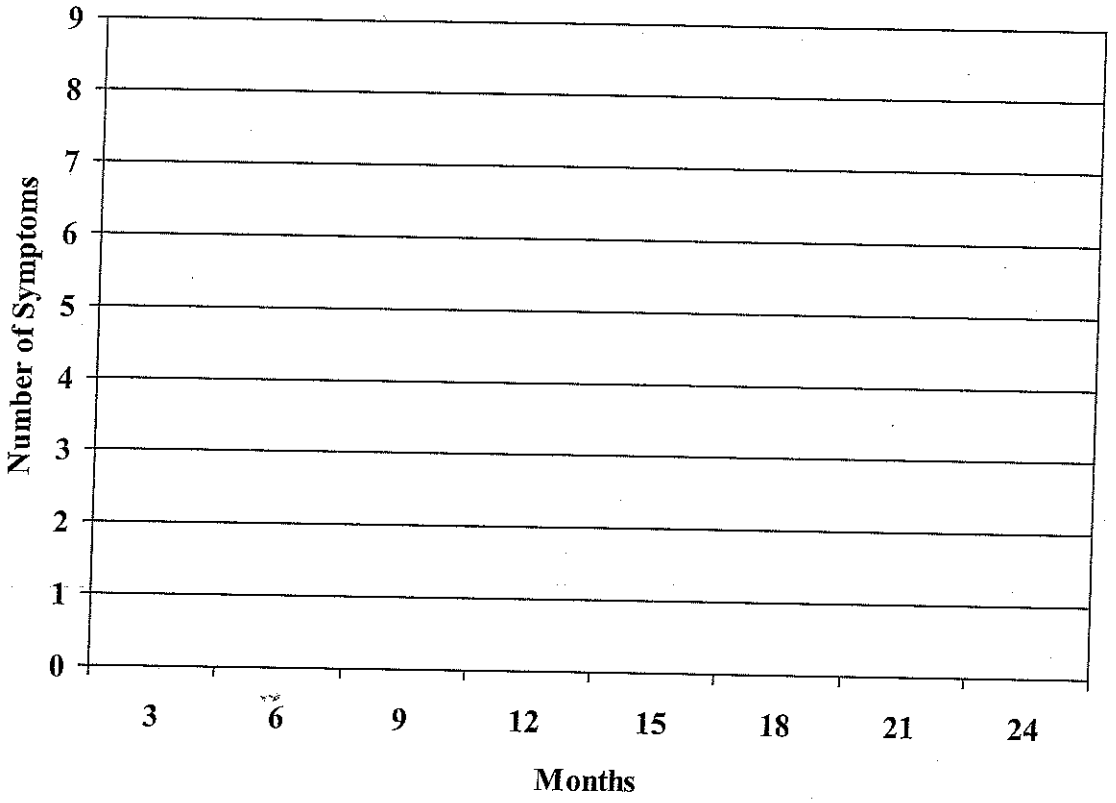


Figure 1.1: Examples of Courses and Severity Levels

EXERCISE 1.3: Assessing the Course and Severity Level of Your Depression

In the following blank graph, chart the progression of your symptoms over the previous two years, to the best of your recollection. You can refer to the list of symptoms in exercise 1.1. Although you may find it hard to remember exactly when you experienced particular symptoms, we encourage you to try your best to establish a timeline of your depressive symptom level.



If the exercises in this chapter lead you to believe that you may be experiencing some form of depression, we recommend that you confirm this impression with a mental health professional or a physician.

HOW PREVALENT IS DEPRESSION?

If you are experiencing depressive symptoms, either major or minor, you are far from alone. Very far, in fact. At any given time, between 4 and 10 percent of the U.S. population is experiencing major depression or dysthymia, and between 15 and 20 percent have experienced major depression or dysthymia at some point in their lives. Another 4 percent experience minor depressive symptoms at any given time but don't meet full criteria for a diagnosis (Judd, Akiskal, and Paulus 1997). Because of its high prevalence, depression is often referred to as the common cold of mental illness. However, the fact that depression is common by no means suggests that it is not

serious or painful. If you have ever had the flu, you can attest to the fact that the flu's widespread nature does not diminish the severity of its symptoms.

An aspect of depression prevalence has concerned researchers and mental health professionals in recent years. It appears as though an enormously important age-related phenomenon may be occurring. If, in the early 2000s, you are about seventy years old, the chance that you have experienced depression in your lifetime is about 2 percent. If, in the early 2000s, you are in your fifties, your lifetime chance of depression is approximately 5 percent. Despite fewer years in which to get depressed, this younger group is nonetheless about twice as likely to have experienced depression. This is remarkable enough, but astoundingly, the same pattern continues in younger and younger groups. Those in their thirties in the late 1990s have approximately an 8 percent risk of lifetime depression; teenagers in the late 1990s, despite approximately four times fewer years than their seventy-year-old counterparts, experience approximately six times more risk for lifetime depression (Seligman 1998). If this trend continues, imagine the rates when these teenagers reach late life.

Apparently, depression is on the rise. Why? One possibility is that the trend is artificial and not really representative of a true increase in depression over time. For example, perhaps the older you get, the more prone you are to forget having experienced a prior depression. Or perhaps health-care professionals are doing an increasingly better job of detecting depression; if so, what has changed is the behavior of health professionals, not the rates of depression. Or perhaps it is increasingly acceptable to report depression. If so, what has changed is the perceived stigma of depression, rather than the actual rates of depression.

But if increased prevalence were merely due to forgetting, why would thirty-year-olds differ so much from eighteen-year-olds? Also, we could only wish that depression were stigma free or that health-care professionals detect it carefully. Although there has been progress on both these fronts, there has not been so much progress as to account for the large difference in rates. The increase in prevalence rates thus appears to be a real phenomenon.

Why might depression be on the increase? Many possible explanations exist, including changes in environmental toxins, increased drug abuse, and changes in parenting practices, but none yet has good scientific backing. Perhaps the increasing prevalence of depression is due to an escalation in general causes of depression, which we discuss next.

POSSIBLE CAUSES OF DEPRESSION

In these times of mass media outlets like television, radio, and particularly the Internet, you have probably heard several theories—all with "expert" support—on the causes of depression. The causes are no doubt many. In fact, most depression researchers long ago dismissed the notion that depression had one and only one cause. A more current understanding is that multiple pathways lead to depression, and these pathways likely interact with each other to produce the symptoms that you experience.

In this section, we very briefly review some general factors that likely play a role in the development of depression. This is by no means a review of all possible causes of depression;

rather, it is a quick overview of general causes before we discuss interpersonal behaviors and depression.

Genetic and Biological

If you have heard some of the claims made about what causes depression, then you have no doubt heard arguments that your genes play a role in determining whether or not you experience depression. Indeed, evidence does suggest a genetic link to depression, although it would be an overstatement to claim that depression is entirely determined by our genetic makeup. The fact that depression tends to run in families supports a genetic component to depression. Interestingly, the greater the level of genetic overlap (for example, brother or sister as compared to cousin), the greater the likelihood that two people will both have depression or neither have depression.

That evidence, while important, isn't particularly compelling because close relatives are also more likely to live in similar environments. As a result, their overlap in depression could be the result of shared environmental factors (such as poverty, death of an immediate family member, or strained relations between family members). Stronger evidence for a genetic component of depression comes from studies that have examined the rates of depression among biological relatives who have been adopted into different homes, as well as from comparisons of twins with other close relatives. Based on these types of studies, estimates suggest that having a close relative with depression makes you two to three times more likely to experience depression (Sullivan, Neale, and Kendler 2000). Ongoing research seeks to identify specific genes that may be implicated in depression, but consistent findings have yet to emerge.

In addition to genetic contributions, biological systems clearly play a role in depression. Although the mechanism is not yet well understood, *neurotransmitters* (chemical messengers in the brain) such as serotonin, norepinephrine, and dopamine all appear to be related to mood and, consequently, depression. Popular antidepressant medications like Prozac (fluoxetine) and Zoloft (sertraline) influence these neurotransmitter systems.

Psychological

Many psychological factors have been linked to the development of depression. In particular, stressful life events—and more importantly, your interpretations of these events—may be causal factors for depression. Stressful events (such as the loss of a job, the ending of a romantic relationship, or failure at school), when combined with a tendency to view them as outside of your control, to repeatedly turn them over in your mind, and to develop a hopeless outlook toward life, greatly increase the likelihood of depression. Moreover, as depressive symptoms develop, people often tend to form negative views about themselves, their environment, and their future (Beck 1976), increasing the likelihood that they will continue to feel depressed.

Interpersonal

There is no doubt that humans are social creatures. Across virtually all areas of physical and mental health, evidence is emerging to suggest that interpersonal relations play an important role in positive—and negative—outcomes. Depression is no exception. Throughout this book, we emphasize the role of interpersonal functioning in causing and reinforcing depressive symptoms. Your interpersonal context greatly influences whether you become depressed, your subjective experience of depression, the ways in which you show depression, and the resolution of your depressive symptoms.

In each of the next seven chapters, we highlight a specific aspect of interpersonal functioning. First, however, we'll provide a broader overview of research suggesting a link between interpersonal behaviors and depression.

HOW DEPRESSION WORKS IN RELATIONSHIPS

In general, people who suffer from depression tend to experience pervasive difficulties in interpersonal relationships, be it with their spouses or significant others, bosses or coworkers, or even with unfamiliar people they encounter in the course of a normal day (for example, in the checkout line at a grocery store). Research indicates that depressed people tend to be dissatisfied with both the quality and the quantity of their relationships (Segrin 2000). They report more relationship conflict, more arguing with family members and significant others, and less support from others, and they are more likely to feel lonely than people who are not depressed. Moreover, and perhaps as a result of these factors, depressed people often withdraw from social relationships. Research suggests that depressed people are more likely to be shy, more passive in interpersonal settings, and more dependent upon others to make decisions for them (Segrin 2000).

In addition to having more relationship conflict and dissatisfaction, people are often less effective in interpersonal relationships when they are depressed. That is, when they interact with others, they are less likely to get what they want out of the interaction. This can be because depression is often accompanied by tendencies toward unassertiveness and avoidance of interpersonal conflict, as well as difficulty connecting with others. For example, people who are depressed may fail to make eye contact, smile infrequently, keep their head down, or speak slowly and in a monotone. When this occurs, it can have the unintended consequence of conveying a lack of interest in social interactions. The key word here is "unintended;" people who are depressed clearly desire good relationships with others. Unfortunately, some of the symptoms of depression interfere with the process of developing and maintaining healthy relationships.

Another example of the way depression interferes with relationships is seen in the things depressed people say: they tend to talk more about topics that have a negative theme. This drift toward negativity even extends to making disparaging or belittling comments about themselves.

Depressed people—and those at risk for becoming depressed—also communicate in ways that may have the unintended consequence of actually promoting unfriendly reactions, or at times even rejection, from others. People who are depressed tend to request or show preferences

for negative evaluations from others. It is not that people like negative evaluations—in fact, such responses are understandably quite upsetting. Nevertheless, negative appraisals are more readily accepted because they are consistent with the negative self-concept that many depressed people hold. You may dismiss positive appraisals if the appraisals don't match your (largely negative) self-concept. Let us be clear again that it is not that people who are depressed enjoy negative evaluations from others; rather, it is difficult to accept positive comments from others while simultaneously holding a negative view of yourself. Remember that one of the primary symptoms of depression is feelings of worthlessness or excessive guilt.

At the same time, and perhaps in an effort to relieve the feelings of worthlessness, depressed people often ask for assurances from others that they are valuable and likable. That in and of itself is not harmful, and it is something that virtually everybody (depressed or not) does; the problem is that depression tends to turn up the volume. In other words, requests for comfort and assurance increase during periods of depression and can become excessive at times. This is a natural response to the symptoms of depression. Depression is characterized by feelings of low self-worth, and asking for others to affirm that you are a good, likeable person is one way of overcoming these feelings. As we discuss in chapter 7, however, this process can damage your relationships.

As a prelude to chapters 6 and 7, consider the following scenario. Jill has been depressed for some time now, feels frustrated with herself and down on herself for being depressed, and believes that nothing she does turns out right. While talking with her husband one evening, she asks him the following:

Jill: Do you still like me, you know, as a person?

John: What do you mean? Of course I like you. I love you.

Jill: Yeah, but all I do is cry all day, and I can't even do little things right anymore. Like yesterday, when I forgot to call the restaurant ahead of time to make a reservation.

John: I know you've been feeling badly lately and struggling with things, but that doesn't change how I feel about you. I still like you.

Jill: Come on, I could tell that you got mad about the restaurant thing last night.

John: Well, yeah, I was upset at the time, but like I told you, I still like you and love you.

Jill: You don't have to be nice just to keep from hurting my feelings. Admit it—you're tired of me and sick of putting up with my mistakes.

John: *(getting frustrated and raising his voice)* What are you talking about? What else do I have to do for you to believe me when I say that I like you?

Jill: See, you're getting angry at me again. I knew you didn't really like me anymore.

Have you recently experienced a lot of stress? List specific sources of stress in your life and rate them on a scale from 1 (not at all stressful) to 10 (extremely stressful).

What is your typical way of responding to these stressors?

What other areas do you think might influence your depressive symptoms?

List the most important people in your life, whether your relationship is positive or negative. For each, describe what you get out of the relationship. Beside each name, rate your overall satisfaction with the quality of that relationship on a scale from 1 (very dissatisfied) to 10 (very satisfied).

OUR APPROACH

While taking other factors into account, we will focus primarily on interpersonal behaviors that lead to and maintain depression, because we believe that changing how you relate to others is often sufficient—and at times necessary—to improve depression. However, we want to make it clear that

we do not view changing your interpersonal style as the only route to feeling better. Indeed, biological treatment (such as antidepressant medications) and psychological treatment (such as cognitive therapy) can be quite effective, and we encourage you to also consider those methods of treating your depression. Likewise, our approach is not mutually exclusive with other forms of treatment. You could simultaneously take antidepressant medications under the care of a physician and use this book on your own. Having said that, we firmly believe that the principles in this book, when routinely and systematically practiced, will help you improve your mood and relationships.

LOOKING AHEAD

In the following chapters, we discuss in more detail the ways that depressed people typically relate to others. We challenge you with exercises that will help you put a stop to those behaviors that maintain or exacerbate your depression and help you develop healthier patterns of interacting.

In chapter 2, we cover the "how," "what," and "with whom" of interpersonal behaviors that are typical of people with depression, and we challenge you to carefully monitor your own patterns of communicating with others. We emphasize both verbal and nonverbal communication.

In chapter 3, we discuss in greater detail social skills among depressed people, including their views of themselves and others' views of their social skills. We challenge you to develop a more accurate view of your social skills by collecting data on your social skills in actual interactions, and then challenge you to test your perhaps long-held beliefs about your ability to effectively interact in social settings.

In chapter 4, we discuss the roles of shyness, loneliness, and conflict avoidance in depression, and we challenge you to overcome your inhibitions by becoming more assertive.

Chapter 5 presents an overview of *self-handicapping*, or selling yourself short to others. Your challenge will be to confront the fear of failure and negative evaluation by putting yourself out on a limb and not publicly underestimating your abilities.

In chapter 6, we cover the interpersonal behavior of negative feedback seeking, and discuss why depressed people ask for negative evaluations. We challenge you to change the mental filter that may lead you to reject positive feedback and solicit negative feedback.

Chapter 7 addresses the problems of excessive dependence on others and continually seeking reassurance from others. We challenge you to become aware of your own reassurance-seeking behaviors, to test the beliefs underlying your desire for reassurance, and then to focus greater portions of your social interactions on others rather than on yourself.

In chapter 8, we discuss depression in the context of family relations and the impact that depressive interpersonal behaviors can have on spouses and children. We challenge you to work toward increasing family cohesion, primarily by applying the strategies discussed in chapters 2 through 7 to your home environment.

Finally, chapter 9 reviews and integrates the material in chapters 2 through 8. We encourage you to examine how changing one set of interpersonal behaviors will often lead to changes in another set of behaviors. We also provide some suggestions and words of encouragement about dealing with potential setbacks, including resistance to change from others.