Interpersonal Psychotherapy for Posttraumatic Stress Disorder:

A Critical Review of the Evidence

John C. Markowitz, MD

Abstract

Importance: Extensively researched, exposure-focused therapies have dominated the treatment of posttraumatic stress disorder (PTSD). No treatment benefits all patients. Interpersonal psychotherapy (IPT), a nonexposure, affect-focused treatment, has emerged over 2 decades as an alternative evidence-based PTSD intervention.

Objective: This narrative review critically assesses IPT outcomes for PTSD. Time-limited IPT focuses on affect toleration and the interpersonal consequences of trauma rather than on reconstructing the trauma narrative and exposure to traumatic cues.

Evidence Review: The author searched the outcome literature on IPT for adults with syndromal PTSD and drew upon personal involvement in studies since 2001. Subsyndromal PTSD studies and 1 adolescent trial were excluded.

Findings: Thirteen published studies of IPT targeted PTSD in individual and group formats for 592 civilians (n = 8, 6 randomized controlled trials [RCTs]) and 187 military veterans (n = 5, 1 RCT). Some trials had methodological limitations. IPT surpassed outcomes of waiting lists and other weak controls and was noninferior to evidence-based PTSD treatments including Prolonged Exposure (n = 2) and sertraline (n = 1). Depression and other outcomes improved. The RCTs demonstrate IPT efficacy for PTSD and allow preliminary exploration of outcome mediators and moderators and differential therapeutics.

Conclusion: While the number of studies remains limited, research by multiple investigators in differing populations supports the efficacy of IPT as a non-trauma-focused PTSD treatment and justifies its inclusion in PTSD treatment guidelines. More research is necessary to determine how IPT compares to exposure-focused treatments in patient preference, attrition, and response for PTSD comorbid with major depression or due to sexual trauma.

J Clin Psychiatry 2024;85(2):23nr15172

Author affiliations are listed at the end of this article.

Exposure-focused approaches have dominated treatment research and treatment guidelines for posttraumatic stress disorder (PTSD). For decades, exposure and habituation to trauma reminders were considered necessary elements for psychotherapy of PTSD.[1–4] Like most broad clinical theories, this has proven inaccurate: while exposure indeed effectively treats PTSD, it is not an exclusively efficacious therapeutic approach.[5] Few psychiatric disorders have a single effective treatment, and no panacea for PTSD exists: even the best tested brief exposure therapies have high rates of dropout and nonresponse and typically leave residual symptoms, particularly for more complex clinical presentations and for military veterans.[6] In recent years, evidence has mounted that affect-focused therapies, addressing the patient's emotional state rather than assigning exposure tasks and using cognitive restructuring, have similar, perhaps comparable efficacy.[5,7] It behooves both patients and clinicians to have multiple potent interventional options for the difficult syndrome of PTSD.

One treatment in the forefront of affect-focused, nonexposure approaches to PTSD is Interpersonal Psychotherapy (IPT), a time-limited therapy originally developed to treat major depressive disorder (MDD).[8] IPT focuses on the link between life events and mood, medicalizing psychiatric diagnoses in a stress-diathesis model as environmentally influenced, treatable illnesses that are not the patient's fault. The success of IPT in relieving depressive symptoms while enhancing social support and social functioning led to its expansion to treating other disorders, including PTSD.[8] Diagnosis of PTSD requires a preceding traumatic life event, which evokes powerful emotions that individuals, feeling overwhelmed, work hard to suppress. This critical narrative review briefly describes IPT as an affect-focused, nonexposure therapy and provides an overview of the still limited but growing and encouraging outcome research on IPT for PTSD.

WHAT IS IPT?

IPT is a time-limited, manualized treatment developed by the late Gerald L. Klerman and Myrna M. Weissman in the 1970s, arising from and heavily

Clinical Points

- Although research literature on interpersonal psychotherapy (IPT) as a nonexposure therapy for posttraumatic stress disorder (PTSD) has gradually accumulated over the past 2 decades, there has been no cumulative summary of these studies.
- This critical narrative review should give the clinician reader confidence in considering IPT as an alternative treatment option to exposure treatments for PTSD.

supported by clinical outcome research.[8,9] Like supportive and psychodynamic psychotherapies, IPT is affect-focused, in contrast to exposure-focused treatments such as Prolonged Exposure[10] and Eye Movement Desensitization and Reprocessing (EMDR).[11] Affect- and exposure-focused treatments are 2 broad psychotherapeutic categories employing fundamentally different stances and interventions (see Table 1).[12] Although all use the so-called "common factors" that all effective therapies share,[12–15] exposure-based and affect-focused psychotherapies may use different "common" elements to different degrees.[12] Exposure-focused therapies tend to be highly structured, cognitively and behaviorally focused, and assign symptom-focused homework. Affect-focused therapies, in contrast, are less structured, more emotion-focused and experiential, and assign no homework.[12]

Traumatic life events elicit powerful feelings of emotional distress: anxiety, anger, sadness, shame, terror, and others, often mixed. Overcome, individuals with PTSD often emotionally distance and numb themselves through effortful affective detachment. They thus feel whipsawed, beset by both a hostile environment and seemingly dangerous inner emotions. Moreover, affective numbing makes it hard to judge whom to trust in one's environment. IPT helps patients to understand their feelings not as dangerous or "bad," as such strong negative affects often register, but as meaningful, useful signals about interpersonal interactions.[16] Suppressing them is not only psychically exhausting but also counterproductive and ineffective. Emotional distancing periodically fails, leading to angry outbursts that further convince patients of their affective dyscontrol and provoke redoubled efforts at suppression.

IPT helps patients to connect their inner mood states to their interpersonal situation. Sessions begin with the question, "How have things been since we last met?" This question elicits an interval history: either a mood ("I've been feeling depressed") or an event ("I was fired"). The therapist helps the patient link the two, to understand mood in environmental context. The patient can then use those feelings to guide social interactions.[8] For example, anger generally indicates that someone is hurting or unfairly treating the patient, behavior to which the patient could respond by objecting. Anxiety indicates an environmental threat or uncertainty; sadness, a loss or separation.

Patients with PTSD present a problem for standard IPT. They invariably answer the opening question by recounting events ("I just stayed home all week") rather than moods and report feeling "numb" or "nothing" when asked about feelings. Thus, one adaptation of IPT for PTSD is to focus in early sessions on affective attunement, helping patients to recognize, tolerate, name, and understand the environmental source of their feelings, particularly negative affects.[16] Emotions are normalized, detoxified. Therapists encourage patients that understanding these uncomfortable feelings is crucial, as the feelings provide guidance about whether people around them are trustworthy. Trust is central to frightened, traumatized patients, who experience "interpersonal hypervigilance."[16]

Building an emotional vocabulary, recognizing that "feelings are powerful but not dangerous"[16] and indeed are crucial to navigating interpersonal situations, helps patients to regain autonomy, cope with life circumstances, mobilize social supports (a vital factor for PTSD, as for other disorders[17–19]), and feel better. As IPT focuses on the social and emotional consequences of having been traumatized, rather than on reliving horrific memories and facing external reminders of the trauma itself, patients may prefer this approach.[20]

In taking a history, the therapist establishes that the patient has in fact experienced trauma and manifests the symptoms of PTSD. Having done so, the therapist explains that treatment will focus not on reconstructing the trauma but on its interpersonal consequences: What have trauma and PTSD done to the patient's social life, and what can the patient do about it? The 14 weekly sessions focus on traumatic complicated bereavement (eg, a murdered family member), a role dispute with a significant other (perhaps a violent partner), or, most commonly, a role transition from the traumatized state back to better emotional comfort and social functioning.[16]

Trauma is thus the root of the diagnosis but, once established, is not further raised in treatment. Nor does the therapist assign homework or encourage exposure. Nonetheless, as symptoms relent, patients spontaneously and autonomously face previously feared trauma reminders in resolving the role transition back to (or beyond) pretrauma functioning.[16,21] IPT thus has a very different feel from exposure therapies for PTSD and is easily distinguished by adherence measures.[21] A key moment in many treatments occurs when a patient feels mistreated, uses that anger to confront the offender ("Please don't do that. It makes me uncomfortable"), and either receives an apology (suggesting the other person may be trustworthy) or not (the other person is unsympathetic or untrustworthy). This helps establish safer relationships.[16]

Table 1.
Comparing Exposure-Based and Affect-Focused Psychotherapies

	Exposure therapy	Affect-focused therapy
Background	Fight vs flight Trauma → fear, avoidance of external stimuli (memory cues)	Trauma → emotional numbness, social withdrawal, social consequences
Putative mechanism	Exposure → habituation	Reflection on feelings; building social supports
Paradigm	Cognitive behavioral	Experiential Impaired attachment, affect dysregulation
Focus	Anxiety in feared situations	Emotional and interpersonal consequences of trauma
Degree of structure	More highly structured	Less structured
Psychoeducation	More	Less
Homework	Yes	No

REVIEW OF STUDIES

A 2020 meta-analysis of IPT for traumatized populations with PTSD symptoms amassed 10 studies,[7] several of which we exclude here because 1 involved adolescents,[22] and in others, patients reported PTSD symptoms but did not all meet syndromal PTSD diagnostic criteria and IPT therapists focused on treating MDD rather than PTSD.[23–27] We located studies of IPT-treated adults with PTSD through PubMed and Google Scholar literature searches using the terms "posttraumatic stress disorder," "PTSD," "interpersonal," "therapy," and "IPT" and through the author's personal research involvement in multiple trials. We located 13 IPT outcome studies for patients with syndromal PTSD, which we divide according to whether they treated civilians (Table 2) or military veterans (Table 3), as the latter appear harder to treat and differ in demographics (eg, gender ratio) and type of exposure (viz., combat).[28] The scant treatment research actually comparing civilian vs military patients with PTSD suggests poorer veteran outcomes.[29–31]

Most IPT PTSD trials have treated civilians, using IPT in either individual (n = 9) or group (n = 4) format. Studies took place in the United States (n = 6), Australia (n = 2), Brazil (n = 2), China (n = 1), Egypt (n = 1), and Kenya (n = 1). Because the number of studies is limited and a meta-analytic approach sacrifices the fine clinical grain of study outcomes to a more abstracted statistical view, we chose instead to provide a chronological, narrative descriptive summary of the extant literature. Expectedly, treatment research began with open trials, which assess preliminary feasibility, and then proceeded to randomized controlled trials (RCTs), the test of efficacy.

Civilian Studies

Bleiberg and Markowitz in 2005 manualized IPT for PTSD as a 14-week, 14-session individual treatment and conducted the first open trial.[32] They treated 14 unmedicated patients with chronic *DSM-IV* PTSD, focusing on the interpersonal sequelae of trauma rather than the trauma itself. Patients were 79% female, mean age 33.1 (SD = 9.0) years, 50% white, 29% African American, 14% Asian, and 21% married or cohabitating. Traumas ranged from childhood sexual abuse to adult assaults; the mean duration of PTSD symptoms was 7.6 (9.5) years. Treatment was typically framed as a role transition from the traumatized state to regaining one's feelings and social functioning. Thirteen of 14 patients completed treatment. Mean Clinician-Administered PTSD Scale (CAPS[33]) scores decreased from 66.9 (SD = 14.9) at baseline to 25.2 (16.6) at week 14: ie, from severe to subthreshold PTSD, with a large effect size ($d = 1.8$). Depression severity decreased from 18.1 (8.6) to 9.4 (6.1) on the 24-item Hamilton Depression Rating Scale (HDRS[34]), and social functioning improved on the Social Adjustment Scale (SAS-SR[35]).[32] There was no formal follow-up after posttreatment evaluation. These encouraging preliminary results led to an RCT.[21]

Krupnick and colleagues[36] conducted the first RCT of IPT for PTSD, comparing 16 weekly 2-hour group IPT sessions to the modest comparator of a waiting list. Patients (N = 48) were mostly ethnic minority (75% African American, 4.2% Hispanic black, 2.1% Afro-Caribbean, 8.3% Latina, 6.2% non-Hispanic white, and 4.2% Asian American), lower socioeconomic class, multiply abused, and non–treatment-seeking women recruited from public gynecology and health clinics in the Washington, DC, area. The mean age was 32 (10.2) years. Adaptations for this population included providing childcare and transportation costs when needed. Paired therapists with limited IPT training following a group IPT manual treated 3–5 patients per group. Seventy-one percent of patients attended more than half of sessions, retention considered acceptable under their difficult circumstances.

CAPS scores fell from 65.2 to 40.6 at IPT termination, whereas waiting list group scores decreased from 62.6 to 56.8 ($P < .001$). HDRS scores decreased from 14.7 to

Table 2.
Civilian Studies of IPT for Chronic Posttraumatic Stress Disorder[a]

Study	Design	IPT	Adaptation	Acute outcome	Remarks and effect sizes[b]
Bleiberg and Markowitz 2005[32]	Open trial N = 14	14 50-min weekly sessions	IPT-PTSD[13]: no exposure to trauma reminders; affect focus	Pre/post CAPS 67 → 25 Attrition: 7%	Large effect size: CAPS *d* = 1.8
Krupnick et al 2008[36]	RCT: IPT vs WL N = 48 (n = 32 IPT, n = 16 WL)	16 weekly 2-h group IPT sessions 4-mo f/u	Adapted for low-income, highly traumatized minority women	IPT > WL CAPS: IPT 65.2 → 40.6; WL 62.6 → 56.8 (CAPS, *P* < .001) Attrition: 29% IPT	Gains persisted at 4-mo f/u Within-group CAPS *d* = 1.3
Campanini et al 2010[37]	Open augmentation of medication trial N = 40	16 weekly 2-h group IPT	Similar to Krupnick et al 2008[36]	CAPS 72 → 37 Attrition: 17%	Medication nonresponders Between-group CAPS *d* = 1.2
Meffert et al 2014[38]	RCT: IPT vs WL (n = 13 IPT, n = 9 WL)	6 individual IPT sessions in 3 wk	Minimally trained Sudanese refugee community member therapists	HTQ decreased 40% in IPT, 9% in WL; BDI −17.1 points IPT, −4.3 WL Attrition 8%	Tiny RCT HTQ *d* = 2.5, BDI *d* = 2.4
Markowitz et al 2015[21]	RCT of IPT, PE, and RT N = 110 unmedicated patients (n = 40 IPT, n = 38 PE, n = 32 RT)	14 weekly 50-min sessions 3-mo f/u	IPT-PTSD[13]	CAPS 68.9 → 39.8 Attrition: 15% IPT vs 29% PE and 34% RT	IPT noninferior; less attrition for comorbid MDD; better for sexual trauma Within-group CAPS *d* = 1.7
Jiang et al 2014[39]	Pilot RCT: IPT vs TAU N = 18 IPT, 10 TAU	12 1-h weekly sessions 3-mo f/u	"Slightly modified" traditional IPT	CAPS 39.4 → 19.6 IPT 52% vs TAU 3% lost PTSD diagnosis Attrition: 27%	Earthquake survivors; IPT > TAU Between-group CAPS *d* = 1.0
Meffert et al 2021[40]	RCT: IPT + TAU vs WL + TAU N = 256 (n = 123 IPT + TAU, n = 133 WL + TAU)	12 1-h sessions 3-mo f/u	IPT by local non–mental health specialists	PCL-5 IPT + TAU 56 → 39; WL + TAU 56 → 47 IPT + TAU 79% vs WL-TAU 63% lost PTSD diagnosis Attrition: 28% IPT + TAU, 12% WL + TAU	Impoverished Kenyan women with PTSD, MDD, HIV, domestic violence IPT + TAU > WL + TAU
Proenca et al 2022[41]	RCT: IPT vs sertraline N = 74 (n = 39 IPT, n = 35 sertraline)	14 50-min weekly sessions	IPT-PTSD[13]	CAPS-5 42.6 → 29.1 Attrition: 33% (sertraline = 43%)	Equivalent outcomes; women with recent sexual assault IPT = sertraline

[a]The CAPS, developed based on *DSM-IV* PTSD criteria, has a scoring range from 0 to 136, wherein ≤20 is essentially asymptomatic, 40–59 indicates moderate illness, and diagnostic threshold, and ≥60 is severe. The CAPS-5, adapted for *DSM-5*, ranges from 0 to 80. In practice, 1 point on the CAPS-5 translates to roughly 2 points on the CAPS.
[b]Effect sizes listed when available from authors.
Abbreviations: BDI = Beck Depression Inventory, CAPS = Clinician-Administered PTSD Scale, *d* = Cohen *d* effect size, f/u = follow-up, HTQ = Harvard Trauma Questionnaire, IES = Impact of Events Scale, IPT = Interpersonal Psychotherapy, MDD = major depressive disorder, PE = Prolonged Exposure, PCL-5 = PTSD Checklist for *DSM-5*, RT = Relaxation Therapy, RCT = randomized controlled trial, TAU = treatment as usual, WL = waiting list.

8.4 in IPT, vs 15.9 to 15.2 for the waiting list group ($P < .01$); self-reported interpersonal functioning significantly improved on 4 of 5 Inventory of Interpersonal Problems subscales.[42] Of assessed completers, 20% made employment gains, and 30% changed partners or left abusive relationships: life gains typical of IPT.[36] Many patients reported enhanced tolerance and expression of their feelings. Gains were largely maintained at 4-month follow-up. Admittedly facing a waiting list control, a weak comparator yielding minimal improvement, and despite considerable dropout, this RCT found efficacy for IPT in a brutalized, non–help-seeking, highly traumatized population.

In 2010, Campanini and colleagues[37] in Brazil tested Krupnick's group IPT in augmenting pharmacotherapy of PTSD. Forty victims of violence with Structured Clinical Interview for *DSM-IV* (SCID[43])-diagnosed PTSD who had shown inadequate symptomatic response to at least 12 weeks of pharmacotherapy were offered 8 weeks of 2-hour group IPT with stable ongoing pharmacotherapy. Pharmacotherapy generally included antidepressant medication augmented by atypical antipsychotic or benzodiazepine. The patients were 70% female, 65% married, with a modal age in their 40s, and reported mostly life-threatening physical violence (60%) among a mix of traumas, with a mean duration of 3.3 years.

Thirty-three (83%) completed the trial in 6 groups of 6–8 patients apiece, with pharmacotherapy held stable. At half of the IPT dosage of the Krupnick et al[36] trial, patients showed clinically and statistically significant PTSD improvement on the CAPS, declining from 72.3 (73.4) to 36.5 (75.4) ($P < .0001$; $d = 1.16$), as well as in depression (26.2 [1.8] to 13.3 [1.6]; $P < .0001$, $d = 1.3$)

Table 3.

Veteran Studies of IPT for Chronic Posttraumatic Stress Disorder[a]

Study	Design	IPT	Adaptation	Acute outcome	Remarks and effect sizes[b]
Robertson et al 2007[44]	Open trial N = 13	8 weekly group IPT sessions 3-mo f/u	"Specially prepared" manual; standard group IPT	"Modest" IES improvement Attrition: 0%	Results stable on 3-mo f/u; ES: IES subscales $r = 0.63–0.67$
Ray and Webster 2010[45]	Open trial N = 9	8 weekly 2-h group IPT sessions 2-mo f/u	Based on group IPT manual[46]	IES significantly improved ($P < .05$) Attrition: 0%	Some symptomatic slippage on 2-mo f/u; (ES: not calculable)
Krupnick et al 2016[47]	Open trial N = 15 women veterans	12 weekly individual sessions 4-mo f/u	Based on Krupnick et al 2008[36]	PCL-M 67.9 → 55.5 ($P = .03$) Attrition: 33%	Gains maintained at 3-mo f/u
Pickover et al 2021[48]	Open trial N = 35	14 weekly 50-min sessions 3-mo f/u	IPT for PTSD[13]	CAPS-5 34.8 → 20.2 Attrition 37%	High MDD and separation anxiety comorbidity
Shea et al 2023[49]	Equivalency RCT: IPT vs PE N = 61 IPT, 54 PE	12 weekly sessions 3- and 6-mo f/u	Based on Krupnick et al 2008[36]	CAPS-5 IPT 36.3 → 27.8 PE 34.8 → 28.2 Attrition: 26% vs 49% PE	IPT comparable to PE on CAPS with lower dropout; gains maintained at 3 and 6 mo; underpowered $d = 0.90$ IPT, 0.49 PE

[a]The CAPS, developed based on *DSM-IV* PTSD criteria, has a scoring range from 0 to 136, wherein ≤20 is essentially asymptomatic, 40–59 indicates moderate illness, and diagnostic threshold, and ≥60 is severe. The CAPS-5, adapted for *DSM-5*, ranges from 0 to 80. In practice, 1 point on the CAPS-5 translates to roughly 2 points on the CAPS.
[b]Effect sizes listed when available from authors.
Abbreviations: CAPS = Clinician-Administered PTSD Scale, *d* = Cohen *d* effect size, f/u = follow-up, IES = Impact of Events Scale, IPT = Interpersonal Psychotherapy, MDD = major depressive disorder, PE = Prolonged Exposure, PCL-5 = PTSD Checklist for *DSM-5*, PCL-M = PTSD Checklist, Military Version, RCT = randomized controlled trial, WL = waiting list.

on the Beck Depression Inventory (BDI[50]) and anxiety (32.0 [2.0] to 17.0 [2.1]; $P < .0001$, $d = 1.2$) on the Beck Anxiety Scale.[51] No follow-up was reported. This study suggests IPT can augment pharmacotherapy for PTSD but does not demonstrate the specificity of IPT relative to any other psychotherapy.

Meffert et al[38] conducted a very small pilot randomized trial of Sudanese refugees in Egypt, comparing IPT (n = 13) to a waiting list control group (n = 9). PTSD was determined by the Harvard Trauma Questionnaire (HTQ[52]), and IPT was conducted by briefly trained Sudanese community members without prior mental health background. Thirteen patients, 81% women and mean age 31 years, received 6 twice weekly individual sessions of IPT over 3 weeks. One IPT patient dropped out (8%). Despite the small sample and small IPT dosage, patients receiving IPT reported significantly greater symptom reduction (40%) on the HTQ than did waiting list patients (9%). Baseline BDI depressive symptoms (mean 28.3) decreased 17.1 points (63%) in IPT and 4.3 points (16%) in the waiting list. Although this is technically a successful RCT, the sample size and methods are so preliminary that it is best considered pilot data for a later study by this investigator.[40]

Markowitz and colleagues in 2015[21] reported the first large RCT of individual IPT for PTSD, comparing it to Prolonged Exposure (PE[10]) and to Relaxation Therapy (RT[53]), an active control condition. Unmedicated patients (N = 110) with SCID-diagnosed *DSM-IV* PTSD of mean 14.1 (14.4) years' duration due to multiple, varying traumas received treatment over 14 weeks. Comprising 700 minutes, IPT was briefer than PE (900 minutes) and RT (840 minutes). Patients were a mean of 40.1 (11.6) years old, 70% female, 65% white, 17% African American, 8% Asian/Pacific Islander, 28% Hispanic, and 15% married or cohabitating. All treatments had large outcome effect sizes ($d = 1.3–1.9$). IPT was noninferior to PE in lowering CAPS scores, with both superior to RT.[21]

With response defined *a priori* as ≥ 30% CAPS improvement from baseline, IPT had a higher response rate (63%) than RT (38%; $P = .03$); PE (47%) did not. Treatments did not differ in *a priori*–defined remission (CAPS ≤ 20), which ranged from 22% to 26%. At baseline, patients preferred IPT despite its having the least research support, likely because it required no exposure.[20] Dropout was 15% in IPT, vs 29% in PE and 34% in RT (nonsignificant [NS]), and particularly elevated among the half (n = 55) of patients with comorbid major depression, who fared better in IPT ($P = .006$).[21] Patients with PTSD related to sexual trauma (35% of patients) had better outcomes in IPT as well.[54] Responders and remitters retained their gains at 3-month follow-up.[55] A neuroimaging substudy (n = 35) found that lower baseline anterior hippocampal gray matter volume predicted IPT but not PE treatment response.[56]

Although requiring replication, these study findings suggested IPT is noninferior to the "gold standard," best tested exposure therapy, conducted by excellent, seasoned PE therapists under expert supervision.[21] Moreover, IPT appeared to have advantages for patients with comorbid depression or sexual trauma. In hindsight, this may make sense: of the 3 treatments, IPT is the proven antidepressant psychotherapy,[8,9] and its

focus on interpersonal trust may have had particularly benefits for sexually traumatized patients.

In 2014, Jiang and colleagues[39] compared 12 1-hour "slightly modified" traditional IPT[5] sessions plus treatment as usual (TAU) (n = 27) to TAU alone (n = 22) in a pilot RCT for Sichuan China earthquake survivors who reported PTSD and/or MDD on SCID interview. In fact, 18 IPT + TAU patients and 10 TAU patients reported PTSD, and 14 and 12, respectively, reported MDD. TAU comprised antidepressant pharmacotherapy and crisis counseling. Patients receiving IPT + TAU were 62% female and a mean of 24.8 (11.7) years old, whereas TAU patients were 77% female and 36.1 (15.7) years old. About 20% in each group received an antidepressant medication with or without benzodiazepines. Seventy-two percent of IPT + TAU patients and 77% of TAU patients reported earthquake-related trauma.

Of 27 patients assigned to IPT + TAU, only 22 started treatment and 6 (27%) dropped out, vs 5 (23%) of TAU patients. Patients receiving IPT showed greater reduction in posttreatment PTSD diagnoses (52% vs 3%) and MDD diagnoses (30% vs 3%), with CAPS scores falling from 39.4 (15.8) to 19.6 (18.0) and BDI scores from 20.7 (11.6) to 10.6 (13.2). (For TAU, comparable scores were CAPS 45.1 [11.1] decreasing to 38.7 [19.8] and BDI 21.8 [12.7] decreasing to 20.7 [12.5].) Between-group effect sizes were CAPS $d = 1.01$ and BDI $d = 0.79$.[39] Treatment gains were reportedly maintained at 3-month follow-up. Study limitations are considerable, including small sample size, differing percentages of active and control patients with PTSD diagnoses, lack of rater blinding, and an apparently less than robust comparison condition. This randomized trial reported positive results but has serious methodological problems.

Meffert and colleagues in 2021[40] randomly assigned 256 multiply traumatized impoverished Kenyan women with comorbid HIV, major depression, and PTSD due to gender-based violence to 12 sessions of IPT plus TAU or waiting list plus TAU. PTSD and MDD were diagnosed by Mini-International Neuropsychiatric Interview[57]; baseline PTSD Checklist for *DSM-5* (PCL-5[58]) score was 56.6 (15.5), and baseline BDI score was 27.5 (10.5). At mean age 39 years, one-third of patients reported 4 or more lifetime traumas. Individual IPT was delivered by high school–educated nonprofessionals who, following a 10-day training course, received weekly telephone supervision from a psychiatrist. TAU comprised informal counseling, HIV adherence, and concrete social supports, but no evidence-based treatment. Waiting list patients were subsequently crossed over to IPT.

Dropout was 28% in IPT and 12% in the TAU/waiting list arm. After 3 months of IPT, patients had significantly lower odds of retaining diagnoses of PTSD ($P = .02$) and MDD ($P = .002$), significantly greater decreases in PCL ($P = .001$) and BDI ($P = .009$) scores, improvement in disability ($P = .01$), and a trend for improvement in work absenteeism ($P = .06$).[40] Interpersonal domestic violence decreased among partnered patients receiving IPT. Gains were maintained after a 3-month follow-up. Wait list patients were crossed over to IPT after 3 months and had a similar response to the randomized IPT cohort. In treating severely traumatized patients in an area with scarce resources, IPT was superior to a waiting list in a RCT. Both Meffert et al studies[38,40] and the Jiang et al Sichuan study[39] describe limited therapist training and limited therapist adherence measures. As such, they may be viewed as effectiveness more than as efficacy trials. Despite their methodological limitations, these international studies suggest the adaptability and applicability of IPT across differing cultures.

In 2022, Proenca and colleagues in Brazil compared 14 weekly sessions of individual IPT (n = 39) to the selective serotonin reuptake inhibitor (SSRI) sertraline (n = 35; mean dosage 118 mg/d) treating women with PTSD due to sexual assault in the prior 6 months.[52] Sertraline has US Food and Drug Administration approval for treating PTSD. This RCT is unusual in targeting relatively acute PTSD and in comparing IPT to pharmacotherapy. Patients were mean age 24.8 (6.8) years, 32% white, 29% mixed race, 12% black, 1% Asian, and 22% married.

Dropout was high, 33% for IPT and 43% for sertraline (NS), likely because traumatized impoverished patients had to take hours-long, crowded public transportation to the treatment center, and Sao Paolo bus stops are notorious sites for sexual assault.[41,59] The treatments similarly improved PTSD symptoms: Clinician-Administered PTSD scale for *DSM-5* (CAPS-5[56]) scores decreased from 42.6 (9.1) to 29.1 (151.5) with IPT and from 42.5 (9.4) to 27.1 (15.9) with sertraline. Depressive and anxiety symptoms also dropped significantly without between-group differences. There were no follow-up assessments following posttreatment evaluation.

Comment. Eight published studies, 6 of them randomized clinical trials, have assessed IPT among 592 civilian patients with PTSD (319 of whom received IPT) due to various traumas. Patients were overwhelmingly female (90%), relatively young, predominantly single, and had suffered a range of traumas. Dropout ranged between 7% and 39%, seemingly higher in lower-income settings and generally lower for IPT than for comparators. IPT has to date yielded comparable results to evidence-based treatments such as PE and sertraline while outperforming weaker controls such as limited usual treatment and waiting lists. Four of the 8 trials included brief 3- to 4-month follow-up assessments during which treatment responders generally maintained gains. Thus, although data remain limited, IPT deserves inclusion in PTSD treatment guidelines.[60] More research is required to determine whether IPT, adapted from an antidepressant intervention,

has advantages over exposure treatment in treating the half of PTSD patients who present with comorbid depression[21] and whether its interpersonal focus provides an advantage for patients with sexual trauma.[54]

Military Veteran Studies

Evidence for IPT as a treatment for veterans has been sparser[61–64]. Until recently, only a handful of case reports[55–58] and small open pilot trials had been published. Given the dearth of research, the United States Veterans Administration (VA) hospital system understandably trained its clinicians to use exposure for PTSD and to deliver IPT for depression but not PTSD.[65]

Robertson and colleagues,[44] using their own manual, in 2007 treated 13 Australian patients with PTSD in an 8-session open trial of group IPT. Patients were mostly male (77%), mean age 54 (10.2) years, and taking stable medication (92% SSRIs, with or without benzodiazepines). Because 54% of patients reported combat trauma, we classify this as a military study. (The remaining patients were civilians.) All patients completed treatment. Symptoms diminished moderately in the PTSD avoidant cluster (P = .02) but not significantly for intrusion or hyperarousal clusters on the Impact of Events Scale-Revised (IES-R[66]). Patients reported improved social functioning and depressive symptoms, with gains persisting at 3-month follow-up. The authors concluded that IPT group had "modest" benefit for PTSD symptoms but enhanced general wellbeing and interpersonal functioning.

Ray and Webster in 2010[45] conducted a pilot study of 2 IPT groups comprising 9 Australian Vietnam male veterans, ages 56–75 years, who had not responded to prior cognitive behavior therapy. They assessed 8 weeks of group IPT following a study-specific manual. Eight patients were taking stable antidepressant medication. Patients overall significantly improved (P = .044) on IES-R PTSD symptoms, although only 2 of the 9 showed a statistically significant individual gain, 1 of whom had worsened by 2-month follow-up. Patients reported modestly decreased depressive symptoms (P = .51) and better interpersonal functioning. Like the Robertson et al[44] report, this is a tiny, exploratory group trial.

Military sexual trauma is a particularly awful trauma variant. Many individuals with childhood trauma join the US military as soon as they reach enlistment age to escape abusive families, seeking an orderly organization with trusty built-in comrades and rules. When these "comrades" assault them, it compounds trauma and mistrust.[67] Krupnick and colleagues[47] in 2016 treated 15 women veterans at the VA with IPT for PTSD. Inclusion required a military-related trauma score >35 on the PCL-Military Version. Of the 15 women, 87% were African American, 7% were white, and 7% were Native American. The mean age was 39.9 years, and the mean duration of trauma was 16.3 years.

Twelve (80%) of the 15 reported military sexual trauma. Nine had comorbid MDD, and 1 had bipolar disorder. Ten patients (67%) completed 12 sessions of individual IPT derived from the Krupnick et al[36] group IPT approach. PTSD symptoms showed a clinically significant posttreatment decline, from PCL = 67.9 (15.1) to 55.5 (17.3) (P = .03), and BDI depression scores decreased from 35.1 (13.3) to 28.9 (16.1) (NS), with gains maintained at 3-month follow-up. Roughly one-third no longer met diagnostic PTSD criteria, an outcome the authors cite as comparable to exposure-based treatments in military samples.[47]

Pickover et al[48] conducted an open trial of 14 weeks of IPT for PTSD in US veterans (n = 35) and their family members (n = 15) in a non-VA setting. Family members of veterans are a high-risk, undertreated, and understudied population. Two-thirds of veterans and all but 1 family member had major depression comorbid with PTSD. More than half of patients were receiving stable pharmacotherapy, mostly antidepressant medication. Veterans were 80% male, 53% white, 20% African American, and 27% other, and 33% were married.

Dropout was higher for veterans (37%) than for family members (7%) (P = .03). CAPS-5 scores of veterans fell from 34.8 (9.7) at baseline to 20.2 (14.3) at 14 weeks, ie, from syndromal to subsyndromal, and to 18.9 (10.1) at 3-month follow-up. HDRS depression scores decreased from 14.6 (6.0) to 11.1 (7.4) to 9.4 (6.4) over these intervals. Family members demonstrated comparable improvement.[48]

This study explored separation anxiety and reflective function among patients with PTSD and found high rates (69%) of comorbid separation anxiety. Results suggested that in treating PTSD, IPT lowers rates of adult separation anxiety, and that repair of insecure attachment and affective dysregulation may be an IPT treatment mechanism.[68]

Comment. These 4 trials treating a total of 72 veterans hint that IPT may benefit veterans with PTSD, much as it does civilians. Dropout rates from these trials are higher than among civilians, as is unfortunately common for military veterans.[6] Overall, 61% were male (excepting the 15 women in the Krupnick et al[47] trial, 77% male). In most of these small trials, gains were maintained during 2- to 4-month follow-up. As open trials cannot demonstrate efficacy, the field has awaited a randomized clinical trial comparing IPT to exposure-focused treatment for military veterans. Thankfully, 2 have been in progress. Difede and colleagues at Cornell University Medical Center have begun an RCT comparing PE and IPT for veterans with PTSD due to military sexual trauma. Shea and colleagues[69] conducted a study comparing PE and IPT in VA hospitals. Its results have recently been published.

Shea et al[49] conducted the first controlled equivalence trial of IPT vs PE for veterans with PTSD at 2 VA hospitals. IPT followed an unpublished manual revised from Krupnick et al[47] adapting IPT for veterans. Military

veterans (N = 115) were randomized to 12 50-minute individual sessions of IPT (n = 61) or up to 12 90-minute sessions of PE (n = 54). Entry required *DSM-5* PTSD due to war zone trauma with a minimum CAPS-5 score of 23. Patients were 95% male, mean age 49 (SD = 16) years, and mostly (68%) reported Middle East war deployment. Roughly half (51%) of study patients had current and 77% reported lifetime major depression.

Attrition was 26% for IPT and 49% for PE. CAPS-5 scores declined in both treatments, from 36.3 (7.2) to 27.8 (9.8) in IPT and from 34.8 (7.4) to 28.2 (13.4) in PE (change scores −8.1 for IPT vs −5.5 for PE; NS). The between-group effect size of 0.26 favored IPT, as did CAPS-5 response rate (defined a priori as >10-point improvement), 50% vs 31% (both NS). Although pre/post CAPS-5 improvement achieved statistical significance, for most completers a considerable symptom burden persisted.[49]

The investigators' hypothesis that IPT would yield superior interpersonal and occupational functioning and quality of life was not borne out. Both treatments yielded comparably modest improvement on the Inventory of Interpersonal Problems.[42] Outcome did not statistically significantly differ between treatments at treatment termination or 3- or 6-month follow-up, during which gains persisted. The enrolled sample size was underpowered to formally demonstrate statistical equivalence, but had the authors tested a noninferiority rather than an equivalence hypothesis, they would have demonstrated noninferiority of IPT to PE (M. T. Shea, Ph.D., personal communication, October 23, 2023).

Thus, Shea and colleagues[68] replicated for military veterans the findings of Markowitz et al[21] for civilians with PTSD: IPT had lower dropout and no less overall benefit than the reputed "gold standard" treatment. Shea and colleagues have not yet evaluated potential moderators such as comorbid major depression or sexual trauma.[21,54] This study had limitations, including lower than intended recruitment, but nonetheless has landmark importance in showing IPT matched PE in treating veterans with PTSD.

The 61 patients in this trial bring the total number of military veterans treated with IPT to a meager N = 133, with attrition in the 5 reported trials ranging from 0% to 37%.

Overall, in RCTs with active comparator treatments (n = 3),[21,41,49] IPT attrition has had a 25% attrition rate (35/140), vs 39% for PE, RT, and sertraline (63/159) ($\chi^2 = 7.2248$, $P = .00719$).

DISCUSSION

IPT appears equipotent to the other active PTSD treatments to which it has thus far been compared, although the number and size of trials remain small. There have been no negative RCTs in adults. (Schaal and colleagues[22] found IPT less effective than narrative therapy in a small RCT of 26 teen and young adult Rwandan genocide orphans.) IPT has benefitted civilians and veterans with PTSD across a range of traumas, whether delivered in individual or group format. Still fragmentary data hint that IPT may have treatment advantages for patients with comorbid MDD, with which about half of patients who have PTSD present. This comorbid population is more difficult to treat and may feel too beleaguered to easily tolerate exposure therapies.[21,70–72]

Exposure therapy at least theoretically depends on the trauma having ended: that was then, this is now, and it is now safe to face trauma reminders. Ongoing domestic violence, for example, is frequently cited as a contraindication for exposure.[73] Does exposure therapy work for populations with high rates of PTSD who face continuing trauma, such as those caught in the current, ongoing wars in Ukraine and the Middle East? IPT, not reliant on exposure, might have advantages for such individuals.

One might theorize that exposure therapy would have greater effects on reexperiencing symptoms of PTSD (eg, flashbacks), whereas IPT might have greater social functioning benefits. In fact, studies to date have found no consistent theory-specific advantages in symptom clusters. Rather, it seems that improvement via any mechanism—exposure, pharmacotherapy, affect-focused therapy—brings generalized remoralization and symptom decline.[74]

This review is limited by the small number of extant studies to review. Its non–meta-analytic approach sacrifices precise estimation of effects across studies. More research is warranted. The US National Institute of Mental Health unfortunately no longer funds such clinical trials.[75,76] A large Dutch study led by van Dijk is underway that first randomizes individuals with PTSD to either PE or EMDR and then rerandomizes nonresponders from the first round of treatment to either the alternative exposure-focused therapy or IPT. We anticipate that IPT will do well treating patients with prospectively tested exposure-nonresponsive PTSD.

Each reviewed study used manualized treatment, the PTSD manuals sometimes differing slightly but all deriving from the basic IPT template.[8] Similarly, there was some variation in the number of sessions, ranging from 12 to 14 weekly individual sessions of 50–60 minutes and from 8 to 16 2-hour group sessions. Notwithstanding these differences, findings largely converge. Multiple independent research teams have now conducted randomized trials with positive results for IPT, fulfilling the criteria for efficacy. Despite limitations, the cumulative IPT findings have widespread clinical implications. The field has now moved past the question of whether IPT works for PTSD to convincing evidence that it does, at least matching PE in civilian and veteran populations, with some possible advantages. IPT also had

comparable outcomes to an SSRI for acutely traumatized civilian women. The parity of IPT with other first-line interventions reshapes the terrain of PTSD treatment, offering an important nonexposure alternative. Other affect-focused, nonexposure therapies may also treat PTSD: present-centered therapy[5] shows promise, as does a time-limited psychodynamic approach.[77]

For years, exposure was considered the *sine qua non* of PTSD psychotherapy. Exposure clearly works and remains by far the best tested approach to PTSD, but not all patients[20] or therapists want to do it. For patients, it means facing their greatest fears, a challenge that comorbid depression may compound.[21] An ambitious rollout of PE and Cognitive Processing Therapy training throughout the VA system met with little uptake, indicating limits to its appeal.[6,78–81]

The VA treatment guidelines have vacillated on IPT. Those from 2017 weakly recommended it, despite the absence of much data on IPT for military patients. The latest guidelines, from 2023, have stricken that recommendation,[82] partly based on the mistaken claim that "no studies of IPT included the critical outcome of clinician-reported PTSD."[82(p53)] The growing evidence from civilian trials, not to mention the recent Shea et al study,[68] challenges that decision. The VA and other guidelines should consider recommending IPT for PTSD and might even consider training clinicians in IPT for PTSD as a better tolerated alternative, as we found treating veterans in a non-VA setting.[48,83] Moreover, patients in the community now may seek an evidence-based, affect-focused[12] therapy to relieve PTSD as an alternative to exposure therapy.

Article Information

Published Online: May 29, 2024. https://doi.org/10.4088/JCP.23nr15172

Submitted: November 7, 2023; accepted January 3, 2024.

To Cite: Markowitz JC. Interpersonal psychotherapy for posttraumatic stress disorder: a critical review of the evidence. *J Clin Psychiatry*. 2024;85(2):23nr15172.

Author Affiliation: Columbia University Vagelos College of Physicians and Surgeons, New York State Psychiatric Institute, New York, New York.

Corresponding Author: John C. Markowitz, MD, Columbia University Vagelos College of Physicians and Surgeons, NYS Psychiatric Institute, 1051 Riverside Drive, Unit #129, New York, NY 10032 (Jcm42@cumc.columbia.edu).

Relevant Financial Relationships: Dr Markowitz receives salary support from the New York State Psychiatric Institute, the National Institute of Mental Health, and the David Lynch Foundation; consultation fees from the Department of Defense; and minor book royalties from American Psychiatric Publishing, Basic Books, and Oxford University Press.

Funding/Support: None.

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