Workshop: Interpersonal Psychotherapy (IPT) for Chronic PTSD

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Agenda

- Review of recent research
- Review of IPT adaptations for PTSD
- Case discussions
Posttraumatic Stress Disorder

- Prevalent, debilitating, often chronic
- How best to treat it?
- Pharmacotherapy
- Exposure-based treatments
- Unusual for a psychiatric disorder to have only one treatment approach
  - Compare major depressive disorder
Background

- PTSD treatment dogma: exposure to trauma reminders is necessary
- Fear/extinction model
- Exposure-based treatments work
  - Recommended in all guidelines
  - Sole recommendation of Institute of Medicine
  - Prolonged Exposure (PE) the exemplar
- ...but not for everyone
  - High attrition (~30%)
  - Patients with ↑ dissociation may worsen (Lanius et al., Am J Psychiatry 2010)
Behavioral Therapy: Exposure

Professor Gallagher and his controversial technique of simultaneously confronting the fear of heights, snakes, and the dark.
APA Consensus Guidelines:

“The shared element among efficacious treatments of controlled exposure may be the critical intervention.”

Am J Psychiatry 2004;161:11(suppl.)
Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.

All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]).
...and the Institute of Medicine

Is Exposure Necessary?
Study Design

- Randomized controlled 14-week trial of
  - Prolonged Exposure (PE; reference treatment)
  - Interpersonal Psychotherapy (IPT; experimental)
  - Relaxation Therapy (RT; active control)

- Separate teams of competing therapists
  - Comparable in age, experience, allegiance

- Treatment-blinded independent evaluators

- Enrollment goal = 165 (4.5 years, single site)
  - Stratified for major depressive disorder (MDD)
Interpersonal Psychotherapy (IPT)

- Well established, time-limited therapy for mood and eating disorders
- Adapted for PTSD as a *non-exposure* treatment focusing on
  - Numbness
  - Affective attunement (especially early sessions)
  - Interpersonal sequelae of trauma
    - “interpersonal hypervigilance”
  - Using emotions to handle daily encounters, determine trust
- Encouraging data in open trial (N=16) (Bleiberg and Markowitz, Am J Psychiatry 2005)
Relaxation Therapy (RT)

- Highly scripted progressive muscle relaxation
- Twice fared pretty well in comparison to Prolonged Exposure
  - Small differences between them complicated powering of this trial
Assessed for eligibility (N = 1390)

Intakes (N = 335)

Included in Random Assignment (N = 110)

Assigned to Prolonged Exposure (PE: N = 38)
- Withdraw (N = 2)
- Received PE (N = 36):
  - Did not complete (N = 9)
  - Completed PE (N = 27):
    - Did not respond (N = 10)
    - Responded (N = 17)

Assigned to Interpersonal Therapy (IPT: N = 40)
- Received IPT (N = 38)
  - Did not complete (N = 4)
  - Completed IPT (N = 34):
    - Did not respond (N = 10)
    - Responded (N = 24)

Assigned to Relaxation Therapy (RT: N = 32)
- Received RT (N = 30)
  - Did not complete (N = 9)
  - Completed RT (N = 21):
    - Did not respond (N = 10)
    - Responded (N = 12)

Intakes (N = 335)

Taken medication: 307; out of area: 57; age: 36; not interested: 452; money-seeking: 116; No PTSD: 10; phone dead: 151; medical condition: 1; bipolar: 3; other: 147

Taking medication: 3; out of area: 3; not interested: 56; money: 1; PTSD not primary diagnosis: 132; medical condition: 5; bipolar: 5; substance abuse: 2; other: 18

Figure 1. CONSORT diagram
Study Hypotheses

1: PE will lower CAPS > RT
2: IPT will lower CAPS > RT
3: IPT will be no more than minimally inferior to PE (<12.5 points on CAPS)
4: a. Remission rates: IPT = PE, and IPT > RT
   b. Response rates: IPT = PE, IPT > RT
5: PE = IPT > RT for social adjustment, QOL
6: In IPT, social function will ↑ before trauma avoidance; in PE, the reverse
Analyses

- Generalized linear mixed effects models on the imputed data
- Outcomes at weeks 7 and 14 modeled as functions of treatment and time, adjusting for baseline value of the outcome and MD status
- A priori definitions of
  - Response = 30% ↓ from baseline CAPS
  - Remission = Final CAPS ≤ 20
Battered Sample

- N = 110
- Only 15% married/cohabiting
- 36% full-time employment
- Trauma
  - 92% had an interpersonal trauma
  - 57% reported chronic trauma
  - 35% reported sexual and 61% physical abuse
50% had current comorbid MDD
  ◦ 34% recurrent

High Axis II comorbidity

75% reported prior psychotherapy

47% reported prior pharmacotherapy

Baseline Reflective Function = 3.9
  ◦ 5 is norm; worse than Panic Disorder (4.2)
Results

- Patients improved in all three treatments
- Large within-group effect sizes on CAPS:
  - PE $d = 1.88$
  - IPT $d = 1.69$
  - RT $d = 1.32$
- On some measures, IPT worked more slowly
Hypothesis 1: PE $>$ RT on CAPS (ES= 0.88, p=0.01)
  ◦ Confirmed, as expected

Hypothesis 2: IPT $>$ RT on CAPS (ES= 0.56, p=0.097)
  ◦ Trend level – not confirmed
Hypothesis 3

- **Hypothesis 3**: IPT will not be more than minimally inferior to PE (<12.5 CAPS points)
- **Finding**: PE > IPT by 5.6 points; ES= 0.32
- **Null hypothesis for minimal inferiority of IPT to PE is rejected** (p=0.035)
- Thus establishing non-inferiority of IPT
Response and Remission Rates

Response:
- Prolonged Exposure: 47
- Interpersonal Psychotherapy: 63
- Relaxation: 38

Remission:
- Prolonged Exposure: 26
- Interpersonal Psychotherapy: 23
- Relaxation: 22

Response: ≥30% ↓ CAPS
Remission: CAP ≤20
Remission and Response

- **Hypothesis 4a. Remission rates:** IPT = PE, and IPT > RT
  - No difference across groups

- **Hypothesis 4b. Response rates:** IPT = PE, IPT > RT
  - IPT > RT (p = 0.03)
Attrition

 Dropout Rate (%)

Prolonged Exposure: 29%
Interpersonal Psychotherapy: 15%
Relaxation Therapy: 34%
Attrition Rates

- No statistical difference across groups
- Yet clear differences
- PE patients with comorbid major depression had 50% dropout rate!
  - OR = 17 (95% CI 1.88-153.26)
Odds of Attrition with Comorbid Major Depressive Disorder

![Graph showing odds of attrition with MDD+ and MDD- treatments](image)
## Comorbid MDD and Outcome

<table>
<thead>
<tr>
<th>Comorbid MDD Diagnosis</th>
<th>Treatment for PTSD</th>
<th>Treatment</th>
<th>Dropout</th>
<th>Response</th>
<th>Remission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>With MDD, N=55</strong></td>
<td><strong>IPT, N=40</strong></td>
<td>N = 20</td>
<td>Dropout = 20%</td>
<td>Response = 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>PE, N=38</strong></td>
<td>N = 20</td>
<td>Dropout = 50%</td>
<td>Response = 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>RT, N=32</strong></td>
<td>N = 15</td>
<td>Dropout= 26.7%</td>
<td>Response= 46.7%</td>
</tr>
<tr>
<td></td>
<td><strong>Without MDD, N=55</strong></td>
<td><strong>IPT, N=40</strong></td>
<td>N = 20</td>
<td>Dropout = 10%</td>
<td>Response = 75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>PE, N=38</strong></td>
<td>N = 18</td>
<td>Dropout = 5.6%</td>
<td>Response = 66.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>RT, N=32</strong></td>
<td>N = 17</td>
<td>Dropout = 35.3%</td>
<td>Response = 29.4%</td>
</tr>
</tbody>
</table>
Social Functioning (SAS-SR)

- Baseline
- Week 7
- Week 14

- PE
- IPT
- Week 14
Quality of Life

Baseline | Week 7 | Week 14
---|---|---
PE | IPT | RT
Inventory of Interpersonal Problems

Baseline
Week 7
Week 14

PE
IPT
RT
Hypotheses 5 and 6

- **Hypothesis 5**: PE = IPT > RT for social adjustment, quality of life
  - SAS-SR confirmed
  - Q-LES-Q confirmed
  - IIP also

- **Hypothesis 6**: In IPT, social function will ↑ before trauma avoidance; in PE, the reverse
  - Still being tested
Does IPT Work Through Covert Exposure?

- Behavioral argument
- Guarded against by supervision, adherence ratings
- Self-Initiated In Vivo Exposure Scale (SIIVES)
  - Invented by Randall Marshall, based on SUDS
  - Measured key traumatic situations and frequency of avoidance (FA)
- We examined whether change in FA in weeks 0-5 predicted week 14 CAPS outcome
Does IPT Work Through Exposure?
Study Hypotheses

1: PE will lower CAPS > RT
2: IPT will lower CAPS > RT
3: IPT will not be more than minimally inferior to PE (<12.5 points on CAPS)
4: a. Remission rates: IPT = PE, and IPT
   b. Response rates: IPT = PE, IPT > RT
5: PE = IPT > RT for social adjustment, QOL

Markowitz et al., American Journal of Psychiatry, in press
Exposure may not be necessary to treat PTSD
IPT “no more than minimally inferior” to PE
IPT had (non-significantly) lower attrition, higher response rate
Patients preferred it
So a reasonable alternative
Comorbid major depression an indication for IPT rather than PE?
  ◦ Occurs in roughly half of PTSD cases
Results need replication
Other IPT Research on PTSD

- Krupnick et al. (2008): group IPT > waiting list for low income abused women with PTSD in public health clinic (N=48)

- Campanini et al. (2010) in São Paulo: group IPT (16 2-hour sessions) enhanced pharmacotherapy of PTSD (N=40)
  - CAPS decreased from 72.3 (4.4) to 36.5 (5.4); ES=1.2
  - BDI decreased from 26.2 (1.8) to 13.3 (1.6);
  - ES=1.3
If Not Through Exposure, Why does IPT Work?

HINT:
Why Might IPT Treat PTSD?

- Good use of “common factors”
  - Especially affect
- IPT mobilizes social supports, improves social skills
- Helps build trusting relationships
  - Re-engaging and normalizing emotions
  - Emotions as social signals
  - Guides to response in encounters
- Reflective Function as a mediator?

  Markowitz et al., J Practical Psychiatry 2009
Towards an Alternative Theory

- Best not to feel alone in a crisis
- Social supports limit risk
  - Brewin et al., 2000; Ozer et al., 2003
- Early attachment may define relationship security
  - Bowlby
- In crisis, social network and ability to mobilize it crucial in averting PTSD, depression, other psychopathology?
  - Markowitz et al., J Practical Psychiatry 2009;15:133-140; Markowitz, Depr Anxiety 2010
The Team

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- and the NYSPI Anxiety Disorders Clinic
So What Did We Do?

- Unlike CBT, IPT pretty much the same across diagnoses
- Relatively minor adaptations for PTSD
Principles of IPT

- **Medical model**
  - Targets a treatable, medical illness
  - Not the patient’s fault
  - Gives the “sick role”

- **Interpersonal focus**
  - Focus on environment and relationships
  - Not intrapsychic
  - Not etiologic
  - Pragmatic, practical, plausible
Mood and Events Interact

Event

Mood
Interpersonal Psychotherapy

- Time-limited
- Diagnosis-targeted
- Forward-looking
- Addresses current problems
- Empirically grounded
Importance of Tolerating Affect

- Depressed patients see strong and especially negative affects as “bad”
  - Evidence of their defectiveness
  - Tend to avoid, try to ignore them
- Versus natural, useful social signals
  - Validate, normalize all but depressive affects
- Need to model for patients:
- Feelings are powerful, but not dangerous
Dealing with Affect

- Catharsis
- Acknowledge that feelings are
  - Complex
  - Can be mixed
- Normalize affects when possible
  - “Of course you feel that way!”
  - “It’s possible to love and hate someone at the same time.”
Tasks of the IPT Initial Phase (sessions 1-3)

- Diagnosis
  - Of mood disorder
  - Of interpersonal context of the illness
- Formulation
- Setting framework for treatment
  - Time limit
  - Sick role
- Therapeutic effect – symptom relief
IPT Initial Phase

- Diagnosis of Major Depression as Medical Illness
- Interpersonal Inventory
- Establishing the Problem Area
- Formulation
- Sick Role
- Psychoeducation
- Instilling Hope
IPT Case Formulation

- Distills and organizes history for often confused patients
  - Links illness to life events
- Provides a treatment focus
  - Need to agree on this
- Pragmatic, plausible fiction
- Keep it simple!
- Customize with patient’s own words
IPT Middle Phase (sessions 4-11)

- Grief (complicated bereavement)
- Role Dispute
- Role Transition
- Interpersonal Deficits
Treatment Techniques

- “How have you been since we last met?”
  - Mood or Event → Affectively charged event
- Explore specifics to elicit affect
- Link affect to environment or role
- “What did you want in that situation?”
- “What options do have to achieve it?”

Communication analysis, clarification, role play
Role Transition

“Life was okay”

Trauma

“It’s been terrible!”
IPT Termination Phase (sessions 11-14)

- Explicit discussion of termination
- Build independence: consolidation of gains
- “Graduation” into competence
  - Bittersweet role transition
- Dealing with non-response
- Continuation/maintenance treatment
Adapting IPT for PTSD

- 14 50-minute sessions
  - Somewhat arbitrary – stuck with pilot study decision
- Early sessions: addressing numbing
- Interpersonal hypervigilance
- Focus on current relationships – not trauma
- Later sessions
Addressing Numbing

- Unlike depression, patients with PTSD cut off from affect
- Need to pull for affect
- “What did you feel?”
- “What kind of upset?” → Anger? Sadness? Anxiety?
- Emotions as “bad” and overwhelming vs. useful social signals
- Normalization of affect
Emotions are powerful but not dangerous
PTSD shatters sense of safety

Patients no longer trust environment...

...or the people in it

And how can they if numb, flying emotionally blind?

Emotions as guideposts to trust

Confronting upsetting behavior → apology, or not
Focus on Current Relationships

- Rather than trauma
  - (which was forbidden)
- Social withdrawal and mistrust in PTSD
- “Live dangerously” testing relationships
- Mobilizing social support despite hypervigilance
  - Brewin et al., 2000; Ozer et al., 2003
Later Sessions (7?-14)

- Once more affectively attuned
- More typical IPT:
  - Communication analysis
  - Exploration of options
  - Role play
Observations

- Need poise to work with chronically ill patients
  - Maintaining hope for improvement
  - (for yourself, too)
- Advantages to not focusing on trauma
- Advantages to not assigning homework
- Advantages for comorbidly depressed patients
- IPT approach thus very different from exposure-based treatment
Questions?

Cases?