

Contributions of Psychodynamic Approaches to Treatment of PTSD and Trauma: A Review of the Empirical Treatment and Psychopathology Literature

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Reviews of currently empirically supported treatments for post-traumatic stress disorder (PTSD) show that despite their efficacy for many patients, these treatments have high nonresponse and dropout rates. This article develops arguments for the value of psychodynamic approaches for PTSD, based on a review of the empirical psychopathology and treatment literature. Psychodynamic approaches may help address crucial areas in the clinical presentation of PTSD and the sequelae of trauma that are not targeted by currently empirically supported treatments. They may be particularly helpful when treating complex PTSD. Empirical and clinical evidence suggests that psychodynamic approaches may result in improved self-esteem, increased ability to resolve reactions to trauma through improved reflective functioning, increased reliance on mature defenses with concomitant decreased reliance on immature defenses, the internalization of more secure working models of relationships, and improved social functioning. Additionally, psychodynamic psychotherapy tends to result in continued improvement after treatment ends. Additional empirical studies of psychodynamic psychotherapy for PTSD are needed, including randomized controlled outcome studies.

Many reviews of evidence-based treatments (e.g., Roth & Fonagy, 2005), list cognitive-behavior therapy (CBT) and eye movement desensitization and reprocessing (EMDR; Shapiro, 2001) as the empirically supported treatments for post-traumatic stress disorder (PTSD). While substantial empirical evidence supports these therapies,

both CBT and EMDR for PTSD have high nonresponse or dropout rates (Schottenbauer, Glass, Arnkoff, Tendick, & Gray, in press), indicating that additional interventions are needed. One possibility is psychodynamic psychotherapy, which provides alternate explanations of symptoms and methods for intervention.

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Psychodynamic psychotherapy is based on a number of concepts, beginning with the original contributions of Sigmund Freud and including various newer theories such as object relations and self-psychology (St. Clair, 2000). There is limited but growing empirical evidence for the efficacy of psychodynamic therapy, both generally (e.g., Doidge, 1997; Miller, Luborsky, Barber, & Docherty, 1993), and in treating PTSD (Brom, Kleber, & Defares, 1989). One randomized controlled trial showed that brief psychodynamic psychotherapy may be as effective as systematic desensitization for symptoms of PTSD, with a secondary benefit of addressing various personality traits (Brom et al., 1989). Another study showed that group interpersonal psychotherapy for women with PTSD resulted in significantly more improvement than a waiting-list control group (Krupnick, Green, Miranda, & Stockton, 2005). Overall, there is a growing body of literature that shows psychodynamic psychotherapy is efficacious for specific problems, psychological symptoms, and social functioning (for a recent meta-analysis, see Leichsenring, Rabung, & Leibing, 2004). Yet more research is needed, particularly with regard to PTSD, since psychodynamic psychotherapy for PTSD is widely used but understudied.

Potential contributions of psychodynamic theory and practice to the treatment of persons with PTSD include addressing developmental, interpersonal, or intrapersonal issues that are related to PTSD, and more generally, the sequelae of trauma (American Psychiatric Association, 2004). In particular, psychodynamic therapy may be more adept at addressing the constellation of symptoms described as “complex” PTSD by Herman (1997). The current article reviews empirical studies that lend support for psychodynamic approaches to PTSD. First, we discuss the distinction between “simple” and “complex” PTSD made by Herman (1997). Then, we consider a number of theoretical points relevant to simple and complex PTSD, including interpersonal problems, developmental issues, personality, and comorbid disorders; within our discussion of each of

these areas, we consider the relevance of those issues for psychodynamic psychotherapy for PTSD.

VARIATIONS OF PTSD: “SIMPLE” AND “COMPLEX”

Determining the best intervention for a particular psychological disorder often depends on an understanding of its etiology. Herman (1992, 1997) distinguishes two types of trauma, “simple” and “complex.” She describes simple trauma as one discrete traumatic event, which can result in PTSD as defined in the DSM-IV-TR (American Psychiatric Association, 2000). Complex trauma, however, is the experience of prolonged, repeated trauma, such as would be encountered as a prisoner of war or as a child in an abusive family. Herman proposes that the psychological effect of the traumatic experience will depend on a number of variables, including the temporal extent of the trauma, prolonged or repeated versus single, the strength of trauma, and the level of adjustment of the individual prior to the trauma. Symptoms associated with complex PTSD can include difficulties with social and interpersonal functioning, occupational functioning, and overall adjustment, as well as comorbid Axis I disorders, such as depression and anxiety, and comorbid personality disorders, such as borderline personality disorder. Research supports the hypothesis that there are significant differences in mental health between persons who experienced one-time trauma and those with cumulative histories of trauma (Krupnick et al., 2004; Zlotnick et al., 1996).

Using the distinction between simple and complex trauma developed by Herman (1997), we discuss the current state of the literature on treatment for PTSD and the potential contributions of psychodynamic psychotherapy for treatment of PTSD.

Simple PTSD

PTSD, as defined in the DSM-IV-TR (APA, 2000), consists of a constellation of

symptoms, including re-experiencing, avoidance and numbing, and increased arousal, lasting more than one month after exposure to a traumatic event, and causing significant disturbance in daily functioning. Empirically supported psychotherapies for PTSD, including exposure, CBT, and EMDR, are typically focused on the symptoms related to a particular trauma and are thus conceptually and technically adequate to address the symptoms of simple PTSD, or PTSD as defined in the DSM-IV-TR. Indeed, considerable evidence has been amassed to suggest that these treatments result in improvement among many survivors of trauma (e.g., Bradley, Greene, Russ, Dutra, & Westen, 2005; Roth & Fonagy, 2005). All the same, a review of published studies revealed a large nonresponse rate for CBT and EMDR for PTSD (Schottenbauer et al., 2005). One might understand this phenomenon as having many possible causes. One possible reason is that not everyone with simple PTSD responds to or completes CBT or EMDR, due to various factors that may be related to that individual, the treatment, the therapist, or interactions among any of these three (Schottenbauer et al., in press). Another possibility is that persons with comorbid disorders or complex PTSD may not respond to CBT or EMDR because not all of their associated symptoms are addressed by these treatments. Many clinicians currently believe that psychodynamic psychotherapy is better able to address the complications of complex trauma, especially with regard to interpersonal functioning, than cognitive and behavioral treatments (APA, 2004).

Several short-term psychodynamic treatments for PTSD have been developed. (A complete history of psychodynamic and psychoanalytic treatments for PTSD is recounted elsewhere, e.g., Bohleber, 2001; Boulanger, 2002). We discuss a model developed by Horowitz (1997) and Krupnick (2002) first, along with empirical support for the treatment, and we then describe a separate treatment developed by Lindy (1993), as well as relevant empirical support for that model.

Horowitz (1997) and Krupnick (2002) provide a 12-session treatment model of psy-

chotherapy for PTSD after a single traumatic event. Important elements of the treatment include bringing conflicts into conscious awareness, use of the therapeutic relationship, and analysis of defenses the person uses to keep wishes, feelings, and impulses from awareness. The treatment also focuses on the trauma and includes intrapersonal and interpersonal themes relevant to trauma. For instance, links are made among feelings and thoughts about the trauma and the relationships, models of relationship, and self-concept that the person had prior to the trauma. The model has three stages: (1) developing working alliance and letting the person tell his or her story, (2) "working through," and (3) focusing on loss related to trauma and loss of therapy. The treatment also includes educating the client about the effects of trauma, and providing support.

A randomized controlled trial (Brom et al., 1989) compared a short-term psychodynamic treatment based on an earlier version of Horowitz's (1997) work (Horowitz, 1976) to systematic desensitization and hypnotherapy. Patients in the study met criteria for PTSD as a result of experiencing various traumas, many involving loss. Brom et al. (1989) found that 60% of patients in each group (psychodynamic, systematic desensitization, and hypnotherapy), improved. They found that psychodynamic psychotherapy resulted in greater reduction of avoidance symptoms while systematic desensitization and hypnotherapy resulted in greater reduction in intrusion symptoms. Immediately post-treatment, participants in the psychodynamic psychotherapy group showed less improvement than the other groups, but by follow-up they had improved to the same level as participants in the other groups. This finding implies that psychodynamic psychotherapy may work more slowly than other treatments, but it establishes a residual process that continues to work after treatment ends.

Krupnick (1980) conducted an uncontrolled study on a small sample of victims of violent crime who were given 12 sessions of the brief psychodynamic psychotherapy de-

scribed above. Of 18 offered treatment, 11% refused; of those who commenced treatment, there was a 13% dropout rate. Of 10 patients who completed the follow-up assessment, 8 had completed treatment, one had dropped out after 8 sessions, and one had refused treatment. Among completers, 87.5% had good outcome and 12.5% had fair outcome. The other two patients who had not completed the treatment but had participated in a follow-up assessment both had poor outcome. Those with good outcome showed some characterological change, increased control over thoughts, feelings, and ability to communicate feelings, as well as complete or almost complete remission of PTSD symptoms. The patient with fair outcome showed improved awareness of feelings and ability for action, but tended to displace anger and fear. Those with poor outcome consisted of one person who dropped out of treatment and one who had refused treatment. The one who dropped out of treatment had been resistant to discussing her family dynamics.

A second model of short-term psychoanalytically informed psychotherapy for PTSD was developed by Lindy (1993), who also proposed a three-stage model. The first stage focuses on developing a working alliance strong enough to allow the patient to shed his or her defense against confronting the feelings and memories associated with the traumatic event. The second stage is characterized by interventions aimed at understanding and working through the defenses, feelings, and memories associated with a specific traumatic event. This leads to the third stage, during which the patient restructures the memory of the event through a mourning-like process in which the trauma is endowed with a specific place and meaning in the life history of the individual, making for continuity and age-appropriate adaptive functioning.

Lindy, Green, Grace, MacLeod, and Spitz (1988) conducted an uncontrolled study of this treatment with Vietnam combat veterans. The treatment focused on dealing with traumatic memories instead of repressing them. There was 30% dropout, with 23 completers over an average duration of 56 ses-

sions. Significant changes were noted in a number of areas, including intrusive phenomena, feelings of alienation and depression, hostility, and substance abuse. Clinical ratings showed no patients were at "normal levels." Noted improvement was made in their increased capacity to trust and manage traumatic stress, as well as to feel appreciation of being alive, greater personal integrity, less estrangement, more investment in adult roles and constructive activities, and continuity with sense of self before the war.

The models provided by Lindy (1993) and Horowitz (1997) are short-term psychotherapy and are intended primarily for individuals who had functioned relatively well prior to a single traumatic event. In addition to these studies, numerous case studies and uncontrolled studies without systematic outcome measures support the use of psychodynamic treatment for PTSD (for a review, see Kudler, Blank, & Krupnick, 2000). Patients with more substantial histories of trauma or with complicating factors may require more sessions or a qualitatively different treatment. The relevance of psychodynamic psychotherapy for these patients is discussed below in the context of complex trauma.

Complex PTSD

Cases of "complex PTSD" (Herman, 1997) occur when the patient has experienced multiple traumas, or trauma over an extended period of time, which cumulatively have an extensive impact on functioning and often personality (Khan & Masud, 1963). Examples of complex trauma include experience of prolonged childhood abuse, abduction, or being a prisoner of war (Herman, 1997). Complex PTSD is often associated with difficulties in social and interpersonal functioning, occupational functioning, and overall adjustment, as well as comorbid Axis I disorders, such as depression and anxiety, and comorbid personality disorders, such as borderline personality disorder. Because of the far-reaching implications of complex trauma for an individual, many believe that psychodynamic psychotherapy may be more effective for com-

plicated types of PTSD, complex PTSD, and the broader interpersonal sequelae of trauma (e.g., APA, 2004; Harvey & Harney, 1997). Since psychodynamic psychotherapy can target basic underlying personality factors that complicate adaptation to or are the result of trauma, psychodynamic psychotherapy is thought to be especially helpful for patients with PTSD and an insecure attachment style or comorbid personality disorder, or those who have experienced prolonged exposure to trauma (Plakun & Shapiro, 2000).

The next section presents empirical studies that lend support into why and how psychodynamic psychotherapy may be particularly beneficial for problems commonly related to PTSD. While some issues presented here are consistent with a DSM-IV-TR definition of PTSD, we also include concepts relevant to the broader subject of complex PTSD. These issues may apply to either simple or complex PTSD, or both, but are discussed together because the research literature does not clearly make distinctions between these categories. Topics covered include interpersonal problems, self-concept, personality, and comorbidity. In each section, conceptual issues are presented first, followed by a discussion of implications for psychodynamic psychotherapy.

INTERPERSONAL PROBLEMS

Theoretical Issues

Interpersonal problems, relating to interpersonal skills, relationship quality, interconnectedness, social support, interpersonal withdrawal, are commonly found among people with PTSD (Okey, McWhirter, & Delaney, 2000). One study found that rates of divorce and marital or relationship problems among those with PTSD were twice that of those without PTSD (Kulka et al., 1988). Lack of social support was found to be associated with increased PTSD symptomatology in veterans both 1 and 2 years after a war (Solomon & Mikulincer, 1990). Okey and colleagues (2000) utilized the core conflictual relation-

ship theme (CCRT) method, an empirical measure of transference, to understand better the relationship problems of veterans with PTSD. They found a core relationship pattern characterized by wishing to be close and accepted, which tended to be thwarted, leading to feeling rejected and being opposed by other people. In response, veterans felt disappointed, depressed, and confrontational, and inclined to lash out at other people. Relationship patterns found among a sample of depressed individuals were much more varied than the ones among veterans with PTSD.

A variety of authors have theorized that interpersonal support during captivity (e.g., prisoner of war status) increases ability to cope with the stress of captivity (Dieperink, Leskela, Thuras, & Engdahl, 2001). While social support has been shown in numerous studies to help reduce stress and improve mental health, traumatized patients may not have appropriate social connections, nor may they be able to use them effectively. Patients' distress may overwhelm those in the social support network and result in rejection. Those with personality disorders may encounter additional complications. Interpersonal problems have been found to be a risk factor for revictimization (Classen, Field, Koopman, Nevill-Manning, & Spiegel, 2001). Indeed, harmful interpersonal interactions can themselves result in PTSD; for instance, emotional, physical and sexual abuse can be thought of as interpersonal traumas. Both repeated trauma from any source and interpersonal trauma specifically are more likely to result in PTSD symptoms than is either a single or non-interpersonal trauma (Green et al., 2000), highlighting the potential harm of some interpersonal relationships.

Clearly, healthy interpersonal relationships are important for ameliorating PTSD; however, not every individual has the ability to form such relationships. One way of understanding the capacity for healthy relationships is through attachment theory, which is also particularly relevant to psychodynamic psychotherapy for PTSD. Attachment theory is built on the notion that early relationships with adults contribute to the formation of "in-

ner resources” for dealing with stress and lifelong patterns of relating to other people (Mikulincer & Florian, 1998). Secure attachment has been conceived by some as a set of expectations that other people will be available, dependable, and trustworthy, and it is associated with a more optimistic, resilient outlook, healthier coping methods, and greater capacity for dealing with stress. Ambivalent attachment is associated with both a longing for relationships and a fear of abandonment; persons with this attachment style may react to stress with cognitive exaggerations, less adaptive coping styles, and strong negative affect. Avoidant attachment consists of a basic mistrust of others, accompanied by withdrawal, less helpful coping attempts, and internalized distress related to exaggerated self-reliance (Mikulincer & Florian, 1998). Insecure attachment has been found to be related to psychiatric disorders, such as alcohol abuse and eating disorders (Brennan, Shaver, & Tobey, 1991).

A variety of studies suggest that secure attachment acts as a buffer for PTSD after traumatic events. Individuals with secure attachment tend to have fewer PTSD symptoms, while individuals with a subtype of ambivalent attachment tend to have more (Mikulincer, Florian, & Weller, 1993; Mikulincer, Horesh, Eilati, & Kotler, 1999). Avoidant attachment appears to be related to a mixture of PTSD symptoms (lower anxiety and depression but higher hostility and avoidance; Mikulincer et al., 1993), which are more likely to appear when the individual is exposed to a high-threat environment (Mikulincer et al., 1999).

Three studies have examined attachment and PTSD among prisoners of war and combat veterans. In general, they found that secure attachment was related to fewer present and past PTSD symptoms and better adjustment (Solomon, Ginzburg, Mikulincer, Neria, & Ohry, 1998; Zakin, Solomon, & Neria, 2003), whereas anxious and avoidant attachment were related to more short- and long-term distress (Solomon et al., 1998), and insecure attachment was the strongest predictor of all PTSD symptoms (re-experiencing,

avoidance, and hypervigilance; Dieperink et al., 2001).

Some hypothesize that insecure attachment may be a result of traumatic experiences in childhood (Allen, 2001). While this conjecture is supported by some research (for a review, see Allen, 2001), it is likely that insecure attachment is the outcome of family dynamics more than of the experience of physical or sexual abuse (Alexander, 1993). Prospective studies have shown that parental attachment styles before birth of a child predict later infant attachment (Fonagy, Steele, & Steele, 1991; Steele, Steele, & Fonagy, 1996). Intrafamilial childhood sexual abuse, but not extrafamilial abuse, has been linked to insecure attachment; in turn, secure attachment appears to mitigate the adverse impact of abuse on later psychological functioning (Roche, Runtz, & Hunter, 1999). Alexander (1993) found that while age of onset of the childhood abuse and other characteristics of the severity of the abuse predicted classical PTSD symptomatology in adults, insecure attachment also predicted some PTSD symptoms. The latter finding has been supported by a prospective study of attachment style and trauma in adults that showed that pre-existing attachment style affects the way in which people cope with trauma (Mikulincer & Florian, 1995). Increasing security of attachment may help patients with PTSD improve the quality and stability of social networks, thereby allowing them to cope better with the trauma (Allen et al., 2001).

Implications for Psychodynamic Psychotherapy

Psychodynamic psychotherapy, unlike CBT or EMDR, focuses on the interpersonal relationships of the client, including the relationship with the therapist. Specifically, it uses the relationship between the therapist and the client to help the client develop insight into his or her interpersonal patterns, by making interpretations that link the therapy relationship to relationships in the client’s childhood and everyday life (Perakyla, 2004). Through experiencing and reflecting on the therapy re-

lationship, clients may develop and maintain healthier models of interpersonal interaction (Frederickson, 1999; Moreno et al., 2005) and the ability to be more flexible in the use of interpersonal patterns (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004). Indeed, one of psychodynamic psychotherapy's most-cited benefits for persons with PTSD is its potential to facilitate remediation of interpersonal problems associated with PTSD (APA, 2004; Plakun & Shapiro, 2000). Two studies of psychodynamic psychotherapy for PTSD noted improvement in interpersonal functioning following treatment, including decreased social inadequacy, agoraphobia, and hostility (Brom et al., 1989) and increased confidence and assertiveness (Krupnick, 1980).

The results of one study suggest that dealing with interpersonal problems promotes remission of PTSD symptoms. This pilot study randomized low-income women with PTSD to group interpersonal therapy or a waiting-list control, and found significant improvement in PTSD symptoms among the women who received the interpersonal treatment (Krupnick, 2002). The treatment was a variant of psychodynamic psychotherapy based on Yalom's (1995) group interpersonal psychotherapy and a different form of interpersonal therapy by Klerman, Weissman, Rounsaville, and Chevron (1984).

Another relevant psychodynamic approach is Control Mastery Theory (CMT), which was derived from psychoanalytic ego psychology. It emphasizes the centrality of the therapeutic relationship in facilitating patients' inherent unconscious capacity to solve problems (Weiss, 1993). CMT posits that patients come to therapy with pathogenic beliefs, often about past traumatic events; and their effort to disconfirm these beliefs motivates their participation in therapy and shapes what they will do in their particular treatment. Specifically, they will engage in one or more tests of the therapist to find evidence for or against their maladaptive grim beliefs. Research supports the notion that therapy is most effective when it disconfirms patients' pathogenic beliefs within the relationship

with the therapist (Curtis, Silberschatz, Sampson, & Weiss, 1994). Disconfirmation can take place through several mechanisms, notably the therapist's steadfast neutral attitude, the therapist passing the tests posed by the patient, and, eventually, interpretation of the unconscious beliefs. Research shows that psychodynamic interpretations that accurately reflect a patient's unconscious beliefs are related to significant improvement at termination and follow-up (Norville, Sampson, & Weiss, 1996).

CMT is a helpful theory for conceptualizing psychodynamic psychotherapy with patients who have PTSD. As discussed previously, patients with PTSD often have difficulty trusting other people and developing effective interpersonal relationships, such as the veterans in the study conducted by Okey et al. (2000) who longed for closeness while fearing rejection, and who tended to lash out at others as a result. Psychodynamic psychotherapy offers these patients a chance to develop awareness of their interpersonal patterns, experience a different type of relationship, and make important changes in their interpersonal functioning.

The therapeutic alliance, or working relationship between the therapist and patient, is both impacted by the patients' interpersonal problems and a means for ameliorating those interpersonal problems (Luborsky & Luborsky, 2006). Development and maintenance of the therapeutic alliance is central to psychodynamic psychotherapy (Luborsky & Luborsky, 2006) and has been shown to be highly predictive of outcome in psychotherapy, even above and beyond other variables (Luborsky & Luborsky, 2006; Zuroff & Blatt, 2006). Yet, little research has been conducted on the therapeutic alliance in psychotherapy for PTSD, largely because the therapeutic alliance is not an overt or emphasized component of cognitive-behavioral approaches to PTSD, which have been the treatments predominantly studied in outcome research to date.

The research on attachment theory discussed previously also has important implications for psychodynamic psychotherapy with

PTSD. Research evidence increasingly supports the notion that taking attachment style into account when conducting psychotherapy may improve the chances of successful treatment (Meyer & Pilkonis, 2002). Persons with insecure attachment find it difficult to utilize relationships as a source of emotion regulation, which complicates their efforts to cope after traumatization (Allen, 2001; Allen et al., 2001). Dieperink and colleagues (2001) caution that it is important to differentiate symptoms related to trauma from those inherent in the individual's attachment style and to focus on interventions that may improve the working alliance of individuals who have insecure attachment. Attachment style has been shown to relate to the quality of the therapeutic alliance (Diamond, Stovall-McClough, Clarkin, & Levy, 2003) and the outcome of psychotherapy (Fonagy et al., 1996). Attachment style may have important implications for treatment matching, for example, determining which patients perform better in certain types of treatments (Tasca et al., 2006).

With regard to attachment, research on psychodynamic psychotherapy has shown that client attachment style changes through therapy. Specifically, this research has shown a shift from insecure to secure attachment states of mind, and from less secure (e.g., unresolved or insecure) to more secure (e.g., cannot classify or mixed) attachment states of mind on the Adult Attachment Interview after object-relational psychotherapy (Diamond et al., 1999; Diamond, Clarkin, et al., 2003; Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Levy, Clarkin, & Kernberg, 2004). This finding is notable, since most studies have found attachment to be relatively stable over time (e.g. Levy, Blatt, & Shaver, 1998; Main, Kaplan, & Cassidy, 1985).

DEVELOPMENTAL ISSUES

Theoretical Issues

There is a reciprocal relationship between trauma and development. On one hand, developmental issues influence an indi-

vidual's response to trauma; on the other hand, experiencing trauma can result in problems in development. Research shows that previous exposure to trauma is related to a greater likelihood of developing PTSD symptoms after a recent traumatic event (Breslau, Chilcoat, Kessler, & Davis, 1999). A 30-year study of the longitudinal effect of trauma found that multiple traumas (a minimum of two, acute or ongoing) before the age of 18 were significantly related to greater psychiatric impairment as adults. Moreover, while better maternal care in infancy was related to a higher level of defensive functioning as an adult, the presence of multiple traumas overrode any advantage that these children had, suppressing overall global functioning at age 30 for children with both adequate and deficient maternal care (Massie & Szajnberg, 2002). Sameroff, Seifer, and Zax (1982) found that children with early emotional advantages had a tendency to be able to endure only a limited amount of trauma before their functioning declined due to stress.

In a comprehensive review of the literature on attachment, stress physiology, trauma, and neuroscience, Schore (2002) found evidence that disorganized-disoriented, insecure attachment in abused infants is related to an inability to process interpersonal stressors. This results in dysfunctional defenses imprinted in brain function and a predisposition towards developing mental disorders such as PTSD. Bremner, Southwick, Johnson, Yehuda, and Charney (1993) and Zaidi and Foy (1994) found relationships between early physical abuse and PTSD among veterans. In particular, persons who tend to be involved in multiple traumatic events had significantly more interpersonal problems than those who suffer only a single trauma (Classen et al., 2001).

Implications for Psychodynamic Psychotherapy

A goal of psychodynamic psychotherapy is to understand the links between childhood trauma and problems of adjustment in adult life (McWilliams, 1994). Psychodynamic

clinicians assume that by processing past traumas and developing insight, including the ability to self-analyze defensive functions, these psychotherapies help patients strengthen their ability to cope with life stressors and become more resilient to future stressors. Levy and colleagues (2004) found that state of mind with respect to trauma, coded from the Adult Attachment Interview, can be resolved over the course of therapy. A large-scale longitudinal study found that psychoanalysis and psychodynamic psychotherapy were associated with improvements in functioning not only during therapy, but also for years after the end of treatment as indicated by continuing decreases in symptoms (Blomberg, Lazar, & Sandell, 2001; Sandell et al., 2000). This finding suggests that psychodynamic/ psychoanalytic psychotherapy may be related to changes within the person that allow continuation of improvement after treatment has ended. Likewise, Brom and colleagues (1989) found that persons who received brief psychodynamic psychotherapy for PTSD continued to improve after treatment had ended.

There is also some evidence that psychodynamic psychotherapy may be a preferred treatment for individuals with certain personality characteristics. Research on matching treatments to patient characteristics has found that individuals high in reactance, a tendency not to want to follow directions from others, tend to do better in non-directive therapies, while individuals low in reactance tend to have better outcome in directive therapies such as CBT (for a review, see Beutler, Consoli, & Lane, 2005).

PERSONALITY

Three specific areas of psychoanalytic theory related to personality will be discussed next. These include psychological defenses, self-concept, and reflective functioning.

Psychological Defenses

Theoretical issues. Defense mechanisms are particularly relevant to processing

traumatic experiences. Defenses are psychological means of dealing with wishes, needs, affects, or impulses that the individual experiences as unpleasant or inappropriate (Paulhus, Fridhandler, & Hayes, 1997; Perry & Cooper, 1986); they may be viewed as mechanisms for maintaining psychological homeostasis (Vaillant, 1992). Some defenses have been shown to be more adaptive than others (Offer, Lavie, Gothelf, & Apter, 2000).

Psychodynamic theory posits that defenses evolve in the course of an individual's psychosocial development. Defense mechanisms and life phases are mutually related. The concept of a hierarchy of defenses corresponding to different levels of maturation has empirical support (APA, 2000; Vaillant, 1992), and it has been associated with interpersonal relationship patterns (de Roten, Drapeau, Stigler, & Despland, 2004). Immature and neurotic defenses have been found to be related to psychopathology, less adjustment, and psychological problems (Kneepkens & Oakley, 1996; Paulhus et al., 1997; Perry & Hoglend, 1998; Steiner & Feldman, 1995).

Negative life circumstances such as trauma can disturb the healthy evolution of defenses, and life stress can reduce the ability to use mature defenses when coping with stress (Vaillant, 1971). Punamäki, Kanninen, Qouta, and El-Sarraj (2002) examined the role of psychological defenses in moderating trauma and psychological consequences of trauma. They found that Palestinian men who had been tortured were more likely to have PTSD symptoms of vigilance, avoidance, and intrusion if they used consciousness-limiting defenses. High levels of torture were significantly related to lower use of mature defenses; however, high levels of torture were not significantly related to use of immature defenses. Immature reality-distorting and immature reality-escaping defenses were associated with high incidence of PTSD symptoms, while mature defenses were associated with low levels of PTSD symptoms. This suggests that while victims with premorbid access to higher-level defenses may be better able to cope with trauma and therefore exhibit fewer symptoms

than patients who typically rely on lower-level defenses, trauma may itself weaken an individual's ability to use higher-level defenses. One other study, however, found no differences in use of mature and immature defense mechanisms between trauma victims with and without PTSD (Birmes et al., 2000).

The defense known as dissociation is linked closely with PTSD (Brenner, 2001). Dissociation as a coping mechanism includes emotional numbing, denial, forgetting, social withdrawal, and freezing; while it may be adaptive in the short-term, it is related to negative outcome in the long term (for a review, see Krenichyn, Saegert, & Evans, 2001). Engelhard, van den Hout, Kindt, Arntz, and Schouten (2003) found that dissociation during a stressful event (pregnancy loss) was related to acute PTSD symptoms, and that this was mediated by self-reported memory fragmentation and thought suppression. Dissociation during the event also was predicted by prior low control over emotions, dissociative tendencies, and less education. A study of Vietnam veterans found that those with PTSD had higher dissociative symptoms than those without PTSD; the level was similar to those with dissociative disorders (Bremner, Steinberg, Southwick, Johnson, & Charney, 1993). In contrast, a clinical study found that the capacity selectively to use dissociation and splitting to adapt to combat conditions, even to the extent of developing a second personality, was associated with lower residual PTSD symptoms in war veterans (Goderez, 1987).

Dissociation can be used to manage strong affect, and it may take many forms, including avoidance of interpersonal relationships and use of alcohol and drugs (LaCoursiere, Godfrey, & Ruby, 1980). Nightmares, which are frequently found in patients with PTSD, can also have dissociative qualities. Up to 67% of samples with PTSD report nightmares, and some may persist for 20 years after combat (for a review, see van der Kolk, Blitz, Burr, Sherry, & Hartmann, 1984). One study found that nightmares related to PTSD have physiological characteristics that are different from those of lifelong

nightmares, suggesting that they contain dissociated affects related to the trauma (van der Kolk et al., 1984). Dissociation, numbing, and avoidance can all be long-term effects of trauma (Honig, Grace, Lindy, Newman, & Titchener, 1999; Terr, 1991).

Implications for psychodynamic psychotherapy. Psychodynamic psychotherapy targets maladaptive defenses through defense analysis (McWilliams, 1994). It may therefore be specifically able to address this aspect of adaptation to trauma. Typical psychodynamic practice includes interpreting not only defense mechanisms, but also warded-off wishes and fears; this combination of wish, fear, and defense is often called the triangle of conflict (Frederickson, 1999), which is viewed by ego- and drive-oriented psychoanalysts to be central to the core of psychoanalytic or psychodynamic psychotherapy.

Research has shown that completion of psychodynamic psychotherapy is associated with use of higher level, more adaptive defenses, and that use of these defenses correlates with decrease in symptoms (Akkerman, Lewin, & Carr, 1999). One example of the relationship between the type of defenses employed and overall adjustment can be found in the work of Speanburg and colleagues (2003) who found that improved global functioning was associated significantly with increased use of mature defenses and decreased use of immature defenses over a 3 to 7 year follow-up. The sample in this study included 48 subjects with treatment-refractory disorders, including 34% with PTSD, who received residential psychodynamic psychotherapy and some follow-up psychotherapy for varying lengths of time.

Process research has shown that psychodynamic techniques targeting defenses result in symptomatic improvement. Pole and Jones (1998) found that in a 2-year psychodynamic psychotherapy, techniques included interpretation of warded-off unconscious wishes, feelings, or ideas, drawing attention to feelings the patient views as unacceptable, and pointing out defensive

maneuvers. These interventions were related to increased freedom of the patient's associations, which was directly predictive of symptomatic change. A study of short-term psychodynamic psychotherapy with patients with varying disorders found that the therapist interpreting warded-off or unconscious wishes, feelings, or ideas was significantly related to outcome (Jones, Parke, & Pulos, 1992). This research is promising and should be extended to working with patients who have experienced trauma to determine if these techniques are also effective with traumatized individuals.

Several studies have shown that psychodynamic psychotherapy is uniquely effective compared to CBT because it actively addresses the triangle of conflict (wish, defense, and fear) (Ablon & Jones, 1998; Jones & Pulos, 1993). In addition, process-outcome research has shown that prototypical psychodynamic treatment as defined by experts is significantly correlated with improvement, whereas a prototypical cognitive-behavioral treatment as defined by experts is not significantly correlated with improvement (Ablon & Jones, 1998; Jones & Pulos, 1993). Thus, psychodynamic psychotherapy may contribute something to treatment of PTSD through interpretation of the triangle of conflict that is not available in other therapies.

Self-Concept

Theoretical issues. Research points to a relationship between PTSD and the view of the self. Muller, Sicoli, and Lemieux (2000) found that PTSD is correlated with a negative view of oneself, but not a negative view of the other. In fact, they found that a negative view of oneself was the best predictor of PTSD symptomatology. They also cite Mikulincer and colleagues (1993) as providing additional support for these findings, in that persons with attachment styles related to having a positive view of the self did not demonstrate high levels of PTSD symptoms. Dunmore, Clark, and Ehlers (2001) also found that negative beliefs about self, along with negative views of

work, were the highest correlated predictors of developing PTSD.

Implications for psychodynamic psychotherapy. Since low self-esteem that predates trauma can predict emergence of PTSD symptoms after a trauma, psychodynamic methods of intervention may help target the underlying problems. Specifically, psychodynamic psychotherapy for PTSD focuses on the meaning of the trauma in victims' lives, helping them to integrate it into their sense of self (Horowitz, 1997; Krupnick, 2002; Lindy, 1993). The various forms of psychodynamic psychotherapy may take somewhat different approaches toward making these changes. Case studies of self-psychological therapy for PTSD indicate that using self-object transference concepts within the therapeutic relationship, including mirroring, idealizing, and twinship self-object transferences, is associated with good outcome in treatment of Vietnam veterans (Catherall, 1989; Deitz, 1986; Garfield & Leveroni, 2000). One study of psychodynamic psychotherapy for PTSD that was not explicitly self-psychological but was based on Horowitz's (1976) approach found that treatment resulted in increased self-esteem and decreased sense of inadequacy (Brom et al., 1989).

The efficacy of self-psychological psychodynamic therapy for PTSD has not been tested in empirical studies, and only one research program has studied a specifically self-psychological treatment (Meares, Stevenson, & Comerford, 1999; Stevenson & Meares, 1992; Stevenson, Meares, & D'Angelo, 2005). Participants in this study consisted of patients with borderline personality disorder (BPD). Since about two-thirds of patients with BPD have histories of trauma, and trauma is hypothesized to be related to the development of the disorder in about a third of the cases (Paris, 2001; van der Kolk, Hostenler, Herron, & Fisler, 1994), it is reasonable to assume that at least some of the patients in these studies had PTSD. An uncontrolled study by Stevenson and Meares (1992) found that a psychodynamic treatment based

on the contributions of Kohut (1984) and Winnicott (1971) that focused on self-development resulted in significant improvement in many areas, including time in hospital, number of occurrences of violence and self-harm, number of medical appointments, drug use, and work history. This improvement was maintained or increased at a 5-year follow-up on all measures except time spent away from work. However, the last outcome may have been influenced by the location of the study and an economic recession in Australia during the follow-up period.

Another study of a psychodynamic psychotherapy, reported by the authors to be based on a combination of object relations theory and self-psychology, found that at termination of treatment of 25.4 months mean duration, 75% of persons who originally had Axis I diagnoses and 72% of persons who originally had Axis II diagnoses no longer fulfilled criteria for these disorders (Monsen, Odland, Faugli, Daae, & Eilersen, 1995a). These gains were maintained at an average follow-up of 5.2 years (Monsen, Odland, Faugli, Daae, & Eilersen, 1995b). The report does not include data indicating which patients had experienced trauma, however. In summary, there is some empirical support for psychodynamic psychotherapy that is derived from self-psychology and object relations theory for individuals with severe psychopathology. Further research is needed to broaden this work to patients who have specifically experienced trauma.

Reflective Functioning and Mentalization

Theoretical issues. Reflective functioning and mentalization are two concepts that may mediate the development of PTSD. Fonagy (2000) postulates that mentalization, the ability to think about mental states in oneself and in others in conjunction with experiencing the relative affective states, is related to various indices of mental health. His research has shown that mentalization is taught by parents through example (Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Fonagy,

Steele, Steele, Higgitt, & Target, 1994). The ability to mentalize is related to an increased probability of developing secure attachment and healthy relationships. Individuals who experience early trauma, however, may defensively inhibit their capacity to mentalize to avoid having to think about the possibility that a significant person may wish to harm them. Inhibiting the ability in order to mentalize may result in personality disorders such as BPD and insecure attachment (Fonagy, 2000).

In those individuals who were abused as children, the ability to reflect on their own self-functioning was found to be a buffer against developing BPD. The attachment types that are unresolved, disorganized, and disoriented with respect to loss, trauma, or abuse have been found to be related to a greater number of mental disorders, especially BPD (Fonagy et al., 1996). Studies have shown that secure attachment is associated with active processing memories of abuse and thereby resolving feelings related to abuse (Alexander, 1993). While Fonagy and colleagues (1996) did not examine whether low reflective functioning was related to development of PTSD, the high comorbidity between PTSD and BPD (Sabo, 1997) raises the question of whether reflective functioning might mediate the development of PTSD as well. Thus, are individuals who use reflective functioning as a way of coping with traumatic experiences less likely to develop PTSD than those who are unable or unwilling to do so? Research is needed to evaluate this hypothesis.

Implications for psychodynamic psychotherapy. Psychodynamic psychotherapy has been found to significantly improve reflective functioning. Levy and colleagues (2004; 2006) found that reflective functioning improved significantly in clients who participated in transference focused psychotherapy, a manualized psychodynamic treatment for BPD, whereas it did not significantly improve in clients with BPD who received dialectical behavior therapy or supportive psychotherapy. In addition, a significant number of participants in the study who had originally failed

to resolve an early trauma were able to modify adaptively their perspective on the trauma during the course of psychodynamic psychotherapy. An earlier presentation of this data indicated that about 50% of the sample in this study had experienced sexual abuse (Levy & Clarkin, 2003). The results of this research have yet to be extended directly to research on PTSD or complex PTSD. Nevertheless, they provide a favorable indication of how a psychodynamic conceptualization may help address a fundamental component of personality, reflective functioning, in order to help the patient resolve issues with respect to past trauma and become more resilient in the face of future life events.

COMORBID AXIS I AND II DISORDERS

Theoretical Issues

PTSD is commonly comorbid with other psychiatric conditions (APA, 2000); in samples of veterans with PTSD, comorbidity was as high as 99% (Weathers, Litz, & Keane, 1995). PTSD is often found to be comorbid with major depressive disorder, substance abuse or dependence, panic disorder, agoraphobia, obsessive-compulsive disorder, generalized anxiety disorder, social phobia, specific phobias, and bipolar disorder (APA, 2000; Hoge et al., 2004). In addition, a history of adverse experiences, including childhood abuse, has been found to be related to borderline, self-defeating, narcissistic, histrionic, sadistic, and schizotypal traits; physical abuse (but not sexual abuse) has been linked to antisocial personality traits (Norden, Klein, Donaldson, Pepper, & Klein, 1995). Although many as 80% of PTSD patients in a special treatment unit carry an Axis II diagnosis (McFarland, 1985), and one study found that 76% of treatment-seeking patients with combat-related PTSD met criteria for BPD (Southwick, Yehuda, & Giller, 1993).

Herman (1997) theorizes that many cases of BPD are essentially a complex form of PTSD (“complex PTSD”), an outcome of ex-

posure to multiple traumas over time. Fonagy and colleagues (1996) found that severe trauma accompanied by a lack of resolution of that trauma is positively related to meeting criteria for BPD, whereas persons who are able to resolve their trauma are less likely to meet criteria for BPD. As many as 50–70% of patients with BPD report childhood sexual abuse, empirical evidence does not indicate a direct link between childhood sexual abuse and borderline personality disorder (Paris, 2001). Many variables, such as constitution, family function or dysfunction, parental psychopathology, and parenting practices may moderate the relationship between these two factors (Paris, 2001).

Repeated trauma, or overwhelming single trauma, has also been linked to the full range of dissociative disorders (Brenner, 2001; McWilliams, 1994). Dissociative disorders associated with sexual abuse affect as many as 15% of psychiatric inpatients (van der Kolk et al., 1994). While these disorders consist of a characteristic reliance on dissociation as a defense mechanism, symptoms of dissociation are often found to a lesser degree in many people who suffer from PTSD (Brenner, 2001; McWilliams, 1994). PTSD has, in fact, been shown to correlate with the extent of dissociation during trauma (Bremner, Steinberg, et al., 1993).

Implications for Psychodynamic Psychotherapy

Psychodynamic psychotherapy may prove to be particularly appropriate for addressing reactions to trauma that have become entrenched in personality traits or disorders (e.g., PTSD with a comorbid Axis II disorder). This is a complicated question, since patient presentations can vary widely. For some, a personality disorder may pre-exist the development of PTSD, while for others, the experience of childhood trauma can result in PTSD as well as contribute to the development of a comorbid personality disorder. Other individuals who are well-adapted prior to the trauma but use immature defenses may

also be more vulnerable than those with more mature defenses.

Psychodynamic psychotherapy may address not only issues that result from an individual having experienced trauma but also those attributable to a preexisting Axis II disorder or a suboptimal defensive style. This is different from RCT-tested CBT approaches, which address only the symptoms of PTSD even if a comorbid personality disorder exists. Approaching the individual as a single functional entity, rather than a collection of symptoms that one addresses separately, may be efficient when PTSD is one part of a complex syndrome. The research of Perry and colleagues (2003) suggests that this may be the case. They examined 226 patients with treatment-refractory disorders and histories of multiple hospitalizations who underwent residential psychodynamic treatment and follow-up psychotherapy. These patients had an average of 4.8 active Axis I and 1.2 active Axis II disorders, and an average GAF of 43 at beginning of treatment; about 36% had PTSD from a specific traumatic incident (conditions for "complex" PTSD, such as ongoing trauma, were not counted towards this diagnosis). Perry and colleagues (2003) found that approximately 80% of these patients improved significantly over time. Other studies specifically for PTSD found that in addition to improved symptoms of PTSD, patients who received psychodynamic psychotherapy experienced characterological change (Krupnick, 1980) and decreased psychoneuroticism, trait anxiety, trait anger, and somatization (Brom et al., 1989).

Psychodynamic psychotherapy may be better suited than CBT or EMDR for patients who have PTSD with comorbid personality disorders, since the outcomes of these treatments have been disappointing. Feeny, Zoellner, and Foa (2002) found that of patients with comorbid PTSD and BPD who were given prolonged exposure (PE), stress inoculation training (SIT), or PE with SIT, 89% did not achieve good end-state functioning at post-treatment, with 78% not achieving good end-state functioning at a 3-month follow-up. About 44% retained a PTSD diagno-

sis at post-treatment and 3-month follow-up. Both Feeny and colleagues (2002) and Hembree, Cahill, and Foa (2004) found that persons with comorbid personality disorders experienced a decrease in PTSD symptoms similar in size to the decrease in PTSD symptoms experienced by persons without comorbid personality disorders; however, persons with comorbid personality disorders tended not to have as good end-state functioning as persons without comorbid personality disorders at the end of treatment. This suggests that persons with comorbid personality disorders might benefit from additional treatment or a different treatment that is aimed at more than just their PTSD symptoms.

Research also suggests that psychodynamic psychotherapy may have a better ability to treat patients with multiple, comorbid disorders and other difficult presentations. For instance, consider the research study that found that patients with comorbid personality disorders, treated by CBT-oriented therapists in the community, had similar or better outcome after treatment on both level of PTSD and end-state functioning than those treated by CBT experts (Hembree et al., 2004). Research on CBT-oriented therapists in the community suggests that they blend psychodynamic and interpersonal techniques into CBT for patients who have experienced trauma (Schottenbauer, Arnkoff, Glass, & Gray, 2006). This research suggests that there is a need to study experienced clinicians in the community to determine how they blend various techniques, including psychodynamic, interpersonal, and cognitive-behavioral therapy, to treat patients who meet criteria for PTSD with comorbid disorders.

CONCLUSIONS

Current empirically supported treatments for PTSD include CBT and EMDR. Studies of these treatments show, however, that dropouts and nonresponders to treatment are fairly frequent, and some patients worsen with these treatments (Schottenbauer

et al., in press). The distinction between simple and complex trauma may be helpful in understanding variations in response to interventions, since research supports Herman's (1997) hypothesis that there are differences in symptomatology between persons who have been exposed to one trauma versus cumulative trauma (Krupnick et al., 2004; Zlotnick et al., 1996). Both CBT and EMDR do not address the full extent of comorbid problems that are associated with extensive trauma histories (Cook, Schnurr, & Foa, 2004), which include interpersonal problems, developmental and personality issues, and multiple Axis I and Axis II disorders (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Zlotnick et al., 1996). For persons who have experienced repeated or prolonged trauma, interventions aimed primarily at reducing PTSD symptoms may not be sufficient. In addition, individuals with certain personality characteristics, such as insecure attachment or reactance, may be difficult to engage in therapy, and psychodynamic methods for enhancing engagement in therapy might better reach these patients.

A final argument for psychodynamic psychotherapy for PTSD is financial. New research shows that psychoanalysis and psychoanalytic psychotherapies are related to reduced health care utilization and costs in the long term not only when patients are compared to untreated patients, but also to the general population 7 years after treatment (Beutel, Rasting, Stuhren, Ruger, & Leuzinger-Bohleber, 2004). This has particular relevance for PTSD, since that study population contained many European survivors of World War II, and military research shows that traumatized soldiers often present with somatic rather than psychological complaints (Jones et al., 2002; Jones & Palmer, 2000; Jones & Wessely, 2001). Given that recent research suggests there is poor long-term follow-up, particularly with respect to healthcare costs, for many persons who re-

ceive short-term CBT for PTSD (Durham et al., 2005), the potential long-term cost-effectiveness of more intensive therapies such as psychodynamic psychotherapy only makes the need for research in this area more essential.

In conclusion, psychodynamic psychotherapy is widely used by clinicians to treat PTSD, especially complex PTSD and the interpersonal sequelae of trauma, and clinical experience suggests strongly that it is effective (APA, 2004). A manual for psychodynamic psychotherapy for PTSD and the sequelae of trauma has not been developed, and this treatment has not, to date, been subjected to rigorous empirical tests. The American Psychiatric Association practice guideline for PTSD states, "Given the widespread use of psychodynamic psychotherapy, it is particularly important to encourage controlled studies to examine the techniques used and their efficacy" (APA, 2004, p. 43). In order to conduct such studies, it is necessary to define the treatment that is being studied, by having a clear manual with adherence measures. Psychodynamic psychotherapy presents particular difficulties in the process of writing a manual, because of the many variations that exist within the umbrella of psychodynamic psychotherapy (including ego-drive psychology, object relations, and self psychology, to name a few), the complexity of psychodynamic treatment, and the importance of the uniqueness of each patient to the treatment. Nevertheless, these issues must be addressed to ensure the highest degree of treatment replication between patients and across studies. Manuals have been successfully written and tested for psychodynamic treatment of panic (Milrod, Busch, Cooper, & Shapiro, 1997) and borderline personality disorder (Bateman & Fonagy, 2004; Clarkin, Yeomans, & Kernberg, 1999). A logical next step would be to write a manual for psychodynamic treatment of PTSD and to submit this intervention to empirical tests.

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