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COGNITIVE INTERPERSONAL THERAPY FOR TRAUMA

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Definition: Therapy to help patients identify emotional and cognitive factors underlying trauma, modify irrational negative thoughts that may increase trauma-related stress, and engage in social relationships.

Elements: *Identify trauma-related emotional and cognitive factors:* Initial sessions focus on current situations at work, home and socially and on what the patient copes with well. The therapist empowers the patient by pointing out good coping examples and aiding goal setting to give a sense of direction, safety and trust, awareness of transference/countertransference issues, and by encouraging self-reflection, communication of ideas and feelings in a safe environment, and expression of feelings associated with the trauma e.g. loneliness, fear, sadness, abandonment. Patients are helped to regard these as now-outdated reactions that hamper everyday functioning e.g. identify anger underlying a current sense of abandonment, and to explore new coping styles that may better deal with present situations e.g. organise outdoor activities vs. being indoors, go for walks, talk to people in a local cafe.
Modify irrational thoughts: Explain how irrational and/or negative thoughts can affect how we feel. Focus on thoughts that are stressful or relate to the trauma. If the patient worries that a particular person thinks s/he is unworthy, challenge this by asking how s/he arrived at that thought and for suggestions of more realistic positive thoughts e.g. *"has X… said that to you face-to-face?"* or *"can you mind read?"* or *"does X often talk about others in the same way?"*. Homework activities can include writing a diary of irrational and/or negative thoughts and next to those, more realistic alternatives. Relaxation can be taught to aid stress management.
Engage in social relationships: Explore patients' current relationships in terms of respect, needs being met, opportunities for self-growth, acceptance, safety, etc. Help patients to identify patterns of relating that may stem from reactions to traumas (e.g. fear of abandonment, constant need for attention and love and to please others), explore alternative responses e.g. communication skills to resume past contacts and establish new social relationships, and joint goal setting on how and when to make such contacts.

Related procedures: cognitive-behaviour therapy; cognitive restructuring; homework, interpersonal therapy; problem solving; relaxation; stress management; writing therapy.

Application: Anxiety, PTSD, anger management; eating disorders; depression; sexual offences; recovery and relapse prevention for psychosis.

1st use? `Interpersonal therapy' described by Klerman et al (1974)

References:
1. Gumley A, Schwannauer M (2008) *Staying Well after Psychosis: a Cognitive Interpersonal Approach to Recovery and Relapse Prevention*. John Wiley & Sons, West Sussex, England.
2. Klerman GL, Dimascio A, Weissman M, Prusoff B, Paykel E (1974) Treatment of depression by drugs and psychotherapy. *Amer J Psychiat* 131:186-191.

3. Kubetin Koch S (2002) Cognitive interpersonal therapy helps resolve anger. *Clinical Psychiatry News*, Baltimore.
4. Wessler R (1993) Cognitive psychotherapy approaches for personality disorders. *Psicologia Conductual* 1, 35-48.

Case illustration (Morrow, unpublished)

Gina, a 43 year old massage therapist, came for help with severe anxiety, panic and PTSD as a result of bullying in her last job. From an early age Gina had been abused by both parents, especially her mother, physically, psychologically, and emotionally. During sessions 1-4 she was encouraged to identify and name feelings connected with her trauma such as loneliness, abandonment and rejection, and to reflect on how those were affecting her present relationships and thoughts. This identification and naming of each emotion evoked memories e.g. being pulled out of bed one night and yelled at that she was filthy with oily hair and slapped for no apparent reason. These needed to be challenged and changed e.g. being ugly, filthy, a shame for the family were altered to: *`you're different and nice in your own way', `you did nothing to shame your family'*. Many sessions focused on transforming negative non-productive thinking patterns into more positive effective ones. Gina had to write a list of negative thoughts and re-write them, e.g. "you're good for nothing", "no one will put up with you", "you're ugly and filthy", were changed to *"you're good at work and can hold a job", "you have friends and people you know who care for you", "we all look unique"*. In later sessions she evaluated her past intimate relationships and whether her reactions and feelings were influenced by her past abuse. She did a 'wants vs. needs' analysis: need for security, affection and respect vs. wanting a boyfriend, having a good time with friends, and finding a job. She also explored what she wanted in future friendships and intimate relationships. Some sessions focused on styles of communication and how to get a message across, attend to body language, tone of voice, 'I' statements, etc.

Her reaction to being bullied at work was explored in terms of her childhood reactions; she was helped to respond more assertively and maturely by expressing her ideas and feelings in different situations and with different people. Her poor self-esteem relating to her childhood need for affection and acknowledgement was discussed and challenged to enable her to react to current situations more effectively. Her anxiety started to diminish around session 16 and she improved overall. Gina became able to identify thoughts and feelings from her childhood and to challenge and modify them if necessary. She attended 24 sessions over 18 months. Follow-up sessions were scheduled.