DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS (Axis I)

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CONTENTS

CHAPTER 6

Dynamic Therapy for Post-Traumatic Stress Disorder

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HISTORY AND DEVELOPMENT

In the field of psychoanalysis, the infantile conflict was historically viewed, for the most part, as the principal pathogenic factor in psychic trauma (Fenichel, 1945; Freud, 1939/1953, 1962). The ego of the victim had to reestablish homeostasis by "discharging," "binding," or "abreacting" (Freud, 1962). In reaction against this classic model of symptom formation, Kardiner and Spiegel (1947) postulated that the factors related to the event are decisive in traumatogenesis. More contemporary authors (Hendin & Hass, 1984; Horowitz, 1986; Krystal, 1985) have reconciled the two extreme positions on the etiology of trauma by emphasizing the role played by the meanings attached by the individual to the traumatic event (Brett, 1993). Horowitz (1974, 1986) further introduced the concept of information, as borrowed from information theory. Information can have inner and outer origins, it applies to both ideas and affects, and if salient information is not assimilated within the existing system, the system must accommodate itself to integrate the incongruent information.

In this chapter, I describe a comprehensive dynamic approach for treating post-traumatic stress disorder (PTSD) that is mostly based on Horowitz's model (1974, 1986). The approach I use is brief in its orientation; it is focused on trauma, its associated conflicts, and their resolution. It encompasses various techniques, including hypnosis. Its duration depends on the severity of the trauma, its chronicity, and the patient's ego structure and motivation for therapy. If trauma is severe and renders the patient dysfunctional, therapy sessions are

held twice a week to both support the patient's ego in dealing with the traumatic aftermaths and counter the avoidance tendencies associated with PTSD.

Basic dynamic concepts are employed to guide patients toward resolving the trauma. Nonetheless, each therapy is tailored to the needs and capacities of the individual. Therefore, all dimensions involved in a traumatic response are considered. A patient's unbalanced neuronal activity, behavioral patterns, coping skills, cognitive schemas, and self-concepts, as well as the influences of familial and social systems, can also contribute to the etiology and maintenance of a traumatic response. My approach recognizes their impact and attempts to manage them adequately. Consequently, therapeutic adjuncts, such as medication, functional analysis, skill acquisition techniques, encouragement toward interpersonal proximity and assertion, anxiety or anger control techniques, hierarchical exposure to stimuli, and cognitive restructuring, can be added.

Furthermore, I realized that exploration of trauma can only be intellectual rather than experiential or involving emotional components. In a normal state of consciousness, information that could contribute to complete understanding of a traumatic response is often missing. Information can be best retrieved in the same emotional state of consciousness in which it was encoded. Therefore, I specifically include hypnosis as a tool for revising the traumatic experience because it enforces the emotional reexperience of trauma and the full review of the event.

INCLUSION/EXCLUSION CRITERIA

Patients who present with a PTSD (APA, 1994) and are susceptible to benefit from this approach are late adolescents or adults with a relatively good premorbid functioning on the psychological, interpersonal, and vocational levels. Those who are most likely to benefit are psychologically minded, respond minimally to interpretations, have some tolerance for pain, and utilize repression only among other strategies to contain painful affects.

Intense anxiety symptoms, however, can mask those capacities in a patient at intake. The most useful criterion is therefore the patient's history of interpersonal relationships, including the presence of an adequate parental figure (even if physical or sexual abuse has occurred) and no history of psychiatric problems. Suicidal patients are not excluded.

Some patients, however, are not predisposed to change in dynamic therapy. These patients usually display a substance abuse disorder, psychotic features, a history of antisocial behavior, a severe personality disorder, or less than average intelligence. Furthermore, dynamic therapy cannot be instigated until a victim is out of danger. Until the threat is eliminated, only supportive therapy should be provided.

DYNAMIC ISSUES IN PTSD

ETIOLOGY

Historically, psychotherapists have tended to focus on one of two possibilities in regard to the etiology of trauma symptoms (Brett, 1993). The first position views the factors related to the individual as decisive in the traumatogenesis. There are three fundamental conceptualizations of this etiology of trauma (Brett, 1993). The first is Fenichel's (1945) model of symptom formation: Symptoms form when current frustrations revive infantile conflicts, and come to reflect ways of feeling and defending that were operative in childhood. The second etiological model was Freud's (1939/1953): Traumatic events lead to excessive incursion of stimuli by exceeding the "stimuli barrier" or "protective shield" of the individual. Consequently, the organism is flooded with impulses, and its functioning is disrupted. The third formulation is Freud's addition of the repetition model (1939/1953): Following the overwhelming assault on the stimulus barrier, a regression occurs, leading to the use of a primitive defense, repetition compulsion, to repeat the event in an effort to master it.

In reaction against these classic models of symptom formation, the second position postulates that the factors related to the event are decisive in the traumatogenesis (Kardiner & Spiegel, 1947). This position sometimes concedes that a preexisting conflict may be symbolically revived by a traumatic event, but the conflict occurs as an independent accompaniment to the trauma, not as a cause of the event being traumatic. It is only when the individual tries to defend against the damage done to his functioning by the event that meanings symbolic of old conflicts are attached to it.

More contemporary authors have compromised between these models (Hendin & Hass, 1984; Horowitz, 1986; Krystal, 1985). Their positions reconcile the two extreme positions on the etiology of trauma. In these models, the subjective meaning of the event deter-

mines whether it becomes traumatic or not, and the meaning is defined through the individual's earlier experiences as they relate to the traumatic event's characteristics. In these interactional models, the primary pathogenic force is nevertheless viewed as coming from the traumatic event itself. There are empirical results supporting this position. It has been shown that, as the intensity of violent events increases, the number of traumatized individuals increases (Green, Lindy, & Grace, 1985). Furthermore, particular types of events are more likely to create trauma in victims than others (Breslau, Davis, Andreski, & Peterson, 1991). This view has been adopted by the *DSM-IV* committee on PTSD, which softened its previous position by stating that, to be traumatic, an event has to provoke intense fear, horror, or helplessness in the individual, rather than being traumatic for most people as it was defined in the *DSM-III-R* (APA, 1985, 1994).

FACTORS AT PLAY

The phenomenologic description of psychic trauma in the *DSM-IV* (APA, 1994) is consistent with most dynamic principles about psychic trauma. The two basic processes involved in psychic trauma are the repetitive and intrusive reexperiencing of trauma and the avoidance of this reexperiencing. A third cluster of symptoms arises from overactivation of the autonomic nervous system, observed through sleep difficulties, irritability and concentration problems, hypervigilance, and startle reactions, which can be viewed as a consequence of the former two clusters of symptoms.

Horowitz's model (1986) proposes a sequence of phases that, before the installment of those symptoms, may lead to psychic trauma, depending on the individual's reactions. The immediate response to a traumatic event is usually an outcry phase. This alarm reaction is often accompanied by strong emotions, usually fear and anger. The individual is likely to postpone any other activity. Internally, the individual may say, "I'm going to die," or, "It can't be happening," the latter providing an indication as to what will happen in the denial phase. When the situation no longer calls for an immediate response or an extensive implementation of coping mechanisms, the individual usually begins to relax and to lower defenses. Intrusion and denial phases ensue.

The intrusion phase is characterized by unbidden ideas about the traumatic event, suddenly feeling and acting as if the event were happening again, and psychological distress and/or physiological arousal at the presentation of stimuli associated with the event. During the intrusion phase, the autonomic arousal is usually at its peak. The

individual may perceive reality through its inner sensations and therefore distort it. Some images may have a pseudohallucinatory or illusory quality. A traumatized individual may also ruminate about the event during these intrusion periods; reenactments of the events can take place involving fantasied responses in which the individual symbolically masters the event, indicating a denial of the reality of the failed enactment. The intrusion phase may manifest itself through distressing nightmares, from which the individual may wake up sweating in fear. The individual may have the impression that these intrusive and repetitive affects and ideas are meaningless and overwhelming and may interpret them as a sign of losing control over his or her internal world.

In an attempt to regain control, the individual enters a denial phase. Repression and avoidance are put in place to reduce the anxiety associated with reexperiencing the event. Actions are taken to avoid talking about the event or being in situations and places that resemble the event. Sometimes parts of the event cannot be remembered, usually the most significant ones, due to a peri-dissociation at the time it occurred. Denial also serves the purpose of pushing away from consciousness unwanted emotions and their associated meanings. The energy required to install repression mechanisms depletes the inner resources of the individual, leaving little to invest in hobbies and daily activities. Often this lack of other interests also indicates the individual's perception of the event: "If such events are part of life, it may not be worth living." Emotional numbing may set in, taking the form of detachment from others, estrangement, and attempts to stop feeling any emotion—at first joy, then anger and sadness. A sense of a foreshortened future follows.

Although the intrusion and denial phases can become pathological, a normal reaction to a traumatic event also involves these phases, which do not necessarily imply the development of a psychic trauma. Reexperiencing and avoidance should be viewed as pathological only if they are enduring and interfere with the individual's functioning. Reexperiencing allows the mind to revise the events in all its facets, and avoidance permits resting periods from this intense psychic work.

Trauma occurs when the intrusion and denial phases are out of the control of the individual, when the oscillation between reexperiencing and avoidance is involuntary. In this case, the individual's defense mechanisms and coping strategies are likely to interfere with the processing of the information attached to the event.

Beyond traumatogenic factors, numerous maintenance factors are at play in psychic trauma. The losses associated with the event may

contribute to the maintenance of symptoms; for instance, an individual may have lost a limb after the event, or his job, because symptomatology interfered too much with his performance at work. Chronic pain may also fuel the repeated reviviscence of the trauma and act in a positive feedback loop with the traumatic memories to augment PTSD symptoms. Responses from others are also important in determining whether a psychic trauma will be easily resolved or not, particularly the responses of those providing immediate help, close ones, and the judicial and medical systems. The more chronic a psychic trauma is, the more difficult is its resolution, and the more likely it is to create permanent sequelae. In addition, trauma often becomes complicated by co-morbidity, rendering the picture more complex and depleting the individual's resources.

The constellation of predisposing, precipitating, and maintaining factors potentially at play in a psychic trauma highlights the presence of individual differences among victims. Consequently, dynamic therapy ought to be tailored to the specific needs and capacities of each individual.

DEVELOPMENTAL HISTORY

The impact of a traumatic event differs according to the developmental stage of an individual. Preschool children who are abused are limited in their capacity to verbally represent the trauma. With increasing maturity, these experiences may not become readily assimilated into verbal representations (Pynoos & Nader, 1993). Inversely, if no harm has been caused to them or others, preschool children may not be cognitively developed enough to understand the realistic implications of a traumatic event but rather may interpret abusive actions as simple play.

During early adolescence, trauma exposure can interfere with the ongoing tasks of separating from parents, developing moral judgment, developing identity, and so forth. In later adolescence, repetitive trauma can result in severe personality disorders, as seen in young combat veterans (Marmar, 1991).

Models of traumatization have less adequately addressed the impact of adult development on trauma. The meaning of an event may depend on the situation experienced by the adult at a certain time period. For example, witnessing a child being hit by a car is likely to be differently traumatic to a parent than to a childless adult.

In late adulthood, a traumatic event may occur when the individual is going through a decline in social status, loss of loved ones, and

diminishing mental and physical capacities. Older adults' perception of self-efficacy in coping with a traumatic event may be low, and they are often left to themselves (Marmar, Foy, Kagan, & Pynoos, 1993).

Major Conflicts

Preexisting neurotic conflicts can be impediments to processing a traumatic event, but only when they are associatively similar to the information attached to the traumatic event. Other more general conflicts may arise when basic illusions that provide a sense of security in the world have been shattered by the traumatic event, revealing anxiety-provoking realities about oneself and the world.

Most of us entertain, consciously or unconsciously, three basic illusions. Humans tend to view the world as benign, controllable, and predictable, and conversely, they view themselves as immortal, invulnerable, and omnipotent (Epstein, 1991). Trauma experientially enforces on us the notions of helplessness and death, to which we usually react with overwhelming anxiety. A rejection of this reality activates a series of defense mechanisms.

Another dimension of an individual's reality can compensate for those painful realizations and bring a sense of relative security in the world, namely, feeling attached to competent and caring individuals (Bowlby, 1988). The saliency of the need for secure attachments has been empirically demonstrated in traumatized individuals (Epstein, 1991). However, a traumatic event can also shatter an individual's representations of being safe in relation to others. A traumatic event can be either natural/accidental or provoked by another human being. If the event is natural/accidental and involves the real or imagined loss of a loved one, we can be abruptly confronted with the painful realization that love objects are not eternal. One defense employed against this painful realization is seeking isolation from others, either physically or affectively, in an attempt to lower the pain associated with future losses. If a traumatic event is provoked by a human being, such as in criminal acts, the individual is brutally confronted with the evilness of others. Through generalization, the victim's relation to others can become severed, or at least questioned, in an attempt at self-protection. The individual comes to fear others, viewing their physical and verbal actions as hostile, especially if the immediate assistance after the event has been neglectful, minimizing, or aggressive. Another defense against this realization of evil is imagining that pain was deserved because one has been bad.

Surprisingly, traumatized individuals rarely feel anger at the

aggressor at the beginning of therapy. Anger is displaced or diffused. Traumatized individuals are often conflicted about the tremendous anger they experience following a traumatic event. If they feel anger or rage, they may conclude that they are bad, and they may fear losing control over their anger. The self is viewed as dangerous and others as helpless (Catherall, 1991).

Victims can also be conflicted about pain, rejecting the unavoidability of its existence. They become angry at life and end up rejecting it, viewing it as not worth experiencing. Such angry reactions are more forceful as more painful elements are attached to the traumatic event. Such anger is usually associated with a wish for others to repair the damage, especially, if available, the person responsible for the traumatic event, or to simply recognize it fully.

DEFENSES AND IDENTIFICATIONS

Any defense mechanism can be observed in traumatized individuals. Because the ego of traumatized individuals is overwhelmed, it resorts to less mature defense mechanisms. Ideally, patients preserve part of their most advanced defense mechanisms, such as humor and distancing, but they sometimes use somatization and projection to express isolated affects. Some patients can even temporarily utilize such immature defenses as splitting and hallucinations. Defenses are usually organized against fear, anger, or helplessness.

While the primary damage is done to the individual's ego, a secondary damage occurs to the individual's relation to internal objects (Catherall, 1991). The latter effect can be clinically operationalized as a loss of trust. The individual has been confronted with the reality that others cannot be trusted to control their aggressive impulses.

Against fear, many victims employ minimization of both the event and the associated psychic damage. They may even resort to extreme repression or denial at times, leaving the psychological distress unattended and operating in isolation. To somehow regain a sense of control and security, the individual may generalize the dangerous features associated with the event to other aspects of reality, thus preparing for any new danger. The individual may also deny the existence of danger, using a counterphobic mechanism, which leads to potentially dangerous actions such as walking alone at night in violent neighborhoods.

The discovery that others cannot be trusted to control their aggressive impulses can be more or less devastating. In general, traumatized individuals become enraged at the injustice of being a victim

and disown aspects of the self, including their own aggression impulses and capacity to victimize. Some individuals already rely on splitting and projection to deal with unacceptable parts of the self; when they are victimized, these individuals may defend through an identification with the aggressor. When this defense mechanism is adopted and well established, it often leads to the characterological use of violence as a means of interacting with others. Most victims, however, do not resort to an identification with the aggressor, violence being ego dystonic or against their moral values. They usually displace anger toward close ones and project it into strangers. Projecting anger often leads to hypervigilance. Only when some victims can calmly acknowledge that they wish to hurt or kill someone are they capable of walking at ease on the streets. In therapy, a direct viewing of these disowned aspects of the self in the therapist is often accomplished through the mechanism of protective identification. As for children, identifying with the object's capacity to cope with the projected material is part of acquiring a more mature internal structure (Catherall, 1991).

Anger may itself serve as a defense, usually against panic or disintegration (Catherall, 1991). Anger may also function as an attempt to restore one's narcissism through the wish to regain control over the aggressor, as usually observed in male victims. Or anger may be aimed at restoring the feeling of being in relation with others, through the wish to make the aggressor recognize that pain was inflicted on the victim and it should not happen again, as usually seen in female victims.

Victims can feel exaggerated guilt as a defense against anger. But most traumatized individuals also feel guilt as a defense against helplessness. A traumatized individual is likely to be better able to tolerate guilt than to acknowledge the reality that sometimes we cannot prevent a terrible accident or interfere with another's malicious plans. Rather than recognize their sense of helplessness, traumatized individuals feel guilty over their failed enactment and develop endless scenarios to ultimately master the event (Lipton, 1993).

Finally, dissociation is an extreme attempt to protect oneself or others. It is characterized by a marked loss of control over one's mental state and is often accompanied by intense panic states. According to Spiegel (1988), trauma can be understood as the experience of being made into an object, and dissociation can be conceptualized as a reflection of the profound loss of physical control experienced during the traumatic event. Trauma seems to foster the use of dissociation, especially when severe physical harm occurs in early childhood (Put-

nam, 1985). Whenever an individual uses dissociation to protect himself or herself against pain, the information associated with the traumatic event cannot be processed. In therapy, it is most often consciously concealed by the individual. To relinquish its pathological use, the consequences of dissociation have to be identified and reappraised, and more mature strategies need to be implemented.

TREATMENT GOALS

There is an overlap between therapist and patient goals in dynamic therapy for psychic trauma. They both aim at restoring the patient's premorbid functioning and eliminating the PTSD symptoms. To accomplish these tasks, the therapist develops process goals in accordance with dynamic theory. The goals of brief dynamic therapy for psychic trauma are limited to ideational and emotional working-through of the stress response syndrome to a point of relative mastery, a state in which both denial and repetitive reexperiencing are reduced or absent (Horowitz & Kaltreider, 1979). It is possible to expand on these goals.

THERAPIST GOALS

Acknowledging and Accepting the Traumatized Self

Many traumatized patients come into therapy seeking relief from their loss of control over themselves and their lives, though they deny that they have been wounded psychologically. The first goal of the therapist is to assist the patient in acknowledging the traumatized self, usually by recognizing his or her psychological distress. The ensuing goal is to help the patient accept the traumatized self by viewing psychological distress as noninfantile. These goals are usually achieved through a parallel process of restoring the patient's damaged narcissism.

Regaining Mastery

The second goal is to help the patient regain or develop a sense of mastery over both external and internal worlds, within realistic limits. For example a patient can be assisted in making decisions about his or her participation to the justice system, actively seeking support, and limiting external demands as much as possible. The thera-

pist can help a patient to lower baseline anxiety or depression levels and regain control over transitions between intrusion and avoidance states. Achieving these goals usually counters helplessness and enhances self-esteem; when they are attained, the therapist can work on freeing the patient from PTSD symptoms.

Integrating the Traumatic Information

The third goal is to make the patient's psychological structure accommodate itself to the new traumatic information, to ultimately transcend the traumatized self. To achieve this goal, the patient must revise his or her self-concept to that of someone able to respond, either internally or externally, whenever it is feasible. This goal also involves developing new concepts of others and the world—mainly, becoming able to perceive the outer world as unpredictable but only within certain limits, uncontrollable but only within certain limits, and hostile but only within certain limits (Epstein, 1991). The attainment of this goal usually ensures the remission of PTSD symptomatology and prevents relapse.

If such a goal cannot be achieved, the therapist can lower the therapeutic objective to a partial assimilation of the new information by the patient's psychological structure, through aiding the patient's ego in developing new skills to counter the impact of the traumatic event so as to ultimately constrain the traumatized self within certain limits.

Viewing Trauma as Challenge

Fourth, the therapist assists the patient in learning to view traumatic events as opportunities for growth. This goal aims at reducing the individual's predisposition to become traumatized. Patients come to perceive potentially traumatic events as challenges rather than threats. The achievement of this goal, however, depends on the patient achieving the three previous ones. Ideally, the therapist should also address issues of life and death, which involve the patient harnessing his or her will to fully experience life and recognize its finality.

These four goals can be attained in sequence. However, depending on the individual's capacity to tolerate intense affects or structural deficits, regaining mastery over the inner and outer worlds may need to be achieved before proceeding to a full acknowledgment of the traumatized self. More often, the patient achieves these two goals in parallel, alternatively working on both, since acknowledgment of vulnerability is often more tolerable when the individual has somehow regained a sense of competency.

PATIENT GOALS

Patients have similar but more limited goals. Patients wish to regain control over themselves and their lives by getting rid of their symptoms. They want to go on with life as usual by resuming their past psychosocial functioning. Sometimes patients also wish to discover new aspects of themselves and life, but this goal develops only over the course of therapy.

THEORY OF CHANGE

CHANGES TO TAKE PLACE

To resolve a traumatic response, it is essential that the individual process the new information attached to the traumatic event, information that is incongruent with preexisting inner representations. The mind continues to process the new information until reality and inner models are brought into accord, in what Horowitz (1974, 1986) calls a "completion tendency." Until memories of a traumatic event are integrated with preexisting mental representations, they are stored in an active form of coding. When each repeated representation of the event causes the individual to process the information attached to the traumatic event, he or she may ultimately revise inner representations. As new structures are established, they may allow the information attached to the event to be integrated into the whole. The traumatic information then becomes part of long-term memory, and codifications in active memory decay (Horowitz, 1974, 1986). After the event is fully reappraised, the individual can adopt new behaviors and attitudes, thus reinforcing the inner changes.

As in Piaget's (1954) theory of child intellectual development, there are two options for integrating new information attached to a traumatic event: assimilation of the information by the preexisting structure, or accommodation of that structure to include the incongruent information. By definition, traumatic information cannot be assimilated into preexisting mental representations. Trauma is viewed as overloading the system because no preexisting schemas are available to assimilate this information without creating overwhelming anxiety. Integration thus needs to occur through the accommodation of the preexisting structure by considering the new information associated with the trauma. New concepts of self and the world have to be elaborated, taking into consideration previous ones

and the ones associated with the traumatic event. The information associated with the traumatic event can then become part of the individual's inner representations (Horowitz, 1986).

At the same time, factors such as the individual's neuronal activity and the reactions of his or her familial and social systems may also need to be altered if trauma is to be resolved. If the individual's neuronal activity is augmented to such a degree as to create panic states, this dimension needs to be managed before initiating the process of reviewing the traumatic information. When high anxiety is associated with PTSD, it should be reduced to a tolerable level. Furthermore, the presence of adequate social support has been shown to be associated with the intensity of PTSD (Solomon, 1986) and is likely to assist the individual in counterbalancing the "bad" news associated with the traumatic event by providing "good" news about others. Therefore, obtaining support from others is also part of the recovery process.

Clinical Factors Responsible for Change

An early intervention has distinct advantages. It has been shown to be shorter and more effective than a therapy instigated only after trauma has become chronic (Friedman, Framer, & Shearer, 1988). With early intervention, chronic responses may be prevented and pathological responses to the traumatized self may not become crystallized. Whenever trauma is chronic, however, therapy needs first to focus on undoing the associated pathological responses, mainly defense mechanisms and interpersonal patterns, before it can revise the information attached to the traumatic event.

The therapist's attitude and theories are crucial determinants of success in helping traumatized individuals. Traditional analytic theory has been weak in dealing with trauma, leaving most clinicians unequipped to handle it. Traditional dynamic therapists are used to dealing most often with unconscious, developmentally based conflicts, an orientation that requires the patient to assume complete responsibility for those conflicts. Most traumatized patients find such an approach demeaning and humiliating, since it relegates to the periphery the importance of the trauma they experienced (Spiegel, 1988). A dynamic therapist should therefore adapt his or her traditional approach by adding to it more contemporary models that recognize the etiological contribution of the traumatic event.

Dynamic therapists also need to keep in mind that an active stance is required on their part. Waiting for the material to emerge usually

involves waiting a long time because avoidance mechanisms are in place. Furthermore, the therapist's attitude of restraint is likely to leave the patient alone and disoriented with overloading affects. A dynamic therapist needs to constantly remember that traumatized individuals actively and forcefully employ denial mechanisms and avoidance coping skills, and that the usual attitude of restraint is not productive with such patients. The therapist must repeatedly question the patient to gather as much detailed and concrete information as possible, while always keeping in mind the patient's sensitivity and not becoming overly inquisitive.

It is imperative that the therapist intervene in a manner that gives control to the individual. Such a strategy counters the helplessness that the individual experienced at the time of the event and that has usually been generalized to many other aspects of his or her life. Giving control to the individual also prevents a regression into dependency, which is often observed in traumatized individuals, although some patients come into therapy presenting themselves as counterdependent. Giving control to the patient requires, however, a delicate balance, because traumatized individuals avoid dealing with the traumatic information; the therapist needs to firmly guide them into acknowledging their traumatized self and revising the event.

The therapist must also pay constant attention to preserving and restoring the patient's narcissism. Traumatized individuals have usually felt humiliation, even if they were not overtly humiliated. The therapist needs to be aware of the damaged self-esteem and should attempt to repair it whenever possible. While empathic recognition of pain and harm is first required, it is also imperative that therapists treat patients as adults capable of making adequate decisions whenever full information is provided, as well as allies in the recovery process. Although the patient is suffering and temporarily damaged, his or her inner resources can be recognized by the therapist. Important and healthy psychological functions can still be accessed in the patient and employed to work with the therapist on salient issues, thus preparing the patient for future self-efficacy.

The therapeutic work should be conducted at tolerable dosages. The revision of the traumatic representations and affects should always be kept in check by the patient's potential for panic. The unconscious material surfacing should not become overwhelming for the self. When a generalized state of high anxiety or panic is observed, it is imperative to reduce the baseline level of anxiety. A low dosage of benzodiazepines is useful, as is reducing caffeine intake or unnecessary exposure to anxiety-provoking stimuli.

These maneuvers provide conditions to help an alliance develop. To establish a safe relationship with the patient, it is essential that the therapist demonstrate involvement and nonjudgmental acceptance, as well as an expert understanding of trauma. By experiencing these qualities in a caring and competent therapist, the patient can come to feel supported. As a consequence, the patient can dare to explore the traumatic event, with its anxiety-provoking features, while returning regularly to experience the safe relation with the therapist (Bowlby, 1988).

When these conditions are in place, it is essential to foster an experiential revision of the traumatic event. Intense distress and emotions are usually associated with trauma, and they need to be recognized as such. To accept his or her potential for vulnerability and helplessness, an individual needs to experience these feelings as they happened, while firmly attaching their experience to the context of the traumatic event, thus avoiding generalization to actual situations. A similar reasoning can be applied to other emotions.

Uniqueness of Approach

The approach presented here may be unique in that it incorporates diverse models of traumatization and applies them differentially to each patient depending on the factors at play. Nevertheless, it is mostly based on Horowitz's model (1974, 1986), which already encompasses concepts borrowed from different fields, explaining both normal and pathological responses to traumatic events.

In its application, this approach approximates the technical recommendations of Horowitz (1974, 1986). While the main technique resides in differentiating reality from fantasies, it not only includes interpreting a patient's problematic reactions but emphasizes validating his or her experience of reality in accordance with the characteristics of this reality. Furthermore, hypnosis is added as a specific tool for experientially reviewing the traumatic event.

TECHNIQUES

Phases

This approach is phase-oriented, like the dynamic therapy outlined by Horowitz (1974, 1986). Three major phases are presented

below, along with the therapeutic goals to be achieved. In general, these phases are of equal duration.

The first phase consists of establishing the conditions for an alliance to develop; gathering information about the traumatic event, the ensuing psychic trauma, and the patient's history and actual situation (mostly about significant past and present relationships, occurrence of previous traumas, past and present psychiatric illnesses in both the patient and family, occupational attainment, and actual additional stressors); reducing the anxiety baseline experienced by the patient to a tolerable level; encouraging the patient to seek effective social support; and addressing the avoidance mechanisms in order to reduce their use in therapy. In doing so, an alliance is usually created, the traumatized self is partially acknowledged, and some mastery over inner and outer worlds is achieved by the patient. The patient can then proceed to reappraise the traumatic event, which often augments the intrusive and arousal symptoms of PTSD.

The second phase involves a detailed revision of the traumatic event, along with addressing the associated defense mechanisms and conflicts, past or present. By repeatedly revising the traumatic event in detail, in terms of both the inner and outer worlds, the patient gains greater understanding of the emotions and meanings attached to the event. Working through the defenses and emotions associated with these meanings, the patient often addresses unresolved conflicts in either past or current relationships. In resolving these conflicts, the patient makes the necessary revisions of his or her maladaptive defensive pattern and associated wishes and emotions, and subsequently adopts more mature defense mechanisms and coping skills. As a result, the patient can revise inner models of self and the world, make new decisions, and engage in adaptive actions. At the end of this phase, the PTSD symptomatology is usually eliminated because the traumatized self has been fully acknowledged and accepted, mastery has been regained and often enhanced, and integration of the traumatic information has been achieved through an accommodation of the psychic structure.

In the third and final phase, the patient is encouraged to practice the new defensive, cognitive, and behavioral patterns until they become automatic. New ways of facing stressful or traumatic events are identified and reinforced. For each new stressful event encountered during this period, the patient is encouraged to readily and experientially recognize the provoked emotions, to explore and acknowledge the meanings attached to them, and to revise them in light of the new inner models of self and the world. During this

phase, the patient realizes greater self-efficacy in dealing with inner and outer phenomena, thus developing greater confidence in his or her capacity to face life and its associated difficulties. Termination issues are then addressed.

Technical Approach

The traumatized individual may regress from the more mature way of relating to internalized objects via empathic resonance to seeking primitive merger states with them in order to maintain self-cohesion (Kohut, 1984). Acknowledgment of the traumatized self can be achieved through empathy, validation of reality, exploration, and interpretation. Very often, the therapist needs to identify the individual's distress through empathic resonance beyond the discourse of the patient, who fears presenting a vulnerable self. Sometimes it can also be helpful to employ reassurance, such as normalizing the individual's reactions to the traumatic event. The therapist should always acknowledge that the psychological damage caused was beyond the control of the individual and validate that hurt was brought upon the individual by others.

Exploration of the patient's reactions to the presenting symptoms often identifies the obstacles to acknowledgment and acceptance of the psychic distress. For those minimizing their distress, the therapist needs to pay attention to the patient's superego attitude toward PTSD symptoms. Patients often criticize and even punish themselves for being so weak. The therapist should encourage more caring attitudes at this point, especially after demonstrating the negative impact of such judgmental reactions. Inversely, other patients put their traumatized self on display. Their distress should be acknowledged but put in perspective by showing them that not all their inner resources have been damaged.

Interpretations may be useful if the patient resists acknowledging any psychological distress beyond obvious anxiety symptoms. Such interpretations focus on the defenses employed by the individual to hide the traumatized self from awareness—such as counterphobic behaviors or minimization—and the fears associated with such recognition. Full acceptance of the traumatized self is achieved, however, only through an experiential exploration of the event and its impact.

To help the patient regain mastery over the inner and outer worlds, several techniques can be employed. When a patient experiences relative failures of control, the therapist's activities are geared

toward helping the patient to regain a sense of self-regulating control and mastery over his or her environment. First, the therapist can encourage the patient to reduce internal and external demands by reducing the daily tasks to be achieved, seeking appropriate help in accomplishing them, reducing the presentation of anxiety-provoking stimuli associated with trauma, taking medication if sleep difficulties interfere with daily functioning, seeking comfort from significant others, using strategies proposed by the therapist to counter concentration and memory problems, and so on.

Another useful approach in the effort to give control to the individual is to explain the mechanisms involved in trauma and its resolution. Educating the patient about the manifestations and mechanisms involved in PTSD usually encourages him or her to participate in the revision of the traumatic material. In doing so, it may be necessary to bring forth, using the evidence gathered from daily facts reported by the patient, that the alternative strategies employed have not been successful. The patient can then decide whether to embark on the painful revision of the traumatic event.

Then the therapist may proceed to use the techniques of exploration and interpretation. To gently initiate the revision process, the therapist may occasionally question the specific details attached to the event, including the patient's inner reactions, while constantly assessing whether the anxiety or emotions provoked are tolerable to the patient and not damaging to the alliance in progress. It is essential to approach gradually the core meaning of the event, proceeding from peripheral to more central issues. Interpretations should be presented as working hypotheses, along with the information gathered supporting them. When these techniques fail to produce the desired effect, confrontation may be necessary. Transformation of basic schemas usually requires working through the emotions and meanings attached to the traumatic event. Most often, through exploration and interpretations, defensive patterns and warded-off unresolved conflicts are highlighted because they have been reactivated associatively by the traumatic information. To undo these conflicts, the therapist often needs to explain to the patient the necessity of addressing these more personal issues. Conflicts associated with past events can be undone by working through the repressed affects and wishes associated with them, while contemporary conflicts need the further work of implementing actions that can effect changes in the patient's current reality.

To facilitate the integration of the traumatic information, the therapist usually focuses on differentiating reality from fantasies. Horowitz

(1974) refers to differentiating fantasies from reality in terms of reducing the perceived threats of reality by reducing the patient's adherence to fantasy expectations. While an effective differentiation involves interpreting the patient's problematic reactions toward reality, I believe that it should also include, and usually in the first place, acknowledging the problematic aspects of reality that created painful reactions in the patient. It is necessary to validate the full traumatic reality of the event, along with the legitimacy of the patient's fear, anger, sadness, or disgust. Some events are terrifying, aggressors can truly be bastards, victims can legitimately wish to hurt and kill their aggressor, and some scenes or actions can be forcefully disgusting. When a therapist acknowledges those aspects of reality, without dramatization, the patient can address his or her problematic reactions to the traumatic reality without overwhelming shame or guilt.

During this exploration and interpretative work, it is essential that the therapist experientially attach the associated emotions and meanings to the event. While therapist and patient are revising the event, it is extremely helpful for the patient to experience the associated emotions in their full intensity in order to attach them to the event and the appropriate object. Such an experiential revision can also lead the patient to remember previous moments in his or her life during which similar affects were provoked. Exploration and working-through can be greatly facilitated by reviewing the traumatic event under hypnosis.

Hypnosis is a technique that involves the development of an altered state of consciousness in which attention is focused inwardly, with heightened awareness and perceptions. As pointed out by Spiegel (1988), hypnosis has long been associated with fears of losing control, but it can be ironically effective in helping traumatized individuals regain control over their traumatic memories. The therapist can reassure the patient about hypnosis by explaining the procedure and by conducting an initial hypnotic trial aimed at revising a happy moment rather than a traumatic one. During a hypnotic session, the therapist should make the patient feel in control of the progression of the exploration in progress. A hypnotic exercise is divided into three parts: a relaxation procedure (such as autogenic training), a deepening phase, and an exploration phase. The unfolding of the exploration phase of the traumatic event has been previously agreed on by the patient and therapist, and it should always start in a place where the patient feels secure and end at a moment when the patient feels secure. The revision can be paced according to the patient's capaci-

ties, as well as timing constraints. The reexperiencing of the event can be slowed, stopped, or fast-forwarded, just like a videotape. Again, it is essential to proceed at tolerable dosages, and to ensure that this happens, the patient talks constantly to the therapist about what is being experienced under the hypnotic state. The therapist guides the patient's exploration, stopping the image at crucial moments and asking the patient to explore thoughts, images, emotions, or perceptions happening then. After the exploration is completed, the repetition of the hypnotic technique enables the patient to distance from the event. It should be noted, however, that such a powerful technique should be used only when a strong alliance has been established, and when the exploration has already been undertaken in therapy but has presented some form of stagnation.

In reflecting on the material newly emerged, the therapist should link the trauma with past or present situations and conflicts and differentiate fantasies from reality. This provides the patient with an opportunity to initiate changes under his or her control and to take responsibility for part of his or her reaction to the traumatic situation. Whenever the processing of the information attached to the event is blocked, the therapist needs to envision the possibility of an unresolved conflict stagnating the processing of the related information. Such conflict needs to be addressed and worked through.

Whenever structural deficits are at play, the therapist needs to provide compensatory skills before pursuing the exploration. Without those skills, the patient may be unable to proceed toward symbolically approaching the traumatic event and experiencing its associated affects, because the ego becomes overwhelmed. Teaching certain techniques, such as anxiety management strategies, is often required at this stage. Whenever an insecure attachment pattern is detected within the therapeutic context, a behavioral technique can be employed at the service of a dynamic purpose. A relaxation exercise can be tape-recorded during a session with the therapist. The patient then listens to the voice of the therapist to calm himself or herself at convenient times at home. The therapist is thus present in the form of a transitional object, which helps reduce the patient's anxiety while also restoring his or her sense of autonomy.

TRANSFERENCE AND COUNTERTRANSFERENCE

As pointed out by Lindy (1989), most analytic literature fails to underline the unique transference reactions in traumatized patients. He identifies four types of transference. The patient may transfer spe-

cific repressed or disavowed memories of the traumatic event onto the treatment situation. The patient may transfer onto the therapist the roles occupied by significant figures during the traumatic event and its aftermath, either the aggressor or other victims. The patient may transfer onto the therapist the intrapsychic functions that have been distorted as a result of the trauma, in the hope of restoring healthier functions. Finally, the patient may transfer onto the potentially understanding therapist a deeper wisdom about life, in the hope of making sense out of the catastrophe and thereby restoring a sense of personal meaning.

McCann and Pearlman (1990) outlined diverse transference reactions to the therapist. The therapist may be perceived as a potential aggressor, a violator of sacred boundaries, an untrustworthy betrayer, an interrogator or a judge, a controller, an indifferent witness, and a potential victim of the patient's aggressive impulses. Inversely, the therapist may be perceived as a caretaker, a friend, a protector, and a potential loss. In response to the patient's damaged functions, the therapist may be viewed as either a soothing other or a container for intolerable affects.

When dealing with a traumatized individual, a therapist is also at risk of inappropriately reacting to the patient in specific ways. Four basic countertransference issues can be identified: namely, becoming hostile toward the patient, feeling helpless or overwhelmed, becoming indifferent, and attempting to save the patient. According to Wilson (1989), the therapist's anger may become directed at the patient because the therapist fears the intensity of the patient's affects or because the experience of the patient's helplessness during the trauma challenges the therapist's notions of unalterable control, invulnerability, and safety. Upon hearing the trauma story, the therapist may identify with the patient more than empathically and thus lack the appropriate distance from the patient's affects. In reaction, the therapist may become indifferent by numbing his or her responsiveness or by deliberately avoiding discussions about the patient's traumatic experience. The therapist may develop anxiety over his or her ability to help the patient by becoming overwhelmed by the patient's feeling of helplessness or by guilt over being exempted from such a traumatic experience. Finally, the therapist may become overcommitted, from an excessive belief in his or her responsibility to rescue the patient, whom the therapist sees as helpless and pitiful.

It should be noted that the therapist can feel anger and even rage toward the victimizer, or toward society for failure to help or protect the victim. These reactions are normal, but the therapist should be

aware of a potential vicarious traumatization and revise, if necessary, his or her own internal representations of self and the world (McCann & Pearlman, 1991).

EVALUATION OF EFFICACY

The evaluation of therapy efficacy is first achieved through an ongoing examination of the attainment of the therapeutic goals outlined earlier. The therapist first considers whether the patient better acknowledges the traumatized self. Acceptance of the traumatized self, however, is usually achieved only after the complete revision of the traumatic event. At the same time, the therapist verifies whether the patient has regained some control over his or her inner and outer worlds. This goal is fully attained only when the revision of the patient's inner representation of self and the world is completed. With integration of the traumatic information, the patient has usually regained premorbid functioning, if not at a more adaptive level, and PTSD symptoms have usually disappeared, along with any other comorbidity. These latter achievements are the cornerstone of the evaluation of the efficacy of therapy. Some anxiety or PTSD symptoms are likely to remain, however, if the individual presented with a premorbid disorder, which usually impedes the processing of the traumatic information.

The finalization of the therapy process involves, nonetheless, attaining two other therapeutic goals: the automatization of mature defense mechanisms and coping skills in the eventuality of potentially traumatic events, and a reconceptualization of trauma as a challenge for growth and of life as necessarily entailing painful aspects.

TIME LIMIT AND TERMINATION

The duration of therapy may vary from three months to two years. While the length of treatment can usually be predicted at intake by an experienced therapist, it can be shorter or longer depending on the patient's motivation for change and/or premorbid ego functioning.

Termination is usually first addressed by the therapist when a revision of the patient's inner representations has been completed. At this point, if the patient was absent from work following the traumatization, a progressive reinstallment at work is planned and undertaken. When the patient has successfully been reintegrated into the workplace, the frequency of therapy sessions drops from two per week to one. Patient and therapist then discuss the therapy work accom-

plished and the work left to be accomplished, including terminating the therapeutic relationship. It is important to set the end date with the participation of the patient, again giving control to the patient.

Before terminating, the patient's reactions to losing the therapist are addressed. A regression in the patient can be encountered at this point, with a resurgence of some symptomatology. Besides interpreting the patient's wish for continuity, it is important that the therapist highlights the patient's much lesser need for the therapist, because therapy has led to a remission of symptomatology, regaining past functioning and an increased sense of self-efficacy. At the end of this phase, the patient usually thanks the therapist for providing competent help, and the therapist recognizes the patient's contributions to the recovery process.

CASE EXAMPLE

Mary was a 40-year-old woman married to a retired policeman. She was the mother of a 13-year-old teenager who was successful at school. They were religious and close to their relatives and friends. Mary had worked as a bus driver for the previous two years. When I evaluated Mary's psychological status, she presented with a severe and chronic post-traumatic stress disorder, along with a conversion disorder that made her hands and arms become painfully swollen.

Her PTSD symptoms appeared six months before she consulted me, when a teenager was murdered by another teenager in the back of her city bus. She discovered a 13-year-old boy moaning, with rolling eyes and blood spitting from his chest cavity. She first attended to him but quickly realized that she had to call 911 because no passenger had done it. She left the bus, running to the garage station across the street. She then returned to the bus, evacuated the remaining passengers, and held the hand of the victim. The boy died before emergency personnel arrived. She went to the police station, where she spent most of the night. The next day, the event was highly publicized in the press; some journalists wrote that the bus driver had had to go to the hospital due to a nervous breakdown. To save her honor and that of her women colleagues, Mary went back to work a week later despite her severe PTSD symptomatology.

The murder trial was held three months later. While waiting to give her testimony, she had to sit in a small room for two days with the friends of the murderer. Just before the trial, the prosecutor had

called Mary to inform her not to say that she had stopped her bus abruptly before the knife went into the victim (which did not happen) because the defense lawyer might attempt to say that she was responsible for the death. Two days after the trial, Mary developed a conversion disorder and had to be hospitalized for a month. After two scans produced negative results, the medical staff let her go home. She called me for an appointment two months later, at the insistence of a friend, after the swelling had spread throughout her upper body.

Before she could return to work, Mary was treated in dynamic therapy that lasted nine months, at a frequency of two sessions per week. I present below the processes and outcomes of this portion of therapy, dividing it into three phases.

At the beginning of the first three months of therapy, Mary complained mostly about her swelling, which she forcefully wished to be of organic origins. She denied any distress over the occurrence of the murder in her bus. I quickly attended to her swelling because it greatly interfered with her functioning and, therefore, her self-esteem. I recorded a hypnotic session in which I had her imagine that she had regained her manual dexterity (she chose to peel a potato successfully) and gave her suggestions that the swelling would reduce (but not vanish). She practiced it twice a day and, within a week, she was functional, with only some swelling and pain still present.

In parallel, I gently but repeatedly questioned her about her PTSD symptoms. I educated her about PTSD symptomatology and interpreted her avoidance strategies, while acknowledging that they were helpful in protecting her against psychic pain. I normalized her irritability, stating that she also suffered when her irritability hurt others because she usually hurt loved ones. I invited her to seek comfort from them, especially her husband, rather than isolate herself. As a result, her relationships at home improved and she became less irritable. I repeatedly inquired about the details of what happened during the traumatic event and about how she reacted, and I repeatedly and empathically interpreted her panic and anger, which she denied less and less, at least her anger toward the press. I gradually linked the swelling to her distress, providing some evidence for this hypothesis, but I also encouraged her to get another neurological checkup, which she vehemently insisted was necessary.

To foster the alliance, I offered the hope of a psychotherapeutic solution to her presenting problems, provided her with empathic comments, and protected her damaged self-esteem by rendering her

more functional. The alliance gradually strengthened as she grew in commitment and capacity to work in therapy and felt a faint, emerging hope. I did not interpret her growing idealization of me, and therefore, positive transference developed.

After three months of therapy, the intrusion and avoidance symptoms had decreased in frequency. Emotions like panic, anger, and sadness were emerging, but numbing was still important.

During the fourth month of therapy, we did exploratory hypnosis about the traumatic event. We stopped the review at crucial moments. One of those moments was when she first realized what had happened, when she saw the 13-year-old boy stabbed to death. I asked her what she felt, what were her thoughts or sensations, and pursued by asking if she saw any image. She had immediately seen her son. I kept up my queries: "What if it were your son?" She replied, "It should be me." Then I asked, "What if it should be you?" She replied, "Then I should be stabbed." Mary had intrusive pseudohallucinations during which she felt that someone behind her was going to stab her. Besides other meanings that emerged from this hypnotic session, we could identify her survivor guilt at the impression that her son had been killed, and her wish to repair the damage by being killed herself. I went on interpreting her panic, anger, and shame. I suggested that her guilt feelings interfered with the resolution of her trauma and that we had to explore its source. She told me that she felt responsible for the happiness of the passengers on her bus; I pointed out how unrealistic that attitude was and wondered why she felt so responsible. She then went on to talk, for the first time, about her husband's manic-depressive disorder, which developed following a shooting in which he intervened as a policeman some years before. During the months following this traumatic event, her husband had regularly abused her verbally and deserted her. She had been hurt by his manic comments and behaviors, which led her to become very angry but she repressed her anger. She had to obtain a court order to have him treated against his will and had felt responsible for his emotional stability ever since. In addition, she had to become the pillar of the family, a role she had not expected to have to fill when she married a policeman. This situation also provoked her anger. We could then start working on her anger and on understanding why she kept herself from acknowledging it.

To reduce her sense of responsibility for her husband's well-being, on my encouragement they decided that he would seek psychotherapy for himself. Having to be less vigilant about his mood changes, Mary could better attend to herself and acknowledge her anger. I

interpreted her pseudoindependence and encouraged her to reach out for emotional support from her husband and friends as well as to set limits on others' demands. At my invitation, she asserted herself toward the media during an interview with a decent television magazine in which she talked about what she had experienced as an indirect victim of a crime, exposed her mishandling by the press and the prosecutor, and corrected the facts surrounding the event.

With respect to her conversion disorder, we identified situations that provoked the swelling. However, as her psychological defenses toward the traumatic event loosened, the swelling extended to her lower body. Consequently, I had to restrain myself from feeling panicky. I kept on exploring, and for the first time, I affirmed that her symptoms were of psychological origin. I discouraged further neurological checkups because there had already been three negative scans. When a neurologist suggested exploratory surgery, she refused it, being capable by then of recognizing that her panic was expressed by her swelling.

After six months of therapy, she approached the various stimuli related to the traumatic event more freely, and her numbing had vanished. Reexperiencing and denial symptoms were reduced. But she had become more depressed and anxious, with emotions emerging in association with relevant meanings. She resumed seeing her friends, including coworkers. She felt that she had regained some mastery over her external world and that her self-esteem had increased, but her gains over her internal world were only partial.

With respect to the alliance and transference issues, I kept on providing empathic support but increased my challenges, while remaining hopeful. She had become very committed and worked hard in therapy, providing more significant information and making relevant links. Her initial fear of hurting me with her anger was dissipated. Her positive transference feelings kept on increasing, but they were not interpreted.

Between the sixth and ninth months, the anniversary of the event occurred. I predicted a surge of symptoms, and as they were reexperienced, I linked the reoccurrence of her pseudohallucinatory symptom to her anger at the murderer, who had damaged the lives of so many individuals, including herself. I conducted another hypnotic session, reviewing both her participation in the trial as a witness and the period during which she had waited to testify. It appeared that she had felt terribly guilty and afraid of being accused (as the prosecutor had suggested might happen, unknowingly playing on her heightened sense of responsibility for everybody on her bus). To com-

pensate, she had held her body very straight, like a soldier, during the entire two days of waiting. I linked her guilt feelings to her anger at her husband for having hurt her so badly a few years before, a connection she resisted at first but affirmed later. She had felt tremendous guilt over being angry at her husband, who was sick and had therefore not been responsible for his behavior and illness. At first, she felt like a bad person for being so angry; her negative self-image was confronted, and her anger validated. Turning her anger toward herself and ending up feeling guilty was the usual defense mechanism she employed against her anger. Her guilt feelings were also at play in her response of denial of her realistic helplessness toward what could happen to loved ones: her husband could relapse, and her son could be hurt or killed by others, like the young victim on her bus.

As her PTSD symptoms dissipated and her conversion disorder became barely noticeable, giving her only some occasional pain, we initiated her return to work. To assist her in facing the associated anxiety, I quickly taught her cognitive and behavioral techniques for anxiety management. For the first two weeks, she returned to work part-time during the day, sitting on a bench next to the driver on duty. Then she drove the bus accompanied by the same driver for another two weeks. Then for two more weeks, she drove the bus accompanied by another driver at night. Because these steps were successful, she resumed a full-time work schedule. Coincidentally, she was assigned the same route she had been driving the night of the murder. After her full return to work, everything went well, except for an intrusive image that emerged every time she stopped at the street corner where the murder happened. She saw the same woman on a balcony, and herself crossing the street to call 911 because a murder had just happened on her bus. To erase this flashback memory, I interpreted it as being there because her mind had not put the event into the perspective of time. We did another hypnotic session in which she was on her bus and had the flashback at the same corner, but this time she actually got out of her bus, as if a murder had just happened again. I made her stop across the street, wonder what she was doing, asked herself whether a murder had really just happened, look at the bus to see whether there was turmoil in it, decide that everything was fine, come back to her bus, and resume driving. The flashback never reoccurred. Furthermore, in the first week after her return to full-time work, two gangs of teenagers started a fight on her bus; she put on her sign for 911 and got out of the bus. She went back only after they had left. She was shaken for a few minutes, realized

her state, and calmed herself down. She was able to finish her shift. We had foreseen such an event, and I had taught her how to cope with it effectively. No relapse occurred.

To maintain the alliance during this period of therapy, I fostered her autonomy as well as her needs and organized her step-by-step return to work. To foster her independence, I interpreted her idealization of me as a belief that I was omnipotent. At first she argued, becoming angry at me for two weeks, but she then conceded that I could also make mistakes and might not know everything. She even acknowledged that she had previously noticed me struggling with different hypotheses. We went on interpreting her conception of God as omnipotent and judgmental; she viewed God as punishing sinners by provoking bad events in their lives. Therefore, she thought she had been punished for being bad. We settled on another conception of God, as the creator of the universe, which includes randomness. We concluded that, as humans, we have to face every event and try to learn from it, even if doing so entails pain; we can then pay better attention to the more essential things in life, like our relationships with loved ones.

During the next few months, therapy sessions were reduced to once a week, then to once every two weeks. I kept on interpreting her exaggerated sense of responsibility on her bus, while providing her with alternative attitudes and behaviors and giving her permission to feel angry at passengers who were nasty toward her but not to act on her anger, because there were inherent dangers in her work. We also addressed her anger at a parental figure who rejected one of her characteristics. This parent had died while they were still in conflict. We worked on recognizing her anger at this parental figure, and then on encouraging her to feel close again to this lost loved object.

She was unhappy when therapy had to terminate, but she thanked me for my help. I recognized both our contributions and stated how much I had enjoyed working with her.

TRAINING

Training in dynamic therapy for PTSD requires that a therapist understand basic dynamic concepts. However, any dynamic therapist who wishes to treat traumatized individuals should become familiar with the features of PTSD, along with the associated conflicts, and should be knowledgeable about the various contemporary

analytic models of its etiology. The main difference between a traditional dynamic therapist and a dynamic therapist specializing in treating PTSD is that the latter fully recognizes that external events can be traumatic in and of themselves and addresses them as such.

Ideally, the educational curriculum of the Society for Traumatic Stress Studies (1989) should be included in the training of any therapist who wishes to specialize in treating PTSD. Pragmatically, I have come to realize that a complete training involves weekly theoretical seminars and clinical supervision for at least one year and bimonthly theoretical seminars and supervision during the second year. A successfully trained therapist should be able to demonstrate a clear understanding of both PTSD and the therapy process, as well as efficacy in the treatments provided. Only already experienced therapists should specialize in treating PTSD.

EMPIRICAL EVIDENCE FOR THE APPROACH

To my knowledge, there exists only one randomized clinical trial that has tested the efficacy of Horowitz's model. Brom, Kleber, and Defares (1989) randomized 112 subjects presenting with PTSD, diagnosed according to *DSM-III*, among three therapy modalities—Horowitz's brief dynamic therapy, trauma desensitization, and hypnotherapy—and a waiting-list control group. The mean length of treatment varied from 15 to 19 sessions. Outcome was assessed, among other measures, on the Impact of Event Scale. The 12 dropouts were evenly distributed among the therapy groups. Results indicated that, after four months, treated subjects presented significantly fewer symptoms related to trauma than did the control group. There was no overall significant difference between therapy modalities at termination and follow-up. However, trauma desensitization and hypnotherapy had a stronger influence on reducing intrusion symptoms, and brief dynamic therapy had a greater impact on avoidance symptoms. Furthermore, the authors underlined that these therapies did not benefit everyone and the effects were not always substantial; only about 60% of treated patients showed clinical improvements. These findings suggest that, as in the dynamic approach presented here, a combination of dynamic therapy and hypnotherapy may be beneficial to traumatized individuals, each therapy primarily addressing either avoidance or intrusion symptoms, and that a longer duration of therapy might yield greater improvements.

With respect to the process of brief dynamic therapy for trauma, Horowitz, Marmar, Weiss, DeWitt, and Rosenbaum (1984) found that, in a sample of 52 bereaved patients, the alliance was predictive of outcome, and that there was an interaction between patient pretreatment motivation and two types of interventions. Patients with lower motivation did better with more supportive interventions, and patients with higher motivation obtained better results with more work on differentiating reality from fantasies. These findings are in accord with the process outlined in this chapter.

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