Interpersonal Psychotherapy and Exposure Therapies for PTSD

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**Interpersonal Psychotherapy is a non-exposure-based PTSD treatment. Patients focus on current interpersonal encounters rather than past traumas. This approach may avoid some of the disadvantages of exposure oriented therapies, such as their lack of focus on individual processes, high attrition rates, lower effectiveness for symptoms of depression, association with fear induction and possible short-lived positive effects.**

Keywords: PTSD, trauma, psychotherapy, treatment

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# Introduction

## Interpersonal Psychotherapy (IPT)

Interpersonal psychotherapy (IPT) is a brief, attachment-focused psychotherapy that centers on resolving interpersonal problems and symptomatic recovery. Interpersonal Psychotherapy was developed by Gerald Klerman and Myrna Weissman for major depression in the 1970s and has since been adapted for other mental disorders. [63]

Interpersonal Psychotherapy is an empirically supported treatment that follows a highly structured and time-limited approach and is intended to be completed within 12–16 weeks. IPT is based on the principle that relationships and life events impact mood and that mood also impacts relationships and life events. [61][62] Along with cognitive behavioral therapy (CBT), IPT is recommended in treatment guidelines as a psychosocial treatment of choice. [64][65]

# Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder (PTSD) is a mental disorder that can develop after a person is exposed to a traumatic event, such as sexual assault, warfare, traffic collisions, or other threats on a person's life. However, the interpretation of an invent is subjective and its effect on a person depends on individual characteristics.

Symptoms of PTSD may include disturbing thoughts, feelings, or dreams related to the events, mental or physical distress to trauma-related cues, attempts to avoid trauma-related cues, alterations in how a person thinks and feels, and an increase in the fight-or-flight response. [2] For the diagnosis of PTSD, these symptoms need to last for more than a month after the event. [2]

PTSD is a widespread [19] and debilitating [7] disorder. In the Western world, its prevalence is between 3 and 4 percent [19] and its lifetime prevalence around 7 percent [5]. The higher risk of suicide associated with PTSD make it a major mental health problem in the world today.

Young children are less likely to show distress but instead may express their memories through play. A person with PTSD is at a higher risk for suicide and intentional self-harm. [54]

# Exposure Therapies

Cognitive Behavioral Therapy (CBT) is the therapeutic approach most often recommended for PTSD [3][6]. Expert consensus and treatment guidelines emphasize: “The shared element of controlled exposure may be the critical intervention” [8]. The Institute of Medicine in 2008 endorsed exposure therapy as the sole adequately empirically supported trauma treatment, finding too little evidence to support other psychosocial techniques and psychopharmacology [9]. There is empirical support for the view that Prolonged Exposure achieves better outcomes than Relaxation Therapy [26][27].

The following exposure focused approaches are considered empirically validated: [8][9][10]

* Prolonged Exposure
* Cognitive Processing Therapy
* Eye Movement Desensitization and Reprocessing (EMDR)

## Auto-Regulation

The problem is that most of the techniques associated with CBT focus on exposure in the assumption that ‘natural’ auto-regulatory processes will lead to a symptom reduction. They expose patients to objectively safe reminders of their trauma, including reviewing traumatic memories, aiming to habituate and extinguish patients’ learned fear responses [15]. There is little focus on the auto-regulatory processes themselves which may be affected by the trauma and other life experiences and differ among individuals.

Higher cognitive functions that process the information from and about the trauma in relation to other experiences are given little attention by therapeutic approaches which focus primarily on exposure and simple learning mechanisms. However, it is these more complex cognitive processes where new strategies can be developed and trauma reactions modified. The mechanism of exposure-based treatment has been derived from basic animal models of fear activation [12], and fear activation has been linked to prefrontal cortical suppression of amygdalar fear responses to trauma reminders [13].

## Trauma Focus

The focus in these therapeutic approaches is largely on the trauma rather than on individual resources. The symptoms of PTSD are only a consequence of the trauma because of how the individual processes the information about the trauma. This largely depends on such factors as personality traits, self-confidence, sense of self, and others. Exposure may not be the key component of how these therapies work. Cognitive Processing Therapy, for example, has demonstrated efficacy without its exposure component [1].

## Individuality

The brain, however, is a large interconnected system of various brain regions and neural networks. The effect of exposure necessarily includes these other regions of the brain, which are in this form of therapy largely treated as a ‘black box’. Individual differences are largely ignored. Not all patients respond to exposure therapy, and most do not remit [14][67].

## Re-Traumatization

Exposure-based treatments can feel grueling for patients and therapists (16). Moreover, PTSD’s complex picture contains a powerful interpersonal theme. Interpersonal traumas more often trigger PTSD (10,17), causing more severe distress than events without human agency such as natural disasters. Many PTSD symptoms reflect interpersonal difficulties (17), such as emotional withdrawal from relationships. Mistrusting their interpersonal environments, traumatized individuals develop “interpersonal hypervigilance” (18). Social support protects against developing PTSD and fosters recovery (10,18).

# Interpersonal Psychotherapy

Interpersonal Psychotherapy [68], a time-limited, diagnosis-targeted psychotherapy efficacious for depression [20] and eating disorders [68], as a non-exposure-based, non-cognitive behavioral PTSD treatment. Interpersonal Psychotherapy demonstrably helps patients master social interactions and mobilize social supports, crucial PTSD issues (18). Patients focus on current interpersonal encounters rather than past trauma (10,18). Interpersonal Psychotherapists may neither evoke nor encourage exposure to trauma reminders. Empirical data has shown that Interpersonal Psychotherapy might benefit PTSD. [18][22][23]

## Depression

Roughly half of individuals with PTSD have comorbid major depression disorder [21], which is not addressed in exposure focused therapies. Interpersonal Psychotherapy was originally developed to treat major depression, and may have preferential advantages over Prolonged Exposure for patients with comorbid PTSD and major depression. The extremely low remission rates across treatments for patients with PTSD and comorbid major depression suggest this group might benefit from combined treatment with medication [14].

Prolonged Exposure was developed to target anxiety. Although it often reduces depressive symptoms [14][46], it may treat major depressive disorder less effectively. Alternatively, comorbid major depression may have rendered tolerating Prolonged Exposure more difficult.

## Attrition Rates

Because Interpersonal Psychotherapy has low attrition rates [18][22], while dropout rates in Prolonged Exposure Therapy is often over twenty percent [29].

## Homework

In Prolonged Exposure patients narrate an increasingly detailed trauma narrative (imaginal exposure) and confront trauma reminders (in vivo exposure) to extinguish fear responses. Relaxation Therapy is highly scripted and has the am to induce progressive muscle and mental relaxation. These treatments require listening to session or relaxation tapes as homework. Interpersonal Psychotherapy addresses not trauma but its interpersonal aftermath, and assigns no homework. The first half of Interpersonal Psychotherapy emphasizes affective attunement, recognizing, naming, and expressing one’s feelings in non-trauma-related interpersonal situations; the remainder addresses typical Interpersonal Psychotherapy problem areas (e.g., role disputes, transitions) [68].

## Latency

Prolonged Exposure did take faster effect, had a slight (non-significant) CAPS edge, and a trend level advantage over Interpersonal Psychotherapy on the self-report PTSD measure.

## The Fear of the Trauma

The traumas which are the worst are those which are also the most feared. This may explain why patients who face their traumas early in Prolonged Exposure and Relaxation Therapy have better PTSD outcomes, whereas patients who avoid it early in treatment fare worse than those who do not. However, often the traumas with the greatest need for therapy are the more sever ones, where the fear of exposure treatment is the greatest and other therapies may be better suited for the individual.

Interpersonal Psychotherapy and many other therapies, which focus more on the relationship and the interactions in therapy, including Psychodynamic Psychotherapy, do not need to address the trauma ‘head on’. Interpersonal Psychotherapy may work through alternative, attachment mechanisms involving emotional understanding, social support, and learning to cope with current life [18][24][47] rather than confronting past traumas. Patients who improved in Interpersonal Psychotherapy seem to gain confidence in daily social interactions, gather social support, and then spontaneously – without therapist encouragement – expose themselves to trauma reminders. [18]

What the trauma means to the individual has to be addressed at some point in treatment, but the ‘objective’ facts are secondary. By focusing on the ‘objective’ facts, exposure therapy pays less attention to what the trauma means for the individual, which is the source of the symptoms.

## The Interpersonal Component

Initial affective attunement and social skills training based on Dialectal Behavioral Therapy principles preceding exposure therapy seemed to benefit PTSD patients more than exposure therapy alone [49]. Interpersonal Psychotherapy, which initially focuses on affective attunement and only later in treatment encourages PTSD patients to change their interpersonal interactions in current relationships, yields somewhat slower symptom improvement than Prolonged Exposure, but catches up over the course of therapy. In studies of bulimia, Interpersonal Psychotherapy yielded slower improvements than Cognitive Behavioral Therapy but eventually pulled even [68]. The clinical experience seems to be that that many relationship and interaction oriented therapies take longer in the beginning, but may have more enduring effects in the long run.



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