Interpersonal Psychotherapy for Posttraumatic Stress Disorder

JOHN C. MARKOWITZ

OXFORD
UNIVERSITY PRESS

CONTENTS

ACKNOWLEDGMENTS

I would like to thank many people: Gerald L. Klerman, M.D., and Myrna M. Weissman, Ph.D., who developed Interpersonal Psychotherapy and encouraged my researching this powerful treatment. Kathryn Bleiberg, Ph.D., who worked with me on the initial adaptation of IPT for PTSD at Cornell Medical Center (and who contributes a case history to Chapter 7). Randall Marshall, M.D., without whom the National Institute of Mental Health would never have funded our randomized PTSD trial. The many members of the Psychotherapies for Chronic PTSD treatment team at New York State Psychiatric Institute/Columbia University, without whom the research supporting this book could never have been accomplished; in particular, Libby Graf, Ph.D.; Hayley Pessin, Ph.D.; and Alexandra Klein Rafaeli, Psy.D., the study IPT therapists who used an earlier version of this manual. Eva Petkova, Ph.D., now at New York University School of Medicine, without whom the grant would never have been funded or analyzed. My supportive, thoughtful, and helpful colleagues at the Anxiety Disorders Clinic at New York State Psychiatric Institute, where the study took place. The National Institute of Mental Health, for funding the study (R01 MH079078). A string of mentors and colleagues too long to recount. Barbara Milrod, M.D., for her tireless help, informal editing, and support. Sarah Harrington, who championed the book at Oxford in the face of some concerns by reviewers. And, of course, the patients who came to our study for treatment of PTSD, and who benefitted from IPT and the other two study treatments, Prolonged Exposure and Relaxation Therapy.

—John C. Markowitz, M.D.

INTRODUCTION

In the midst of life, tragedy strikes. Upsetting things occur in people's lives, and they have an emotional impact. Mostly we roll with the punches: we may feel upset or worry for a few days; our sleep or appetite or concentration may briefly suffer. But for the most part, we bounce back: people are resilient. Although most individuals will experience some major trauma in the course of their lives (Kessler et al., 1995; Breslau et al., 1998), most will not develop serious psychiatric sequelae.

Some individuals have greater vulnerability to upset than others, based upon their genetic makeup and early life experience—including early life trauma. Some individuals experience greater life difficulties than others. Some life events are sufficiently horrific that the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) deems them "trauma"—a term that has undergone multiple redefinitions. In the current *DSM-5* (2013), the definition is:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
>
> 1. Directly experiencing the traumatic event(s).
> 2. Witnessing, in person, the event(s) as it occurred to others.
> 3. Learning that the traumatic event(s) occurred to a close family member or close friend [. . .].
> 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). (APA, 2013)

After experiencing such an event, most people still show resilience, but some 3.5% of people annually (Kessler, Chiu et al., 2005) and 6.8% over a lifetime (Kessler, Berglund, et al., 2005) will be unable to shake it off. Rates are still higher in military personnel (Wisco et al., 2014; in press) and other high-risk groups. The traumatic experience stays with them: they can't get it out of their minds; they relive the event continually, involuntarily. At the same time, the story may seem overwhelming, fragmented, hard to put together. Everything reminds them of the trauma: the weather, smells, sounds, particular objects, places, etc. The trauma affects their sleep and mood. They feel overly emotional, or alternatively numb. They withdraw socially. Their sense of safety is shattered: the world feels like a bewildering and menacing minefield, and the people in it, untrustworthy. At such a point we begin to think about posttraumatic stress disorder (PTSD).

Example: Amy, a 37-year-old, married, white, Catholic businesswoman and mother of one, presented for treatment after having been robbed at knifepoint on a dark street eight months before. She described recurrent flashbacks to this frightening event, in which she lost her purse but also feared for her life. She reported trouble falling asleep, waking to nightmares, poor concentration, and high distractibility. Her mood was anxious and somewhat depressed. She tried to avoid thinking about the event, yet almost everything reminded her of it: the neighborhood where she was robbed, similar streets, sharp objects, the tone of people's voices, smells from the street, darkness. There were aspects of the event she had blocked out or couldn't piece together.

Amy had also begun to fear contact with people and with the environment. Previously gregarious, she no longer went out at night, and even minimized leaving home by day. Her work suffered. She no longer wanted to travel for business, fearing contact with strangers. She felt helpless, mistrustful, confused, and empty. She no longer spoke to her boyfriend or to friends or family. She also reported that in childhood she had been physically abused by her mother.

PTSD is a widespread (Kessler, Chiu, et al., 2005), painful, debilitating (McMillen et al., 2002; Sareen et al., 2007), often chronic, and even lethal disorder (Sareen et al., 2007). Thankfully, it's treatable. Several treatments have been tested in randomized controlled clinical trials and shown to benefit patients, reducing PTSD symptoms and improving social functioning and quality of life. The dominant treatment approach for PTSD in recent decades has been Cognitive Behavioral Therapy (CBT), which can take several forms. All of the variants have focused on the principle of fear-habituation and fear-extinction, and on the practical clinical approach of exposing patients to the traumatic memories they most fear, asking them to face the fears that

reminders of their trauma evoke. This initially makes people more anxious, but if they face their fears rather than avoiding them, they can realize that the danger is behind them. They *habituate*: they get used to facing their fear, and the fear subsides. With practice, someone who witnessed a fatal train wreck can get used to riding in trains again, realizing: "That was then, this is now. The danger has passed, and its memories are not dangerous." Individuals may still have a very unpleasant memory of the traumatic event, but it need not affect their anxiety level or behavior.

These treatments, mostly cognitive behavioral in format (Foa et al., 2000), work very well for many patients. Like all psychiatric and psychological (and medical) treatments, however, exposure-based cognitive behavioral treatments are imperfect: they don't benefit everyone. Some patients who might benefit from an exposure-based approach are understandably too frightened to face their worst fears, and refuse to try one.

This book addresses an alternative to the fear-extinction model. We tested Interpersonal Psychotherapy (IPT), a very different kind of psychotherapy that, like CBT, has been shown to benefit patients with major depression and with eating disorders, as a treatment for patients with chronic PTSD. IPT is not an exposure-based therapy. In a randomized controlled study, we found IPT was essentially equivalent to Prolonged Exposure, the best-proven exposure-based CBT treatment, in reducing PTSD symptoms (Markowitz et al., 2015). Moreover, IPT had some advantages among PTSD patients who were also depressed. IPT is based on interpersonal principles: on helping benumbed patients to regain emotional awareness and to use their rediscovered emotions to handle interpersonal encounters, building social skills to determine whom to trust, how to defend themselves against the untrustworthy, and how to mobilize trustworthy social support.

When tragedy strikes, how we survive it may depend not only upon our genetic makeup, prior traumas, and degree of exposure to the traumatic event, but also on interpersonal factors, such as our social skills and social support. Who we are as social beings matters in our response to tragedy and trauma. Our study results have prompted interest in this interpersonal approach—IPT for PTSD—among both clinicians and patients. This book is intended to address that growing interest.

This book began as a research treatment manual for the therapists in our study. In expanding it for publication, I struggled with the tension between retaining the flavor of a research manual and toning down its technical rigor. Most research psychotherapy manuals are technical, expecting therapists to already have experience with the treatment techniques and its jargon. Most popular books make no such assumptions. I have aimed, successfully or not, for a compromise: trying not to write in jargon, but preserving the sense of research rigor. I hope that readers of this book will include both research

therapists in treatment trials (our study requires replication!) and general clinicians who have no intention of conducting formal research.

For the latter readers, this book should at times provide a peek into how psychotherapy research proceeds. This will be most evident in Chapter 1, which supplies the research background that validates the IPT treatment approach for PTSD, and in Chapter 12, which presents prescriptions and proscriptions for research therapists. Readers not interested in heavy data or research limits can skip these sections, but should know that the data are there.