

The Bulletin of The International Society for Interpersonal Psychotherapy.

The bulletin of the International Society for Interpersonal Psychotherapy

Editor in Chief:

Dr Michael Robertson

E-mail:

mroberson @med.usyd.edu.au

Academic Advisor:

John Markowitz

Publications manager:

Rebecca Reay

Email:

reay@netspeed.com.au

Notice to contributors: The editor welcomes articles, letters, book and conference reviews, research in progress and items of interest to members of the ISIPT. The editor reserves the right to accept, or reject any contributions and to make editorial changes.

A message from the editor:

This edition of the ISIPT Bulletin features a number of reports of investigators utilising IPT in the treatment of PTSD. The various pilot studies all appear to replicate the findings of the initial adaptation of IPT for PTSD back in 2002. The field of traumatology is changing. Clinicians working in the area have long been aware of the limits of behaviourist approaches to the management of traumatic stress syndromes. Many patients seek help in improving the interpersonal consequences of the experience of traumatic stress, and the preliminary findings of these investigations indicate that IPT may offer sufferers real benefits. The academic support for the clinical use of IPT over the last few years is welcomed by clinicians. It seems that as larger psychotherapy studies are struggling to be funded, we have to infer what we can from these smaller scale pilot studies.

On another note, the ISIPT is maintaining its momentum. It has been five years since the organization was founded in Chicago.

Subscription levels are healthy and meetings appear to occur semi-regularly. IPT is now consistently mentioned in the same breath as CBT and training in IPT is now regularly sought. In the Asia-Pacific chapter, there has been intensive IPT training in Singapore and Malaysia and sales of the Chinese language versions of IPT texts have been strong. There has also been consistent research into IPT's efficacy, particularly in New Zealand. Whilst there have been some differences of opinion over issues such as governance and the viability of the European chapter, the ISIPT appears to have a viable future. Like many enterprises, the main threat to ISIPT is decline through neglect. The organization, quite simply, needs to have a substantive existence beyond the good will of those people whose efforts have kept the organization afloat. It is now time for others to step forward and keep ISIPT viable into the future.

Michael Robertson

Inside this issue:

	Page	
Interpersonal Psychotherapy for suicide survivors	2- 8	
Complicated grief: Posttraumatic loss disorder.	9- 12	
Research in progress	13-15	
IPT Scotland	16-19	
ISIPT Meeting: Atlanta,	20	

Interpersonal Psychotherapy for suicide survivors

Scocco P*+, Frasson A+, Costacurta A*+, Frank E[°], Corinto B*, Drago A*, Pavan L*+

*Department of Mental Health, ULSS 16; and Department of Neurosciences - Psychiatric Section, Padua, Italy

[°]Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center, Pittsburgh, Pa, USA

+SOPRoxi Project

Introduction

It is estimated that, on average, every suicide leaves at least six people profoundly affected by the death of a loved one (1). Family, friends, co-workers and even therapists left in the aftermath of suicide are commonly referred to as suicide survivors. This expression does, however, refer to a blurred category of people whose features remain to be defined. Well-designed epidemiological studies are clearly warranted to determine how many survivors there are, their characteristics, and their needs. Is the status of survivor better defined by specific characteristics as kinship ties or by the nature and quality of the relationship shared with the deceased? Can passing time modify survivors' needs?

Some studies hold that people bereaved by suicide present more similarities than differences compared with those bereaved by other kinds of death i.e. accidental or sudden death (2). Other research work has suggested that people who have lost a significant person to suicide can present slower recovery (3) because they have to deal not just with the loss, but also with shame, fear, rejection, anger and a sense of guilt (4).

Other aspects specific to this type of bereavement are the social stigma confronting survivors and the different impact suicide has on the family system compared with other types of death (5). All these elements seem to corroborate the hypothesis that survivors who were close to the deceased are at heightened risk for complicated grief or other psychosocial consequences (6; 7).

The term postvention was coined by Shneidman in 1971 to indicate the support given to those who have lost a significant person. It can also be understood as an opportunity to provide professional intervention to people bereaved by suicide. Interpersonal psychotherapy (IPT; 8) can play an important role in facilitating the recovery of survivors because of its overt interest in the

Scocco P, Frasson A, Costacurta A, Frank E, Corinto B, Drago A, Pavan L.

problems facing these individuals. Alternatively, these clients can be offered Crisis Intervention (9) to help them overcome the emotional impasse experienced after the suicide.

Survivors usually seek professional help for problems related to loss, but not infrequently they have to deal with other types of psychological distress, such as role dispute or interpersonal deficits. These problem areas represent ideal foci for Interpersonal Psychotherapy. In this brief report we will present two cases of suicide survivors treated with IPT, within a broader postvention protocol specifically designed to meet the unique needs of this type of patient.

Methods

Considering that in the Veneto Region (North-East of Italy) there are over 300 suicides per year (336 in 2001; ISTAT, 2002), yielding a substantial population of potential clients, we have developed a research-intervention scheme named SOPRoxi, in response to the lack of postvention schemes in area. The term SOPRoxi is derived from survivors (in Italian SOPRavvissuti) and proximity, to define the closeness of the relationship (10).

Once the survivors have been identified, it is important to evaluate those who need support and/or treatment and those who are coping with the grieving process by themselves through informal support from the social network.

The scheme envisages two assessment sessions to obtain more information and identify both psychiatric disorders and unspecified psychological pain. In addition to a clinical interview, subjects are administered tests for the purpose of categorial and dimensional assessment. Evaluation centers on:

- Axis I and II diagnoses (Mini International Neuropsychiatric Interview, Brief Symptom Inventory and SCID-II);
- level of depression and other psychopathological conditions (Hamilton Rating Scale for Depression; Brief Symptoms Inventory);
- interpersonal distress area (Interpersonal Questionnaire);
- suicidality (Interview of Suicidal Feelings; Reasons for Living Inventory);
- perceived stigma (Link Stigma Scale);
- complicated grief (Inventory of Complicated Grief)
- suicide-related feelings.

Scocco P, Frasson A, Costacurta A, Frank E, Corinto B, Drago A, Pavan L.

Finally, outcome is discussed by the clinical/research team which then draws up a program that is presented to and shared with the client.

Some clients benefit from a counseling approach, lasting a few sessions, on how to appropriately deal with their feelings; others benefit from participation in self-help groups (the SOPRoxi scheme is promoting the creation of these groups). However, some clients may need a more profound approach to help them overcome the emotional turmoil triggered by the suicide of a significant person. Such clients are invited to undertake either Crisis Intervention (for people grieving for less than 6 months) or Interpersonal Psychotherapy (for people grieving for 6 months or longer). All psychotherapy sessions are videotaped and the therapist is supervised on a weekly basis.

Clinical Vignette 1

Initial phase

Mrs. V, a 65-year-old housewife, separated, mother of two married children, was referred to the SOPRoxi group by her general practitioner (GP). Mrs. V. had been to her GP complaining of initial insomnia and depressed mood, with frequent crying bouts and occasional night-time binge eating. This picture, which had gradually worsened, had lasted since the death of her husband by suicide (Mr. A) some 9 months beforehand.

Mrs. V. was legally separated from Mr. A. During their thirty-year marriage, Mr. A. had subjected his wife to every form of physical and verbal abuse while under the effects of alcohol. Even during their 2-year engagement, Mr. A. had been violent towards the patient, but his immediate apologies had always managed to dissuade Mrs. V. from leaving him.

After the marriage, events had rapidly come to a head: Mr. A. began to constantly abuse alcohol and use violence against Mrs. V., who was admitted to hospital on several occasions with contusions and fractures in various parts of the body. The situation would temporarily return to normal when Mrs. V. threatened to leave home, but when it became clear that this was not the case, her husband would resume his usual behavior.

Mrs. V. brought up two children in this setting. They, too, had often been the target of their father's fury. The family's social circle had been restricted to the husband's friends who made Mrs. V. feel uneasy. She had been forbidden from seeing anyone else, including her own relatives.

The patient had always had a precarious financial situation. Her elder son, who had partially contributed to the family budget, married at an early age and left his parents' home. The younger son had continued to live with his mother until two years previously.

Mrs. V. filed for separation in 1989 but had continued to live with her husband and endure violence for two more years. After the actual separation, the husband had abused alcohol to an even greater extent, accumulating debt. Yet Mrs. V. had continued to help him with the housework,

Scocco P, Frasson A, Costacurta A, Frank E, Corinto B, Drago A, Pavan L.

though avoided meeting him or being near him whenever possible since it caused her great anxiety.

The day before the suicide, Mr. A. had telephoned his ex-wife asking her to tell their sons not to go and see him on that day because he had a few matters to deal with and informing her that should something happen to him, she would find a letter addressed to the family in a box. Mrs. V. said that at the time she had not thought her husband had wanted to tell her of his intention to take his own life and she consequently felt very guilty.

At initial evaluation, Mrs. met the criteria for dysthymia, with a HDRS score of 22, but scored below the cut-off on the Inventory of Complicated Grief (11). In addition to grief for her husband's suicide, an interpersonal dispute with the sons was identified as the interpersonal focus.

Intermediate phase

In the fourth session, Mrs. V. continued to complain of repeated thoughts about her husband's death and a sense of guilt and responsibility for failing to understand his intentions. She reported thinking of suicide at times but had not made any precise plans. Her relational style led her to mask the pain and anxiety related to her experience and avoid significant contact with others.

At the fifth session Mrs. V.'s depressive state and death thoughts had worsened. Her account of marital relations and her husband's death was resumed and further investigated. Since she found it hard to spontaneously express her feelings of anger, the therapist sought to facilitate contact with this emotion through role playing and affect clarification techniques.

At the sixth session, her sons' behaviour was identified as another source of distress. Mrs. V. felt her sons were unaware of her needs and were not sufficiently available. Yet she did not wish to inform her sons of her needs because she was afraid of "bothering them", of preventing them from looking after their own families, and of irking her daughters-in-law. By exploring these potential interpersonal disputes and analysing communications the therapist sought to highlight her communicatory problem with her sons. To avoid the risk of vexing others, the patient often put aside her own wishes, hiding her distress behind a "mask". In an attempt to break this vicious circle of missed opportunity for communication alternative behaviour options were discussed.

At the seventh and eighth session, the discussion centered on Mrs. V.'s feeling of solitude. She was unable to develop satisfactory friendships, believing she did not measure up socially: "I have nothing interesting to say; what I have to say is of no importance". Hypothesizing that this might also be reflected in the psychotherapeutic setting, the therapist verbally stressed the importance of communications, proposing the psychotherapeutic space as a place where the patient's thoughts and feelings were highly valued and where even anger and aggressiveness could be expressed without fear, as different from her husband's years of physical violence.

Mrs. V. still found it hard to let her sons know she needed attention. Through a communications analysis procedure, the therapist sought to help the patient identify her specific communicatory pattern and see how it contributed to communicatory difficulties. During subsequent sessions, the patient reported progressive improvement in her relations with her sons.

Scocco P, Frasson A, Costacurta A, Frank E, Corinto B, Drago A, Pavan L.

The patient's traumatic married life was re-examined in detail at the tenth and eleventh sessions, providing a source of empathetic listening and helping Mrs. V. accept and express feelings of hostility towards her husband. Current interpersonal difficulties were linked to painful past experiences and the patient was asked to find a meaning for her behaviour and symptoms (e.g. night-time binge eating caused physical pain that she found more familiar than the psychological distress linked to her husband's memory). The time leading up to and immediately after the suicide were re-examined to foster the expression of associated thoughts and feelings, particularly those related to the sense of guilt initially reported by the patient.

During the final sessions, the patient showed gradual, progressive improvement in symptoms, particularly in mood. The opportunity to openly and unrestrictedly discuss the relationship with her husband and his recent death helped alleviate the suffering associated with past memories and led to a reappraisal of the suicide-related guilt. This simultaneously promoted reconciliation with her sons and helped overcome relational difficulties, enabling Mrs. V. to express previously unpronounceable needs and desires to her sons.

Conclusive phase

The final sessions were used to discuss future plans and to analyse progress achieved. The opportunity to openly and unrestrictedly confront her own aggressive and guilt feelings and recount the relationship with her husband and his recent suicide also enabled the patient to tackle her relational problems with her sons, motivating her to come to terms with interpersonal needs that had lain dormant for years. At the end of the cycle of psychotherapy, Mrs. V. had no difficulty separating from the therapist and showed an appropriate sense of gratitude.

Clinical Vignette 2

Mr L. was a 30-year-old man, referred to the SOPRoxi group by a psychiatrist who had seen him in an emergency setting following the onset of depressive and anxious symptoms and suicidal ideation, which the patient openly associated with the death by suicide of a co-worker one month previously. The interpersonal relationship with the co-worker was of moderate duration but involved no affective relationship or particular affinity. Yet he had been particularly struck by his colleague's suicide which, for the first time in his life, had triggered intrusive self-destructive ideation.

The patient met the criteria for a diagnosis of depressive disorder not otherwise specified with a history of major depressive disorder; HDRS and ICG scores were 18 and 15, respectively. The suicide method and circumstances had upset him deeply and were the subject of discussion for most of the first session. It had been a "dyadic" death: the colleague and his fiancée had made a suicide pact involving death by car exhaust fumes. The image of the suicide of two lovers "joined in life and death" greatly disturbed him (although Mr. L did not see the bodies nor take part in any way in their discovery).

In the initial phase it emerged that Mr. L. was part of a very close family, although verbal and affective communications were highly constrained. His interpersonal network outside the family was extensive, but lacked significant others. Mr. L. had had brief, uninvolved romantic experiences. In the very first sessions, the survivor experience clearly proved to be an epiphenomenon that had triggered and brought to light the interpersonal deficit that was to become the key focus of IPT.

Scocco P, Frasson A, Costacurta A, Frank E, Corinto B, Drago A, Pavan L.

Discussion

These two vignettes describe two clinical presentations rather frequently found among survivors of suicide who are unable to autonomously work through the grief process. The first case describes a survivor unable to deal with feelings of isolation, self-stigmatisation and fear of being negatively judged by others. This caused her to withdraw and act in such a way as to inhibit social and family support.

The loss of Mr. A. had a major impact on the functioning of the entire family system which, prior to his the suicide, had been close and mutually supportive in response to the role of (physical and psychological) persecutor played by the husband/father during his life. However, rather than real conflict, this family system was experiencing a communicatory and affective block related to the bereavement. This convinced us to propose individual treatment for the patient without any direct contribution, in any session, by the sons.

In other similar cases, the suicide triggers open and at times durable conflict within the family unit. This is particularly frequent among married couples when the suicide involves a child, but may also be encountered between a parent and children when the victim is the other parent. In these cases, although the person unable to work through the grief process or the patient “designated” by the family unit is generally the spouse, it is essential to intervene with family or couples treatment, since working with only the “identified” patient does not seem to achieve very positive results.

The case of Mrs. V. stresses how IPT with suicide survivors often requires a dual focus, even in the acute setting: grief associated with the suicide and interpersonal disputes. With respect to the grief focus the aim of therapy is to promote the expression of feelings (e.g. anger, hostility, guilt, etc.). With respect to the disputes focus, the purpose is to solve communication problems with other significant survivors, through clarification, communication analysis, problem-solving, use of affect etc., and to help the patient towards gradual, adequate expression of his or her own needs and feelings.

The second clinical vignette addresses another group of survivors, in which the suicide uncovers latent distress. However, the different type of relationship between the victim and the survivor (in the case in point they were colleagues) probably has a profound effect on grief management strategies (12), the resulting psychopathological and relational manifestations, and short- and long-term outcomes.

Scocco P, Frasson A, Costacurta A, Frank E, Corinto B, Drago A, Pavan L.

On the basis of current experience, we feel that individual, couples, family (and probably group) interpersonal psychotherapy is a beneficial therapeutic tool that lends itself very well to this particular population. Efficacy studies that compare IPT with other therapeutic methods and longitudinal assessment of untreated suicide survivors are warranted to confirm this hypothesis.

Correspondence: Paolo Scocco email: scocco.paolo@virgilio.it

References

1. Shneidman, E.S. (1969) Prologue, In E.S. Schneidman (Ed.), *On the Nature of Suicide*. San Francisco. CA: Jossey-Bass.
2. Van der Wal, J. (1989) The aftermath of suicide: a review of empirical evidence. *Omega*, 20 (2),149-171.
3. Farberow, N, Gallagher-Thompson, DE, Gilewski, M, Thompson, L (1992). The role of social supports in the bereavement process of surviving spouses of suicide and natural death. *Suicide and Life Threatening Behavior*. 22 (I), 107-124.
4. Scocco, P., Frasson, A., Costacurta, A., Donà, M., Pavan, L. (2004). Postvention in suicide. *Studies on aggressiveness and suicide* (www.aggressuicide.org) 4, 41-55.
5. Jordan, J.R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life Threatening Behavior*. 31, 91-102.
6. Prigerson, H.G., Bierhals, A.J., Kasl, S.V., Reynolds, C.F., Shear, M.K., Day, N., Beery, L.C., Newsom, J.T., Jacobs, S.C. (1997). Traumatic grief as a risk factor for mental and physical morbidity. *American Journal of Psychiatry*. 154, 616-623.
7. Mitchell, A.M., Kim, Y., Prigerson, H.G., Mortimer-Stephens, M.K. (2004). Complicated grief in survivors of suicide. *Crisis* 25, 12-18
8. Klerman, G.L., Weissman, M.M., Rounsaville, B.J., Chevron, E.J. (1986) *Interpersonal psychotherapy of depression*. New York: Basic Books (It. Transl. *Psicoterapia interpersonale della depressione*. Bollati Boringhieri editore, Torino, 1989).
9. Pavan, L., Fusco, E., Gambaro, F., Granà, S., Marini, M., Padoani, W., Piovan, C., Semenzin, M. (2003). Open trial on crisis psychotherapy in Padova, Italy. *Brief Treatment and Crisis Intervention*. 3, 37-46.
10. Scocco P., Frasson A., Pavan L. SOPRoxi: a research-intervention project for suicide survivors. Submitted for publication.
11. Prigerson HG, Maciejewski PK, Reynolds CF III, Bierhals AJ, Newsom JT, Fasiczka A, Frank E, Doman J, Miller M (1995). Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. *Psychiatry Res*. 59, 65-79.
12. Reed, M., Greenwald, J. (1991). Survivor-victim status: attachment and sudden death bereavement. *Suicide and Life-Threatening Behavior*. 21, 385-401.

“Complicated Grief” (Posttraumatic Loss Disorder)

Katherine Shear M.D.

Complicated grief is recently defined syndrome that occurs in approximately 10-20% of bereaved people. Symptoms resemble both depression (sadness and loss of interest in the world) and posttraumatic stress disorder (sense of disbelief, intrusive thoughts and avoidance behaviors.) Additionally, there are symptoms specific to bereavement (feelings of intense yearning and longing and preoccupation with thoughts about the deceased.) Studies have shown that a cluster of complicated grief symptoms can be reliably identified (Prigerson et al 1995) and that these symptoms are not highly correlated with either depression (Prigerson et al 1995) or anxiety (Prigerson et al 1996). The following example illustrates a patient with complicated grief.

Case Example

Mary is a middle aged woman who presents 4 years after the death of her granddaughter, Deborah, the second child of a beloved son and daughter-in-law. Mary frequently looked after this child when her daughter-in-law needed a baby sitter. Mary did not have a daughter of her own, and she was infatuated with Deborah. The child died in a freak accident at a swimming pool while under Mary's care.

On initial presentation Mary is an attractive, casually dressed woman who has a full range of affect. She is warm and responsive with the interviewer and says she has come because others are worried about her, but she believes she is really doing the best that can be expected, given the terrible loss she experienced. She says her life has totally changed, but she has a new life and new friends, all of whom have also lost children or grandchildren. These friends feel pretty much the same way she does and they support and comfort one another. She doubts that anyone who has not lost a child could ever really understand her. She talks freely about plans she and her husband have for an upcoming trip and generally appears comfortable until the conversation turns to a discussion of her granddaughter's death. At this point she becomes tearful and begins to look exhausted.

Mary explains that she is plagued by a strong sense of guilt and feels hopeless about her life. She sobs as she describes the story of the death, and says it would have been better if she had died instead of the baby. She has had thoughts of taking her own life that were especially strong in the

Katherine Shear M.D.

first period after the accident. She repeatedly “forgot” to take prescribed medication for her diabetes and, on several occasions, seriously considered taking an overdose of her husband’s blood pressure pills. The only thing that stopped her was the idea that she would never see the beloved child again if she did this. She considers herself a religious person and she has the idea that suicide is a sin, though she has lost her faith in God as a result of this death. No real caring God could allow something like this to happen.

Mary explains that she often spends hours at a time daydreaming about her granddaughter Deborah. These reveries are intensely pleasurable and comforting until she has to “wake up”. Then, when reality hits, it feels like she is reliving the horrifying experience of the death all over again. When not daydreaming, she is sometimes plagued by images of her granddaughter running around laughing. Instead of bringing her joy, these images remind her of what she lost through her own carelessness. At these times she frequently finds herself picturing the baby lying lifeless on the ground by the swimming pool.

She avoids all parks and can’t stand to hear anyone talk about swimming. If there is a program on television that includes someone swimming, she turns it off. She also avoids anything that reminds her of the deceased child, including her own grandchildren. She goes out of her way to avoid passing by a store where she used to buy clothes and trinkets for Deborah. Since the baby was buried, she has never visited the cemetery and cannot remember the location of the grave. She has a box of toys she had in her house for Deborah that she keeps in her bedroom though she cannot bring herself to open it. A torn old Teddy Bear that was Deborah’s favorite toy is on a table in the center of her living room. She has put away all the pictures of Deborah and her other grandchildren as it is too painful to look at them. At the same time, she is compelled to call her daughter-in-law every day to make sure the other children are ok. She has intrusive thoughts that something bad will happen to them. She has tried to work as a cashier in the local grocery store so she can feel useful, but she lost her concentration whenever she saw a child, and made so many mistakes that she lost the job.

Also causing her deep pain is the disruption in her relationship with her daughter-in-law, Sally. Sally, too, has been plagued by this death. She keeps asking herself, over and over, questions that she knows are irrational. Why wasn’t her daughter more careful? How did she slip and fall in the pool? Why didn’t someone see Deborah fall in? and so on. These questions besiege her, and she

Katherine Shear M.D.

hates herself for this. Still, she cannot be herself around Mary anymore. Mary, plagued by similar questions, no longer trusts herself to look after children, and she too feels awkward around her daughter-in-law and uncomfortable with her other grandchildren. It is especially difficult recently, since the fourth child, a girl, is approaching 18 months. It does not help that this baby, Diana, closely resembles Deborah. Seeing Diana makes her heart ache so that she thinks it will literally break. So she stays away from the family.

Though affected by the death Mary's son Tom is continuing to work. Previously, a star performer, he thinks he barely succeeded in getting his last promotion at the bank. He is generally a meticulous man who takes his work very seriously and who is exceptionally reliable. In the last few years, he has made mistakes that were not serious, but he reproaches himself for sloppiness. The other children are a source of joy to him. He feels his family has fallen apart but tries not to think about it. He can no longer turn to his mother, who has always been a source of support, so has been having long talks with his father. Mary's husband John is also sad about Deborah's death, but is less affected than the rest of the family. John has been very supportive of his wife but is also worried about her. He is greatly relieved when Mary decides to seek therapy

This vignette illustrates how the syndrome of complicated grief typically occurs when there has been a very positive relationship to the deceased, rather than a troubled or ambivalent relationship. This grandmother was deeply attached to her granddaughter, as well as her daughter-in-law. She was devastated by the loss and experienced intensely painful emotions that persisted even in a supportive environment. Her partially effective way of coping was to avoid all reminders of her grandchild, including her own family, and to develop an entirely new friendship group and pattern of activities. This, however, was not working optimally.

In our work with bereaved people, we use the term "trauma" to refer to the loss rather than to exposure to violence. Thus, traumatic loss generally refers to the loss of an attachment figure, and the death may occur by natural as well as violent causes. Attachment theory posits that mental representations provide a sense of connectedness to important people who are not physically present. In the early period of bereavement, the mental representation of the deceased has not been revised to fit the reality of the death. This kind of marked disconnect reality and the inner assump-

Katherine Shear M.D.

tive world is the hallmark of trauma. Acute grief is the usual response to traumatic loss, and this response subsides as the mental schema accommodates the reality of the death. The loss is integrated into ongoing mental functioning through a reconfigured mental representation of the deceased (Shear & Shair, 2005).

However, for some people acute grief does not subside. Instead, there is a persistent sense of disbelief in the reality of the death. There is also a persistent intense longing, yearning and searching for the person who died and recurrent painful pangs of grief. The bereaved person remains preoccupied with the deceased and often experiences recurrent intrusive images of the death or the dying person. Avoidance of a range of situations also occurs. The resulting syndrome of complicated grief might better be named "Posttraumatic loss disorder (PTLD)".

Our treatment for PTSD utilizes an IPT framework of an initial, middle and termination phase. The treatment begins with psychoeducation and an investigation of the state of current relationships, as well as the relationship to the deceased and the story of the death. However, we use a different approach than the grief focus used for bereavement-related depression in IPT. We add components derived from efficacious treatments for PTSD since we conceptualize PTLD as related to PTSD. Our treatment aims at facilitating acceptance of the death and revision of the mental representation of the deceased. The treatment is also guided by the dual process model of coping proposed in the bereavement literature, and includes components targeting loss and restoration within each treatment session. Our treatment approach for PTLD was more successful than standard IPT for the kind of patient illustrated by Mary (Shear et al, 2005).

1. Prigerson HG, Maciejewski PK, Reynolds CF, Bierhals AJ, Newsom JT, Fasiczka A et al. Inventory of Complicated Grief: a scale to measure maladaptive symptoms of loss. Psychiatr Res 1995; 59(1-2):65-79
2. Prigerson, H. G., Frank, E., Kasl, S. V., Reynolds, C. F., Anderson, B., Zubenko, G. S., Houck, P. R., George, C. J., & Kupfer, D. J. Complicated grief and bereavement-related depression as distinct disorders: preliminary empirical validation in elderly bereaved spouses. Am J Psychiatry 1995,152, 22-30.
3. Prigerson HG, Bierhals AJ, Kasl SV, Reynolds CF 3rd, Shear MK, Newsom JT, Jacobs S. Complicated grief as a disorder distinct from bereavement-related depression and anxiety: a replication study. Am J Psychiatr. 1996 153:1484-6
4. Shear K and Shair H Attachment, Loss and Complicated Grief Dev Psychobiol. 2005 Oct 26;47(3):253-267
5. Shear K Frank E Houck P and Reynolds C Complicated Grief Treatment: A Randomized Controlled Trial JAMA. 2005 293:2601-8.

IPT Research in progress

This is a new section of the bulletin which will be a regular feature providing a snapshot of IPT research around the world. It is encouraging to see the diversity of research happening in IPT. We welcome your contributions and encourage collaboration amongst our society members.

New Zealand

Psychotherapy for bipolar disorder - randomised comparison of IPSRT and specialist supportive care

Researchers: Professor Peter Joyce, Assoc Prof Sue Luty, Dr Stephanie Moor et al.

Location: Dept of Psychological Medicine Christchurch NZ

Aims or hypotheses: Comparing two psychotherapies for outpatient treatment of bipolar disorder

Progress to date: Recruited 38 so far each has 18 months of outpatient therapy with psychotherapist and sees clinician for medication management Other relevant information (recent publications, appeal for information):

Contact person: Prof Peter Joyce Dept of Psychological Medicine, Christchurch

Randomised comparison of IPT and CBT for depression

Researchers: Prof Peter Joyce, Prof Roger Mulder, Associate Prof Sue Luty

Location: Dept of Psychological Medicine Christchurch NZ

Aims or hypotheses: Comparing efficacy of two psychotherapies for outpatient treatment of depression

Progress to date: Now starting 5 year follow up data of 177 patients who completed therapy and finishing 3 year follow up.

Other relevant information: Submitting initial outcome data and analysing follow up data

Contact person: Prof Peter Joyce Dept of Psychological Medicine, Christchurch

Brazil

Comparative study of the treatment of Posttraumatic Stress Disorder

Researchers: Marcelo Feijó de Mello, Mariana Pupo Cardrobbi, Aline Schoedl, Janice Krupnick

Location: Universidade Federal de São Paulo São Paulo Brazil

Hypotheses: Patients treated with combined treatment (IPT-G adapted to PTSD + aripiprazole) have a better outcome compared to those which received only APZ.

Progress to date: 18 patients enrolled

Other relevant information: We have a pilot trial using IPT-G PTSD with 7 patients with good results

Contact person: *Prof. Dr. Marcelo Feijó de Mello*

Universidade Federal de São Paulo

Email: amfeijo@uol.com.br

(Brazil continued)

IPT for Post-schizophrenic Depression. 3 case report

Researchers: Fernando S. Lacaz, Rodrigo A. Bressan, Marcelo Feijó de Mello

Location: Universidade Federal de São Paulo São Paulo Brazil

Description: 3 patients with post schizophrenic depression (PSD) were submitted to IPT adapted to PSD with good clinical results

Progress to date: accepted for publication at Rev de Psiquiatria do Rio Grande do Sul

Contact person: *Prof. Dr. Marcelo Feijó de Mello*

Coordenador do Programa de Estresse e Violência

Departamentode Psiquiatria

Universidade Federal de São Paulo

Email: amfeijo@uol.com.br

IPT Research – New York

IPT for Borderline Personality Disorder

Researchers: John Markowitz, M.D., Kathryn Bleiberg, Ph.D., New York City

Aims: Open trial to determine feasibility and preliminary efficacy of IPT, modified as an up to 8 month treatment, for patients with borderline personality disorder in interpersonal crisis. Funded by NARSAD.

Progress to date: Nine subjects entered, one currently in treatment. Two dropouts, one removed from study; five completers no longer met criteria for BPD at 8 months or at follow-up.

Publications: Markowitz JC, Skodol AE, Bleiberg K: Interpersonal psychotherapy for borderline personality disorder: possible mechanisms of change. *Journal of Clinical Psychology* (in press); Markowitz JC: Interpersonal therapy of personality disorders, in *Textbook of Personality Disorders*. Edited by Oldham JM, Skodol AE, Bender DE. Washington, D.C.: American Psychiatric Publishing, 2005, 321-338

Interpersonal psychotherapy for chronic PTSD

Researchers: John Markowitz, M.D., Kathryn Bleiberg, Ph.D.. New York City

Aims: IPT, as a non-exposure-based, 14-week individual treatment, relieves symptoms of PTSD.

Progress to date: Open trial of 16 subjects indicates feasibility and possible efficacy of intervention. Grant submission for comparative trial.

Recent publications: Bleiberg KL, Markowitz JC: Interpersonal psychotherapy for posttraumatic stress disorder. *American Journal of Psychiatry* 2005;162:181-183

Contact person: John Markowitz, M.D. jcm42@columbia.edu; (212) 543-6283

IPT research– Pittsburgh, USA

Title: Culturally Relevant Brief Interpersonal Psychotherapy (IPT-B) for Perinatal Depression

Location: University of Pittsburgh School of Social Work: Magee-Womens Hospital Pittsburgh PA.

Contact Person: Sharon L. Geibel Project Coordinator/Email: Shg24@pitt.edu (412) 624-4192

PRINCIPAL INVESTIGATOR: Nancy K. Grote, Ph.D., MSW

Assistant Professor, School of Social Work University of Pittsburgh

CO-INVESTIGATORS: Holly Swartz, M.D. University of Pittsburgh School of Medicine,

Ellen Frank, Ph.D. University of Pittsburgh School of Medicine, WPIC

Hypothesis and Specific Aims:

The overall aim is to investigate the effects of using Brief Interpersonal Psychotherapy (IPT-B; Swartz, Frank, Shear et al., 2004), followed by biweekly and monthly maintenance sessions up to 6 months postpartum, to treat antenatal depression in pregnant low-income women who attend the Magee Womens-Hospital Ob/Gyn outpatient clinic, Oakland site. The 8 session model of IPT-B delivered is advantageous because it offers depressed women a non-pharmacological, viable treatment alternative and is convenient because it can be scheduled, as much as possible, in the Ambulatory Clinical Research Center of the Magee Ob/Gyn clinic before or after their prenatal clinic visits. Our ultimate objective is to reduce women's depressive symptoms during pregnancy and prevent the continuation or recurrence of their depression during the postpartum period. Pilot data will be collected in support of the following specific aims:

Aim 1: To estimate the effects of IPT-B on participant outcomes (treatment attendance, symptoms of depression and anxiety, and social functioning) by examining the “mean levels” of these outcomes in participants assigned to IPT-B compared to those receiving a facilitated referral to treatment as usual (F-TAU). We predict that IPT-B participants will show fewer depressive symptoms compared to the F-TAU group, at post-treatment and at 2 months postpartum and 6 months postpartum.

Aim 2: To further the process of refining perinatal IPT-B, including the development of a treatment manual and therapy fidelity measures to insure the integrity of the intervention. The audiotaping of each IPT-B session will provide the clinical information we will that use 1) to revise the first draft of IPT-B treatment manual and 2) to rate therapist adherence to IPT-B standards via a scale developed for evaluating the integrity of IPT-B pilots.

Aim 3: To compare the percentage of IPT-B participants who attend an initial treatment session with the percentage of F-TAU participants who attend an initial treatment session.

Progress to date:

41 women have been enrolled in the study to date. 20 in the IPT-B group. 21 in the F-TAU group.

Recent Publications:

Grote, N.K., Bledsoe, S. E., Swartz, H. A., Frank, E (2004). Culturally Relevant Psychotherapy for Perinatal Depression in Low-Income OB/GYN Patients. *Clinical Social Work Journal*, 32, 327 –347.

Grote, N.K., Zuckoff, A., Swartz, H.A., Bledsoe, S.E., Geibel S.L. (Under review) Engaging Depressed Disadvantaged Women in Mental Health Care. *Social Work*.

IPT Scotland – A National Training Programme: Evidence into Effectiveness

Dr Roslyn Law & Dr Chris Freeman

2005 is a year of great development and innovation for IPT in Scotland. With the launch of IPTSCOTLAND and a national training programme in evidence based psychotherapies for depression, IPT training will be taken to all areas of the country. This has become possible through funding from the Doing Well by People with Depression (DWBPWD) project – a national, centrally funded initiative which aims to restructure and improve drug, psychological and self help services for people suffering from depression in Scotland.

Doing Well by People with Depression

DWBPWD is a three-year programme which was launched just over one year ago. The programme takes a collaborative approach to service improvement in partnership with local organizations. It is supported by £1.5 million per annum from the Centre for Change and Innovation (CCI) until at least March 2006. It is being co-ordinated nationally but will work with local health systems to redesign services.

Some of the programme aims are to:

- ⇒ Improve mental wellbeing for people with depressive disorders
- ⇒ Improve access to interventions with have an appropriate evidence base
- ⇒ Build capacity for psychological interventions in primary care to reduce pressure on secondary services
- ⇒ Improve access to a range of community based services and support.

Local development projects are based in ten NHS board areas (Argyll & Clyde, Dumfries & Galloway, Borders, Greater Glasgow, Ayrshire & Arran, Grampian, Highland Fife, Lanarkshire and West Lothian). Other areas of Scotland will benefit from the programme too through a Scotland wide national development network, a national training programme in evidence based psychotherapies and a comparative evaluation of the programme to understand what services work best in different contexts.

Law R. & Freeman C.

IPTSCOTLAND has received two funding grants from this project - both of which will operate on a national basis. The first strand of this development aims to serve those areas which have successfully made bids to participate in the DWBPWD project. This proposal was made in response to the considerable interest and demand for IPT training across Scotland, including in the ten funded areas.

This reflects the growing awareness of IPT as an effective and empirically validated intervention for people suffering from depression. This also reflects the achievements of IPT Edinburgh over the last eight years. This group have sought to bring IPT into routine practice among NHS and private practitioners in Scotland (and latterly, far beyond). During this period they have provided approximately 400 therapists with introductory training courses either in Edinburgh or in local training course around the UK.

Introductions to IPT have also become established components of the East of Scotland Clinical Psychology training course, the East of Scotland psychiatry training scheme, undergraduate teaching for psychology students at Edinburgh University and Queen Margaret University College and on both the Dundee and South of Scotland CBT diploma training courses. Despite this groundswell of interest and knowledge about IPT however it has remained a persistent challenge to develop a devolved and sustainable national network of IPT practitioners, trainers and supervisors across the country.

While efforts have been made to support this endeavor it has proved a significant challenge without adequate or centralized funding. Consequently a very small number of increasingly exhausted IPT supervisors have attempted to meet the ever increasing demands - often resulting in up to 15 trainees being taken on at one time! Not a moment has been free from audio tape review (or perhaps it has just felt like that.).

The aim for IPTSCOTLAND in the DWBPWD project is to produce localized and sustainable core groups of IPT therapists, trainers and supervisors across the regions. This plans to take advantage of the work of many innovative IPT practitioners and researchers who have adapted and

Law R. & Freeman C.

modified the original model to aid its implementation with different client groups and across service settings. Consequently IPT delivered in different forms including IPC, IPT-Brief, and IPT- Group will be part of the final picture.

Training will be developed at a number of different levels:

⇒ **Introductory Workshops**

These will be half-day workshops aimed at a wide variety of mental health workers including GPs. The aim of these workshops will be to introduce IPT and IPC outline the basic principles and clarify what parts of the IPT model can be incorporated into routine clinical practice (for example the Interpersonal Inventory and choosing a focus).

⇒ **Training in IPC**

This is 2 days of training either delivered in a block or in half day workshops over 4 weeks. This training will obviously take a little more time and commitment. The training will be designed so that some students could go onto take on supervised cases for IPC and become fully trained; others would be able to incorporate IPC into their existing practice and deliver IPC informed therapy.

⇒ **Full IPT Training**

This involves a 4-day workshop plus continuing supervision on 2 cases with audio taped review. Out aim is to be highly selective and identify key individuals who would be trained in the full model who would then go on to be supervisors locally.

⇒ **Group IPT**

The model of Group IPT used in Uganda where therapy was delivered on a group basis to rural women with heavy domestic commitments who were unable or unwilling to attend routine clinical services could be adapted for many areas in Scotland. This would be the most experimental but potentially the most exciting part of the training.

The second strand of funding for this training programme will allow those areas not already included in DWBPWD to gain access to training and supervision opportunities. The principles of training would be as follows:

⇒ Delivered locally.

⇒ Delivered at three levels

- **Introductory Workshops:** to give information, explain the model, inform as many clinicians as possible about the treatment
- **Practitioner level:** to train a group of clinicians in each area to deliver the treatment.
- **Supervisor level:** to train 2 or 3 clinicians in each area to a higher level, so they can supervise treatment. This will be the key ingredient to the project in terms of making sure that training is sustainable and that an effective clinical service is developed.

Who will do the work?

Dr Chris Freeman and Dr Roslyn Law have been responsible for developing this proposal. Dr Freeman is Chair of the Advisory group and Clinical Lead for DWBPWD and Dr Law will be project manager for both areas of IPT development. Both have been involved in IPT Edinburgh since its inception and have contributed to the teaching and supervision which has been provided over the last eight years. Given the aim of decentralizing IPT training from the original Edinburgh base however it has been exciting to recruit from the existing population of IPT therapists in Scotland to develop a team to take on this challenge.

To date four Consultant Psychiatrist – all graduates of the IPT Edinburgh course – have been identified to contribute to the project and operate as key local co-ordinator following implementation of the training programme. In addition four more sites have a number of therapists who have completed basic IPT training and it is hoped that this individual interest will be nurtured into healthy and growing localized groups. Two additional therapists will be supported to complete level D training during the course of the study.

Ideally therapists will represent other disciplines to those already involved to ensure dissemination across a wide and representative range of professionals working as psychotherapists with depressed patients within the NHS today.

The authors would welcome any suggestions or comments on this undertaking from IPT trainers and supervisors and also from practitioners who have faced the challenge of taking a model and putting it into practice in a variety of clinical settings.

Correspondence:

Dr Roslyn Law, Royal Edinburgh Hospital

Tel. 0131 537 6778

Email: roslynlaw1@o2.co.uk

ISIPT Meeting: Atlanta, USA

A small and informal ISIPT meeting took place on May 22, 2005 in Atlanta, Georgia, in conjunction with the American Psychiatric Association Annual Meeting. The eight attendees hailed from Canada, Italy, Spain, and the United States. Participants discussed the following issues:

1. Should the next ISIPT meeting be linked to the APA meeting? There was concern that it might be asking too much of people who would come to Toronto in May 2006 for the next APA Annual Meeting to return to Toronto several weeks later, particularly for ISIPT members traveling from beyond North America. [This question has been resolved, since the next ISIPT will probably now be held in Toronto in the fall of 2006.]
2. Dr. Liria reported that IPT was the most commonly used psychotherapy in the public psychiatry system in parts of Spain and in Lisbon. He conducts a three-year Master's level training program in psychotherapy for residents and M.D. and Ph.D. clinicians in the Spanish public psychiatry program. Some 90 therapists have been enrolled. There has not yet been research in Spain on training or treatment issues.
3. Psychooncology was discussed as a promising area in which to apply IPT.
4. Dr. Patry raised the topics of training in IPT for Francophone therapists in Canada and the use of IPT to treat non-responders to ECT.
5. Dr. Scocco described his interest in IPT for the depressed families of suicide survivors in Italy.
6. Dr. Liria has had technical difficulties in communicating with the ISIPT website. Several participants suggested that the acronym "TIP" be developed as a search link to the website, inasmuch as IPT is abbreviated that way in at least several of the Romance languages. There was discussion of interest in IPT in Panama and Guatemala.
7. What is and what should be the role of the ISIPT? We discussed the ISIPT constitution, for which ratification voting was underway at the time of the Atlanta Meeting. The group agreed that the constitution seemed technically appropriate so far as it went, but that it included no real mission statement. Should the role of the ISIPT include recruitment of local IPT societies around the world? Should it simply provide a forum for IPT clinicians and researchers to discuss aspects of and the evolution of the therapeutic approach? Some sort of monitoring or training in order to maintain the uniformity of the treatment, to control the potential for therapeutic drift? Might it provide teaching aids, including training videotapes?

The participants agreed that we should continue to try to meet at APA meetings when these were not linked to larger ISIPT gatherings.

Dr John Markowitz