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Interpersonal Psychotherapy for PTSD: Treating Trauma without Exposure

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Abstract

Interpersonal Psychotherapy (IPT) is a time-limited, diagnosis-targeted psychotherapy originally developed for the treatment of major depression. Research studies have repeatedly demonstrated its efficacy in treating mood disorders and other psychiatric disorders over the past forty years. As IPT is a life-event based treatment that focuses on improving interpersonal functioning, it seemed natural to adapt it for the treatment of posttraumatic stress disorder (PTSD), a life-event based illness that affects interpersonal functioning. Preliminary data suggest that IPT has equal efficacy in alleviating PTSD symptoms as Prolonged Exposure, the best tested exposure-based treatment. We describe the principles of IPT and its modifications for treating PTSD. A case illustration describes a patient with PTSD related to military trauma. The authors discuss their reluctance to integrate IPT for PTSD with other psychotherapeutic perspectives.

Keywords

Posttraumatic Stress Disorder (PTSD) Interpersonal Psychotherapy (IPT); Exposure; Trauma; Treatment

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Treatment guidelines of the American Psychiatric Association (APA; 2004, 2010), American Psychological Association (2017), Institute of Medicine (2008), and other organizations have repeatedly recommended exposure-based psychotherapies as the first-line interventions for treating Posttraumatic Stress Disorder (PTSD). These treatments help many patients with PTSD, but others are loath to undergo treatment that involves repeated exposure to frightening reminders of their trauma that they actively avoid. Furthermore, some research suggests that exposure may increase symptoms of anxiety and avoidance (Lanius, et al., 2010). Inasmuch as no treatment has universal benefits, patients with PTSD and their therapists can only gain from having a choice of range of evidence-based treatments, including therapies not involving repeated *in vivo* or imaginal exposure. We appreciate the editors' invitation to describe how Interpersonal Psychotherapy (IPT), which does not require exposure to past trauma, helps relieve symptoms of PTSD.

IPT is a time-limited (12–16 sessions), diagnosis-targeted, manualized treatment that focuses on addressing current interpersonal difficulties to alleviate symptoms. It was developed in the 1970's by researchers at Yale and Harvard as an adjunctive therapy for a study testing medication for major depression. Given their research bent, Klerman, Weissman, and

colleagues created a psychotherapy based on research on life events and social support as well as interpersonal and attachment theory (Klerman, et al., 1984). They found IPT was effective in both relieving depressive symptoms and improving interpersonal functioning (Bleiberg & Markowitz, 2014, Weissman, et al., 1981). Numerous subsequent studies have replicated these findings (Cuijpers, et al., 2011).

Principles of IPT

IPT for major depression has two main principles. First, major depression is a medical illness that is treatable and not the patient's fault. Using the medical model of illness to explain depression relieves the overly self-critical depressed patient from blame for the illness and instills hope that he or she can feel better. Second, recent or current stressful life events affect mood, and in vulnerable individuals can provoke a depressive episode. Conversely, depressive symptoms affect how people navigate stressful life events and related interpersonal interactions. Linking mood symptoms to a recent life event and an interpersonal context for the depressive episode provides a simple formulation that even a very depressed patient with difficulty concentrating can understand. IPT is thus an affect-based, time-limited treatment that links mood changes to disruptive life events, bidirectionally: upsetting events can trigger upsetting mood, and *vice versa* (Bleiberg & Markowitz, 2014). Using emotional understanding to manage interpersonal encounters creates positive life events, benefitting mood.

During the initial sessions, the IPT therapist reviews the patient's social and psychiatric history and takes an interpersonal inventory: a detailed review of the patient's current and past relationships, how the patient generally interacts with other people, and how depression may be impairing interpersonal functioning. In taking the history, the therapist seeks an interpersonal crisis in the patient's life, a "problem area" connected to the patient's current depressive episode. IPT problem areas include complicated bereavement following a death, role dispute (conflict with an important person in the patient's life), role transition (major life change) and interpersonal deficits. (The interpersonal deficits focus is used only when a patient reports no life events. Patients in this category tend to be very isolated and respond least well to IPT.) Together, therapist and patient agree on which problem area will serve as the treatment focus. Sessions focus on resolving the chosen problem area to bring about symptom relief.

IPT focuses on the present – not the past – and on improving the patient's understanding of her feelings, interpersonal functioning, and interpersonal situation. IPT's time limit encourages patients to stay focused in treatment, instills hope that their symptoms and life situation can improve, and pressures patient and therapist to work quickly to resolve the patient's interpersonal crisis and symptoms. IPT's repeated efficacy in research studies encourages patient optimism about treatment and likelihood of improvement.

IPT emphasizes identifying and expressing feelings. Depressed patients often report feeling "bad" and have difficulty distinguishing among their negative feelings, such as anger and hurt. The IPT therapist not only validates the patient's negative feelings, but helps the patient to better identify and use her feelings as signals for making decisions in interpersonal

conflicts and situations. The therapist guides the patient in exploring options for resolving problems. While recognizing the patient's suffering and difficult interpersonal situation, the IPT therapist takes an active, supportive, enthusiastic stance, almost cheerleading to motivate the patient to make changes and reinforce progress. Solving the interpersonal focus gives the patient a sense of mastery of the environment, countering helplessness and hopelessness, relieving symptoms through solving social difficulties.

The therapist gives the patient the "sick role" (Parsons, 1951), a temporary status intended to help the patient recognize that she suffers from a medical illness that causes suffering, compromises functioning, and is not her fault. The sick role is intended to relieve the patient from self-blame and to encourage the patient to assume responsibility for working on improving her depression (Bleiberg & Markowitz, 2014). The IPT therapist provides psychoeducation about depression, teaching the patient to identify the discrete symptoms that comprise depression and how depressive symptoms affect social functioning. The therapist encourages the patient to seek social support, which provides crucial protection against depression. Depressed patients avoid asking for help lest they burden others. They avoid asserting themselves because they deem their needs unimportant and fear that others will respond badly. The therapist elicits the patient's emotions; validates desires, anger, sadness, and other emotions as valid and useful social signals; and through techniques like role-play helps the patient learn to assert herself with others to get her needs met.

Since its conception, IPT has shown repeated efficacy in research studies and the treatment has been disseminated internationally. IPT has been adapted for various sub-populations of mood disordered patients and to treat psychiatric disorders including bulimia, social anxiety disorder and borderline personality disorder (Weissman, Markowitz, Klerman, 2018). In the early 2000's, we began adapting IPT for PTSD. The initial pilot study (Bleiberg & Markowitz, 2005) and a randomized control trial (Markowitz, et al., 2015) have shown encouraging findings, as have trials by other investigators. We describe below the adaptation, and how IPT reduces symptoms and improves interpersonal functioning in patients with PTSD. We include a case example and discuss whether IPT can be integrated with other therapeutic approaches to PTSD.

Interpersonal Psychotherapy for Posttraumatic Stress Disorder

It seemed intuitive to adapt IPT to treat PTSD. IPT is a life event-based psychotherapy that focuses on improving interpersonal functioning; PTSD is a life-event based illness that compromises interpersonal functioning. The characteristics that distinguish IPT from other psychotherapies make it a natural fit for treating PTSD (Bleiberg & Markowitz, 2005).

Symptoms of PTSD like flashbacks and startle response can so overwhelm and frighten a suffering patient that she can feel she is crazy. Traumatized patients often describe themselves as "damaged" and defined by their trauma, and assume that others see them this way too (Markowitz, 2016). Using the medical model to describe PTSD and the related interpersonal difficulties helps the patient see herself as a person struggling with a treatable illness comprised of distinct symptoms resulting from trauma. Approximately half of patients with PTSD suffer from comorbid major depression (Flory & Yehuda, 2015), which

IPT has been shown to alleviate. IPT for PTSD can address two illnesses, PTSD and major depression, simultaneously.

Traumatized patients, while having difficulty concentrating and dissociating, nonetheless can grasp the simple focus of IPT. While identifying a problem area can sometimes be challenging for patients with major depression, choosing problem area with patients with PTSD is often easier, as the trauma provides a defining life event. Some patients want to focus on a personal transition, conflict, or death that exacerbated symptoms of PTSD related to a past trauma. If no life event has occurred subsequent to the trauma, the therapist may use the role transition problem area to focus the treatment on helping the patient with their transition from life before to life since the trauma. While the initial trauma may serve as the focal problem area precipitating the patient's symptoms, IPT therapists do not reconstruct or habituate patients to the trauma. Instead, they focus on how the patient's past trauma and PTSD symptoms have compromised their current interpersonal functioning. As the diagnosis of PTSD requires a disturbing life event, this obviates using the interpersonal deficits IPT problem area (Graf & Markowitz, 2012).

IPT's "here and now" approach mobilizes patients with PTSD, who feel stuck in the past and may fear a foreshortened future, to feel present and move forward. Patients with PTSD are preoccupied with their past trauma and are negatively self-focused. By focusing on *current* functioning and situation, the IPT therapist redirects the traumatized patient's attention to the present.

Patients with PTSD manifest significant interpersonal difficulties, which IPT addresses. They often have difficulty trusting others and experience "interpersonal hypervigilance" (Bleiberg & Markowitz, 2005), feeling guarded in social situations. Consequently, patients with PTSD tend to socially withdraw. Their sense of control in relationships, social interactions, and of their physical integrity has been compromised. The IPT therapist does not use the therapist-patient relationship as a therapeutic tool as a psychodynamic therapist does. However, the IPT therapist's supportive and collaborative approach may help patients with PTSD manage the sense of vulnerability they feel in therapy and in other interpersonal situations. The IPT therapist empowers the patient by engaging her in the choosing the focal problem area, by blaming illness rather than patient through psychoeducation about PTSD, trauma and their impact on interpersonal functioning, by imparting social skills, and encouraging the patient to engage in activities and social interactions in between sessions. The therapist guides the patient in exploring options for addressing interpersonal problems and helps the patient decide which option to pursue.

Patients with PTSD struggle with affect dysregulation (van der Kolk et al., 1996). IPT emphasizes eliciting affect, which provides a crucial signal of the meaning of interpersonal interactions. Patients with PTSD have great difficulty managing negative feelings, particularly in interpersonal interactions. They feel numb, dissociate to disconnect from (or consciously suppress) painful feelings, and may have excessive anger reactions or irritability. Patients with PTSD often avoid trauma reminders in order to avoid experiencing the distress such reminders evoke. Yet avoiding feelings makes it hard to know whom to trust and whom not to. Addressing the emotional numbness, IPT therapists help patients identify and

articulate feelings ("How did you feel in that situation? What kind of 'upset'?" What's the name for that feeling?) and help them to use their feelings -- both positive and negative -- as important information for navigating relationships. IPT therapists do not encourage patients to confront the past trauma, but they do encourage them to face strong and negative feelings (Markowitz, 2016).

Once patients can recognize their emotions, the therapist moves into typical IPT mode: normalizing the feelings and helping patients to verbalize them in order to address interpersonal difficulties. This often involves role-play to find a comfortable expression of anger, which patients with PTSD generally see as dangerous or bad. Yet without anger, patients cannot set boundaries with others. Confronting another person yields an important outcome: the other's response -- an apology or a rejection -- helps determine whether the patient can trust him.

Evidence supporting IPT for PTSD

Research on IPT for PTSD is still emerging, but the limited research suggests that IPT is at least equally effective in reducing symptoms as exposure-based treatments. In our initial pilot study (2005), we provided 14 weeks of IPT to 14 subjects with chronic PTSD related to various traumas. During the recruitment process, one subject asked, "Does this involve tapes? I don't want to do the therapy with the tapes." This exemplifies patients with PTSD who prefer treatment that does not require even imaginal exposure. Thirteen patients completed IPT, and after 14 weeks, 12 of the 14 no longer met criteria for PTSD. Interpersonal functioning, depressive symptoms, and anger reactions improved.

These promising results led to a treatment manual (Markowitz, 2016) and a randomized 14-week trial comparing IPT, Prolonged Exposure (PE), and Relaxation Therapy as an active control psychotherapy (Markowitz, et al., 2015) for 110 unmedicated patients with chronic PTSD related to varied traumas. All three treatments showed large improvement effect sizes on the Clinician-Administered PTSD Scale (CAPS; Weathers, et al., 2001). Patients who received IPT had non-significantly higher response and lower attrition rates than patients who received PE. At baseline, patients chose IPT preferentially over the alternative treatments (Markowitz, et al., 2016). IPT had a lower dropout rate for patients with comorbid major depression than both PE and Relaxation (Markowitz, et al., 2015). IPT also had greater benefit than the alternative treatments for patients who presented with childhood and adult sexual trauma (Markowitz, et al., 2017). Responders to IPT generally maintained their gains at three-month follow-up without further treatment (Markowitz, et al., 2017a). Recently, Krupnick, Melnikoff and Reinhard (2016) conducted an open, 12-session trial of IPT with a small sample of women veterans with military-related PTSD. This first trial of IPT for PTSD with a veteran sample yielded comparable results to studies of PE and Cognitive Processing Therapy in military samples.

Several researchers have adapted IPT in group format (IPT-G) for PTSD. Krupnick et al. (2008) compared IPT-G with a waitlist control for non-treatment seeking low-income women with chronic PTSD related to interpersonal trauma. IPT-G was significantly more effective than the waiting list in reducing PTSD and depressive symptoms and in improving

interpersonal functioning. Campanini et al. (2010) assessed the efficacy of group IPT among patients with PTSD non-responsive to standard psychopharmacological treatment. Group IPT effectively decreased PTSD and depressive symptoms and significantly improved social adjustment and quality of life.

Thus empirical support, while limited, suggests IPT may be a tolerable, efficacious treatment for PTSD.

Case example

Bo, a 36 year old single Protestant African American man, presented for treatment of chronic PTSD. Serving in the Middle East, he had witnessed the deaths of fellow soldiers, including some close buddies. He had also suffered hazing by his comrades while overseas, including racist and sexual threats. Returning stateside after several deployments, he had joined a police department – where his fellow cops again hazed and humiliated him. His appeals to his superiors were ignored. Leaving the police, he found himself unemployed and dependent upon the financial support of his hypercritical military father. Job interviews felt like humiliations. He had tried dating but felt inadequate and too broke to proceed. He had an occasional beer with a couple of former buddies, but generally felt isolated from and mistrustful of the military, the police, and people generally. Bo presented with a Clinician-Administered PTSD Scale (DSM-5 version) score of 40, in the severe range. He was beset with nightmares and flashbacks both of Iraq and of his humiliations by his fellow soldiers and cops, which he termed “friendly fire.” He reported feeling nothing most of the time, and shame and humiliation when he was not numb.

Having established Bo’s trauma history, the IPT therapist explained its relation to his PTSD symptoms but never explored it further. She noted the isolation Bo had suffered in consequence of these events and his PTSD, which left him feeling lonely, inadequate, but mistrustful of people he did encounter. “You’ve been through a lot of pain, and it’s still haunting you. It may have helped to feel numb while you needed to stay alive under fire, but now the numbness makes it hard to know whom to trust. You’re having understandable difficulty in readjusting to civilian life under the circumstances, and it’s left you feeling lonely. We call this kind of adjustment a *role transition*. What I suggest we do over the remaining twelve weeks is to explore how you feel in interactions with other people, because trusting your own feelings in those encounters is key to successfully coping in your life.” Bo felt this formulation made sense and accepted this focus to the treatment, which then proceeded into the middle phase. As part of the opening phase, the therapist gave him the “sick role,” noting that PTSD was not his fault, impairs functioning, and that he might not be at his best until symptoms subsided (Markowitz, 2016).

The role transition of the middle phase focused on how he could understand his feelings and use them to assimilate back into civilian life. The therapist opened sessions with the typical IPT query: “How have things been since we last met?” This elicits an interval event or mood state: for a numb patient like Bo, it at first inevitably evoked the former. When he reported an uncomfortable encounter with (or avoidance of) his father, or discomfort surrounding yet another unavailing interview, his therapist asked how he felt. “I don’t know, nothing.” With

gentle probing, he acknowledged having felt somewhat “uncomfortable,” which the therapist asked him to define: What kind of uncomfortable? Anger has a different social meaning than sadness: the first reflecting mistreatment, the second separation or loss. Once he had verbalized these feelings, the therapist asked whether the emotional responses were appropriate. Yes, Bo supposed, the feelings made sense. This helped to normalize the feelings, to help him to trust them. This in turn helped Bo accept his anger toward his critical father, mixed with gratitude for the financial help he provided. The therapist then asked what options he had, what he could do with those feelings. In role-play, he experimented with telling his father than he appreciated his financial help but could use emotional support rather than criticism – particularly as he was suffering from PTSD.

The therapist never assigned homework (one does not, in IPT), but role-play primed the patient to approach his father a week or two later. While not exactly apologizing for his behavior, the father did say that he felt proud of Bo, something he had never stated before, and subsequently restrained his criticisms. Bo felt encouraged at this progress. His symptoms decreased. He meanwhile was using role-play to handle daily encounters with other people, in preparation for attempting to socialize more; and to practice job interviewing. Symptoms continued to gradually wane.

In the last few sessions (termination phase), the therapist and Bo reviewed his progress. Bo was socializing more, on better terms with his father, and had had a successful sequence of job interviews that seemed likely to lead to a position that would relieve him from financial dependence on his Dad. His week 14 CAPS score was 11, essentially remitted. He thanked his therapist for her help, saying he would miss her but that he felt he could proceed without further immediate treatment.

Note that once a trauma history was established and linked to PTSD symptoms, treatment focused entirely on current interpersonal issues rather than on reconstruction of and exposure to trauma reminders. This treatment should sound like IPT to therapists familiar with the approach, but very different from an exposure therapy. This treatment went fairly smoothly. Had Bo’s father not responded to his confrontation, it would have been disappointing but would have shown that the father was untrustworthy, and that Bo needed to maintain a distance from him.

Integrating IPT With Other Psychotherapies

We are still at a fairly early stage in developing IPT for PTSD, and further refinement may follow. Little is known about differential therapeutics for patients with PTSD. Until we know more about which treatments are more likely to benefit the various subpopulations of traumatized patients, it is hard to make informed decisions about which approach to use, let alone integrate. For example, patients with PTSD who also meet criteria for major depression or sexual trauma might possibly fare better with IPT, but more research is needed to confirm this. Severity of childhood trauma is linked to the severity of psychiatric symptoms in adulthood and worse treatment outcome (Shilling et al., 2015). Future research should examine the relationship between level of severity of childhood trauma and response to IPT.

Furthermore, we feel it important to give patients a coherent approach in any time-limited treatment, so that they can leave therapy with an organized sense of how to address future traumas and symptoms. IPT's simplicity and coherent focus are among its important mechanisms of change (Lipsitz & Markowitz, 2013), which incorporating another approach might disrupt. A mixed approach may confuse a patient with PTSD suffering from dissociation or poor concentration. The therapist may understand multiple approaches, but a single theme (interpersonal or trauma exposure) may best organize a patient. Furthermore, the patient may attribute the introduction of diverse techniques to the therapist's brilliance, encouraging dependence on the therapist instead of empowering the patient by presenting a consistent approach the patient can integrate (Markowitz & Milrod, 2015). Coherence trumps eclecticism.

Thus, we are reluctant to consider merging IPT with another treatment perspective, and uncertain that such an amalgam would enhance either approach. Instead of integrating treatments, we believe it important to consider sequential treatments. As no treatment is a panacea, when one fails it is crucial to have alternative treatments to offer suffering patients. Cloitre and colleagues (2002) developed a sequential treatment approach to treat PTSD related to childhood sexual abuse. STAIR-PE is a two-phase treatment that begins with Skills Training in Affective and Interpersonal Regulation (STAIR) followed by modified Prolonged Exposure (PE) treatment involving imaginal exposure only. STAIR, although based on cognitive and dialectical behavior approaches, overlaps somewhat with IPT in targeting affect dysregulation and interpersonal dysfunction. Theoretically, IPT too could be considered as a lead-in for exposure. Yet inasmuch as IPT may work as well as exposure therapy does, it may be unnecessary to add exposure in many cases. If IPT does not benefit a patient, it makes sense to prescribe a subsequent course of exposure or other treatment.

IPT is a new, non-exposure based, tolerable, and increasingly evidence-validated form of PTSD treatment. Before considering combining IPT for PTSD with other psychotherapies, it needs to be better established as an effective, stand-alone treatment option for patients with PTSD.

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