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The Cutting Edge:

IPT AND PTSD

John C. Markowitz*

> "The facts will eventually test all our theories, and they form, after all, the only impartial jury to which we can appeal."
>
> —Jean Louis Rodolphe Agassiz[1]

How do you treat posttraumatic stress disorder (PTSD)? Exposure, exposure, exposure. If your patient gets traumatized at Carnegie Hall, he or she needs, either in vivo or in mind, to revisit the location. So say an expert consensus,[2] the American Psychiatric Association treatment guidelines,[3] and the Institute of Medicine;[4] indeed, the last recommends nothing but exposure for PTSD, based on available research evidence. The paradigm is to evoke the patient's memories with reminders of the trauma, activating the "fear network," and then give the patient a chance to habituate to the fears in safe circumstances, eventually extinguishing the fear response.[5]

There is no question that exposure-based treatments (EBTs) work for patients with PTSD, but whether this is the royal road to reprocessing—the lone route to treatment—is hardly clear. It would be unusual for treatment of a major psychiatric disorder to have a single mechanism. Consider the many different efficacious treatments for major depression: cognitive therapy, interpersonal psychotherapy (IPT), behavioral activation, serotonin and noradrenergic reuptake inhibitors, monoamine oxidase inhibitors, bupropion, ECT, TMS, etc. Furthermore, treatment studies have shown some benefits for non-exposure-focused psychotherapies for PTSD.[6]

Another vantage point for studying PTSD is interpersonal. Many PTSD symptoms concern interactions with others. Individuals with PTSD tend to withdraw socially and feel cut off from their feelings: they become socially and emotionally detached. PTSD shatters their sense of safety in their environment, and with people in that environment, leaving them interpersonally hypervigilant.[7] Their marital, social, and occupational functioning is impaired. Lack of perceived social support is a replicated, major risk factor for developing PTSD following trauma.[8,9] Much research indicates the generalized protective effects of social supports against psychopathology (a source of resilience), and the disruptive effects of losing social supports. So in considering alternative theories to the activation of patients' cognitive fear networks in PTSD,[5] we might posit the disruption of their social networks.[6]

IPT

Interpersonal psychotherapy (IPT[10]) is a time-limited, diagnosis-targeted treatment that focuses on affect and life events. IPT has repeatedly demonstrated efficacy for major

*Correspondence to: John C. Markowitz, Research Psychiatrist, New York State Psychiatric Institute, Professor of Clinical Psychiatry, Columbia University College of Physicians & Surgeons, 1051 Riverside Drive, Unit #129, New York, NY 10032. jcm42@columbia.edu.

The author discloses the following financial relationships within he past 3 years:

depressive disorder, a common PTSD comorbidity. Treatment is based not on exposure but on the link between the patient's feelings and the environment—intuitively a nice fit for PTSD. Following a medical model, the IPT therapist emphasizes that PTSD is a treatable disorder and not the patient's fault, thereby relieving patient self-blame. Treatment addresses the patient's current interpersonal status, focusing on either complicated grief (following the death of a significant other), a role dispute (a struggle with a significant other), or a role transition (e.g. the aftershock of a traumatic event).

The IPT therapist neither assigns homework nor encourages exposure to trauma reminders. Instead, IPT addresses the interpersonal sequelae of having been traumatized by exploring the patient's feelings and actions in current daily life encounters. This helps emotionally detached and dissociated patients to face, name, understand, integrate, and use their feelings in interactions with others in their lives. Rather than seeing feelings as inchoate, dangerous, and best avoided, patients with PTSD learn to recognize them as useful social responses, put them into words, and use them to renegotiate interpersonal relationships. This sense of (re)gaining control over their feelings and environment is the sort of psychotherapy success experience[11] that generates clinical improvement. IPT has been shown to help patients to build social supports that protect against psychopathology and to build interpersonal skills.[6,10]

We tested IPT in an open, 14 weekly session trial of 16 individuals with chronic (7.7 + 9.9 [*SD*] years) PTSD. This required little adaptation of standard IPT[10]—mainly the explicit proscription of encouraging exposure to trauma reminders. Sessions focused on daily interactions with family members, friends, co-workers, and others in the patients' environment. Fifteen (94%) subjects completed treatment. Scores on the Clinician Administered PTSD Scale (CAPS[12]), the canonical PTSD assessment, fell from 66.3 (16.0) to 23.5 (16.1) ($P = 0.001$) with gains across symptom clusters. A CAPS score of 66 indicates severe PTSD and is roughly comparable to severity scores in many other PTSD trials. Treatment response, defined a priori as > 30% decline in CAPS score, was 81%; and remission, defined as CAPS <20, was 44%. Depression, anger, and social function also improved. Intriguingly if unsurprisingly, as patients improved, they spontaneously exposed themselves to trauma reminders—a necessity, after all, for PTSD remission.[6,7]

These results are encouraging, but an open trial can only provide preliminary support for an approach, not determine efficacy. Other IPT researchers have reported similarly encouraging results in small open[13,14] and controlled[15,16] studies of group IPT for PTSD. To test the efficacy of individual IPT for PTSD, we are currently conducting an NIMH-funded, randomized controlled trial comparing IPT, Prolonged Exposure, and Relaxation therapy at Columbia/New York State Psychiatric Institute.

Discussion

Exposure-based treatments may suit some patients better than others. If life had previously been stable, the patient well adjusted, and an unforgettable catastrophe then occurred and triggered PTSD, focal EBT might be ideal. Stovall-McClough and Cloitre,[17] Lanius et al.,[18] and others have argued that chronically traumatized individuals and other PTSD patients who present with prominent dissociative symptoms may respond poorly to EBTs and need a more affect-based approach, at least as an initial treatment step.[19] If so, IPT might fit that bill.

Every treatment strategy has tradeoffs. There may be disadvantages to not immediately confronting the precipitating traumatic events in treating PTSD. A potentially compensatory advantage of IPT for PTSD is its flexibility of focus. Most EBTs for PTSD, for better and

worse, focus almost exclusively on the patient's trauma, repeating the traumatic history week after week. For some, the trauma is central, but in other cases it may not be the patient's predominant current concern. Patients who have major interpersonal or other difficulties to address—for example, a marriage gone bad in the aftermath of an extra-domestic trauma—may benefit from focusing on life circumstances that lack direct trauma reminders. IPT focuses on the patient's current life situation, whether or not that lies where the trauma hit.

Many individuals with PTSD are understandably agitated by the prospect of an EBT that forces them to face the fears they have chronically avoided. IPT, by avoiding this direct confrontation of trauma reminders, may prove relatively patient friendly. Our open pilot study had excellent patient retention. Our current comparative psychotherapy trial assesses patients' preferences about the psychotherapies to which they face randomization. We even-handedly and encouragingly explain each treatment approach, noting that Prolonged Exposure has the best empirical support. Of our first 50 enrolled patients, 11 had a preference for Prolonged Exposure, whereas 13 preferred not to receive it (the rest reported no preference). By contrast, 13 hoped for and 11 hoped against Relaxation, whereas 21 desired and only one did not want IPT. As patient preference is a moderator of treatment outcome,[20] this suggests a potential advantage for IPT. Time will tell.

Why should IPT work in treating PTSD? We need first, of course, to demonstrate that IPT does work. But if it should, it might be interesting to speculate why. This brings us to attachment[21] and social support, theories that underlie IPT.[6] A child who develops secure attachment to a mother grows up more confident of his or her environment, more trusting of relationships, and probably having a larger social network. In contrast, a child who from trauma or other reasons develops insecure attachment will likely have fewer and more distant relationships, feel less confident of them, and less likely to confide in them; such individuals carry a greater risk of developing anxiety disorders.[6,22] The individual with a secure attachment style who endures trauma later in life may therefore have a more secure social support network to fall back on and feel more comfortable using it than an insecurely attached individual. Having confidants to talk things over with may help process traumatic events and forestall PTSD. Resilience in the face of trauma may thus reflect underlying secure attachment.[23] Treatments like IPT that focus on affect tolerance and social supports might work on PTSD through improving security of interpersonal attachment. We are examining this possibility by measuring Reflective Function,[22] a measure of interpersonal mentalization and a proxy for attachment, as a potential mediator of IPT in our treatment study.

Whether or not IPT eventually proves an efficacious alternative to EBTs, the interpersonal aspects of PTSD bear further study.

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Biography

John C. Markowitz, M.D., is a Research Psychiatrist at New York State Psychiatric Institute, a Professor of Clinical Psychiatry at Columbia University College of Physicians & Surgeons, and an Adjunct Clinical Professor of Psychiatry at Weill Medical College of Cornell University in New York City. He had the fortune to be trained by the late Gerald L. Klerman, M.D. in interpersonal psychotherapy, which has become one area of study. He conducts comparative outcome research, currently focusing on chronic posttraumatic stress disorder and mood disorders.

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