Psychodynamic psychotherapy for posttraumatic stress disorder related to childhood abuse—Principles for a treatment manual

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In this article, the authors present a psychodynamically oriented psychotherapy approach for posttraumatic stress disorder (PTSD) related to childhood abuse. This neurobiologically informed, phase-oriented treatment approach, which has been developed in Germany during the past 20 years, takes into account the broad comorbidity and the large degree of ego-function impairment typically found in these patients. Based on a psychodynamic relationship orientation, this treatment integrates a variety of trauma-specific imaginative and resource-oriented techniques. The approach places major emphasis on the prevention of vicarious traumatization. The authors are presently planning to test the approach in a randomized controlled trial aimed at strengthening the evidence base for psychodynamic psychotherapy in PTSD. (Bulletin of the Menninger Clinic, 76[1], 69–93)

Posttraumatic stress disorder (PTSD) is a psychiatric disorder that is particularly prevalent among individuals who experienced...
childhood trauma (Margolin & Vickerman, 2007). Childhood trauma leading to PTSD markedly differs from childhood trauma leading to neurosis. A childhood trauma leading to neurosis can be described as a phase-specific (e.g. oedipal) traumatic experience occurring in an overall family environment of caring and trust, with the individual’s ego being strong enough to repress his or her conflict-laden wishes. In contrast, a childhood trauma leading to PTSD like physical, sexual, or emotional abuse affects an individual’s basic attachment relationships and ego functions, thus rendering him or her vulnerable to being overwhelmed by traumatic memories (Bokanowski, 2005). Individuals with PTSD related to childhood abuse typically exhibit problems of emotion regulation, self-concept, and interpersonal relationships and a broad variety of affective, anxiety, dissociative, and somatoform symptoms in addition to the PTSD symptoms as defined in ICD-10 or DSM-IV. These symptoms have been referred to as “comorbid conditions,” although convincing evidence suggests that they reflect a “complex trauma” condition (Herman, 1992). A history of childhood trauma has been shown to predict outcome in chronic PTSD (Ford & Kidd, 1998).

Although largely understudied (Cloitre, 2009), psychodynamic approaches have been widely used for treatment of PTSD among practitioners (Schottenbauer, Arnkoff, Glass, & Gray, 2006). Several reasons might contribute to this (Schottenbauer, Glass, Arnkoff, & Gray, 2008a): First, a basic understanding of psychic trauma has been crucial for psychoanalytic thinking from its beginning (Freud, 1888/1966, 1917/1953, 1920/1955), and psychodynamic authors have constantly underscored the importance of trust and relationship issues involved in childhood abuse (Ferenczi, 1949; Rangell, 1986). Second, contributions on the basis of psychodynamic object-relations theory are valuable tools to understand the special relationship structures of traumatized persons, which is necessary for constructing a strong therapeutic alliance (Balint, 1956, 1969; Luborsky, 1984; Winnicott, 1960). Third, techniques to handle difficult transference and counter-transference phenomena common in complex trauma patients are best elaborated in psychodynamic psychotherapy (Dalenberg, 2000; Gabbard, 1995; Wilson & Lindy, 1994). Fourth, the attach-
ment disorder and mentalization deficit underlying most complex trauma conditions can be successfully treated by psychodynamic approaches (Bateman & Fonagy, 1999, 2004, 2009; Solomon, Ginzburg, Mikulincer, Neria, & Ohry, 1998). Fifth, approaches informed by ego psychology provide a broad spectrum of interventions to develop deficient ego functions of complex PTSD patients, for example, impaired emotion regulation and disturbed interpersonal regulation (Bellak, Hurvich, & Gediman, 1973; Leichsenring, Masuhr, Jaeger, Dally, & Streeck, 2010; Rudolf, 2004). Sixth, impaired capacity of self-care and poor self-esteem typically found in complex trauma patients can be conceptualized in terms of internalized object relationships (Ferenczi, 1949; Jacobson, 1964).

However, there is growing consensus among psychodynamic trauma therapists that a “classical” psychoanalytic treatment approach using free association and transference interpretation does not adequately take into account the psychobiological nature of impaired information processing in PTSD (Reddemann, 2004).

Instead, PTSD-specific and neurobiologically informed psychodynamic concepts addressing the broad comorbidity of PTSD related to childhood trauma are required. Among the PTSD-specific approaches, the short-term psychotherapy models by Lindy (1993), Horowitz (1997), and Krupnick (2002) were intended primarily for highly functioning individuals exposed to a single traumatic event. On the other hand, those concepts that do address complex trauma conditions and the inherent problems of impaired information processing and emotion regulation (Chu, 1998; Cloitre, Koenen, Cohen, & Han, 2002; Courtois, 1999; Gil, 1998; Herman, 1997) lack a specific psychodynamic orientation. Against this background, we present an integrative psychodynamic treatment approach.

Overview of a psychodynamic resource-oriented psychotherapy approach for PTSD related to childhood abuse

A psychodynamically oriented approach to treat complex PTSD has been developed in Germany during the past 20 years by Reddemann (2004) and further elaborated by Sachsse (2004), Wöller
It is based on more general psychodynamic theories concerning ego functions and object relations (Bellak et al., 1973; A. Freud, 1937; Hartmann, 1939/1958; Jacobson, 1964; Kernberg, 1976) and on specific psychodynamic theories of posttraumatic disorders (Ferenczi, 1949; Freud, 1920/1955; Horowitz, 1997; Janet, 1889; Reddemann, 2004). It integrates psychodynamic and trauma-focused treatment approaches within a theoretical framework informed by affective neuroscience, resilience research, and attachment theory.

While being clearly based on psychodynamic theory (Gabbard, 2000, 2004; Wöller & Kruse, 2010), the repertoire of therapeutic interventions for working with traumatic memories has been broadened by introducing imaginative and resource-oriented techniques. The concept takes into account the high comorbidity and the large degree of ego-function impairment typically found in PTSD related to childhood abuse, especially in the domain of emotion regulation and interpersonal regulation. As resource activation including guided imagery is an important ingredient of the approach, the concept draws on hypnotherapeutic and solution-oriented psychotherapeutic approaches. Today, the approach is widely used in German-speaking countries to treat patients with complex posttraumatic disorders.

The following four elements are the cornerstones of this integrative approach:

1. The psychodynamic relationship orientation implies an understanding of the patient’s symptoms against the background of current and earlier interpersonal relationships. Hence, psychodynamic work aims not only at the modification of the symptoms, but also at influencing the interpersonal relationships that maintain the current symptom pattern. In line with consistent findings of psychotherapy research (Luborsky, 1984), psychodynamic therapy places a strong emphasis on the quality of the therapeutic alliance. Furthermore, it emphasizes the role of recognizing transference for establishing a stable working alliance.

2. Resource orientation is also considered a major element of the therapeutic approach. In terms of psychodynamic ego psychology, activation of internal resources means enhanc-
ing the patients’ mastering and coping competencies (Bellak et al., 1973). In terms of psychodynamic object-relations theory (Kernberg, 1976), it can be understood as a process of restoring the ability to activate positive internalized object relationships. This can be accomplished by evoking memories of positive relationship experiences or by stimulating fantasies of positive experiences. For example, evoking a memory of a personal success aims at restoring self-esteem by actualizing an internalized object relationship of a self being mirrored by a good object. Likewise, the imagination of a “safe place” aims at enhancing the feeling of safety by actualizing an internalized object relationship of a self being protected by a good object. As trauma blocks the patients’ access to positive internalized object relationships and the related positive emotions, the approach aims at evoking in traumatized patients a psychological state of well-being. Furthermore, it aims at improving coping strategies by directly activating the respective ego functions and internalized object relationships. Imaginative techniques are valuable tools to activate positive resource states (Flückiger, Caspar, Grosse Holtforth, & Willutzki, 2009; Grawe, 2006).

3. The neurobiological orientation takes into account PTSD patients’ impaired capacity of emotion regulation and altered information processing (van der Kolk, McFarlane, & Weisaeth, 1996) by adding trauma-specific techniques to improve emotion regulation and to process dysfunctional memories. (These trauma-specific techniques will be described later in this article.) Clinical studies have suggested PTSD to be a disorder involving both emotional undermodulation (lack of control over or disinhibition of emotional responding), which occurs during reexperiencing/hyperarousal reactivity, and states of emotional overmodulation (overcontrol of emotional states) in an attempt to restrict unwanted emotional experiences, which occurs during states of dissociation, numbing, and analgesia. Emotional undermodulation has been proposed to be mediated by failure of prefrontal inhibition of limbic regions, whereas
emotional overmodulation may be mediated by prefrontal inhibition of the same limbic regions (Lanius, Frewen, Vermetten, & Yehuda, 2010; Lanius et al., 2010).

4. Last but not least, an emphasis is placed on the therapists’ well-being and mental health because of the always impending danger of vicarious traumatization and professional burnout (Pearlman & Saakvitne, 1995).

For these reasons, treatment planning follows the “Consensus Model of Phase-Oriented Trauma Therapy” (Courtois, 1999; Herman, 1969; Reddemann, 2004), which involves stabilization, trauma processing, and reintegration phases. The model demands a comprehensive stabilization and a marked improvement of emotion regulation in the first phase before work with traumatic recollections can be undertaken in the second phase. The phase structure of the concept does not imply that it needs to be followed rigidly. Rather, it provides an orientation for treatment planning. The relative importance and time structure of the phases can vary to a large degree, according to clinical requirements.

Diagnostic prephase

Before starting the therapy, descriptive and psychodynamic diagnoses have to be established. Descriptive diagnoses of PTSD and all comorbid disorders are recorded according to the criteria of DSM-IV. For establishing a descriptive PTSD diagnosis, a trauma has to be identified that fulfills the criteria required. Because it is not recommended to elaborate the details of the traumatic experiences, clients are asked to give the information necessary for diagnosis in an emotionally detached and “observing” way in order not to be overwhelmed by the material. If the patients are unable to adopt this detached and observing attitude toward their trauma in the early phase of the therapy, exact trauma diagnosis is postponed until they have acquired this ability.

Psychodynamic diagnostics include a diagnosis of conscious and unconscious conflicts and a diagnosis of structural deficits on the basis of the “Operationalized Psychodynamic Diagnostics” (OPD Task Force, 2001). Affect regulation and coping capacities
are conceptualized as ego functions in terms of psychodynamic ego psychology (Bellak et al., 1973).

Phase 1: Stabilization and structure building

The first phase of the treatment is dedicated to building up a stable therapeutic alliance, improving emotion regulation, and strengthening coping capacities. Many severely traumatized patients will not proceed beyond this phase, while some will go on to phases 2 and 3 as soon as stability and emotion regulation have improved. This is especially important for traumatized patients who live in unsafe conditions of ongoing domestic violence or sexual harassment. In these cases, the focus should be entirely on providing support and developing safety, and the therapy should not move beyond the first stage of treatment.

Providing information about the disorder and the treatment

At the beginning, information about the disorder, its origin, and treatment modalities are communicated to the patients. Special emphasis is placed on explaining the phase model of trauma therapy and the risks of premature exposure to traumatic memories (Allen, 2001; Wöller, 2006). The patients are informed that they will maintain full control over the therapy process. They should be assured that no therapeutic activities will be undertaken without their consent. Furthermore, the patients’ commitment and shared responsibility for the healing process are clarified.

*If a patient insists on working through traumatic memories at an early stage of the therapy, the therapist might say: “I’d like to give you an explanation why stabilization is so important and what it makes advisable not go into the traumatic memories too early.”*

Ensuring safety

Providing a feeling of safety is of crucial importance in the first phase of therapy. In addition to providing external security, enhancing the feeling of safety in the therapeutic relationship is an explicit goal. It is essential for the patients to create an inner sense of safety by internalizing the therapist as a security-providing ob-
ject. This includes a firm framework and a reliable structure of the therapy. To enhance the patients’ sense of safety, the therapist asks the patients what they need in order to feel safer and more comfortable in the therapy room. Self-endangering behavior has to be addressed as a top priority throughout all therapy sessions. Treatment contracts are advisable for suicidal impulses and self-destructive behaviors. This procedure is in line with Transference-focused Psychotherapy for Borderline-Personality Disorder (Clarkin, Yeomans, & Kernberg, 2001). For emergency situations, the therapist develops a detailed emergency action plan. The patients should know what to do and whom to contact when in distress.

Therapist: Please tell me what you need to feel safer and more comfortable in this room. Please make sure both of our seating positions are okay. Maybe you would like me to sit closer or further away from you?

**Strengthening the feeling of control**

In consideration of traumatized patients’ frequent fears of losing control, their sense of being in control has to be strengthened. The therapist should explain to them that they will maintain full control over whatever happens during the therapy and that nothing will happen during therapy without their explicit consent. The patients are requested to check the utility of all therapeutic recommendations. They should have the possibility of accepting them if they are fitting or of rejecting them if they are not. Whenever possible, they should be given choices.

Therapist: Please tell me if it is okay for you to talk more about....

Therapist: What do you think we should do next: Should we work on X or on Y?

**Antiregressive and resource-oriented therapeutic stance**

In order to foster the patient’s mastering capacities by actualizing his or her internalized good object relations, the therapist adopts a therapeutic stance that actively discourages regression and strengthens the adult ego of the patient. The therapist focuses on current coping styles and interpersonal reality rather
than on dream material or fantasy production. Existing coping resources and successful strategies to cope with negative emotional states are actively explored, and the search for new coping strategies is encouraged. In addition to identifying situations that trigger a negative response, the patient is encouraged to identify those situations that make him or her feel a little better. Instead of proclaiming abstract therapy goals, the patients are asked to describe in detail which positive effects will occur if therapy will be successful. Generally, the therapist is more focused on solutions than on how the problem has developed. To stimulate a resource-finding process, the client is asked what resources he or she needs to solve a problem and how he or she could find them. The therapist’s active intervention style, focusing current problems, and calling upon the patient to actively cooperate contribute to counteracting patients’ regressive attitudes and passive healing expectations.

Therapist: To feel better, what do you need?

Therapist: If therapy works well, what will have changed in your life when therapy is over? How will you notice that?

**Intervention style of the therapist**

Contrary to classical psychoanalysis, the intervention style of the therapist is more active and based less on interpretive interventions. An overly neutral and abstaining style is avoided because it might easily activate feelings of abandonment. The preferred insight-oriented interventions are clarification and confrontation, whereas interpretation of unconscious material is used only exceptionally. The therapist mainly clarifies the patients’ impaired ego functions and invites them to regularly practice and exercise to improve them. Maladaptive and self-destructive behavior patterns are addressed, and more adaptive ones are encouraged. If needed, calming, relieving, and other supportive interventions are provided. While the concept of a continuum of psychodynamic interventions ranges from pure supportive to insight-oriented interventions (Gabbard, 2004; Luborsky, 1984), interventions in the first phase of the treatment are geared more toward the supportive end of the continuum. If a patient remains silent for
a long time, the therapist tactfully interrupts the silence and inquires about the patient’s emotional state. Questions will always be answered unless this is not considered to be adequate. In this case, a reason is given for not answering the question.

_Therapist: I understood that it is rather difficult for you to say “no” if you don’t agree. What do you need to clearly say “no” in situations where you don’t agree?

**Recognizing and managing transference phenomena**
The therapist should be familiar with the most frequent transference patterns encountered in complex PTSD patients, including perpetrator, rescuer, and nonprotecting parent transferences (Dalenberg, 2000; Wilson & Lindy, 1994), as well as unconscious perpetrator identifications (Ferenczi, 1949) resulting in inadequate provocative patient behaviors. Contrary to classical psychoanalysis, the development of a regressive transference neurosis is discouraged. Rather, the therapist identifies and actively works through transference reactions that affect the pursuit of the therapy goals, that is, inadequate patient reactions and behaviors resulting from infantile fears and wishes activated in the therapeutic situation (Greenson, 1967). Likewise, the therapist should carefully monitor subtle disruptions of the therapeutic alliance as a result of transference phenomena or unconscious perpetrator identifications. Not infrequently, repairing alliance deficits can provide an opportunity for strengthening the alliance. Working through transference reactions includes educating the patient about the reality of the therapeutic situation. Specifically, the patient should be reminded that he or she has full control over the therapy and that no therapeutic actions will be taken without his or her consent.

_Therapist: Obviously, the topic was very frightening for you. Maybe you couldn’t tell me this because you assumed that I would criticize you?
Recognizing and managing countertransference reactions
Therapists should recognize and control their own countertransference reactions to provide a secure emotional presence and reliable therapeutic boundaries. The therapist should be especially familiar with the mode of action of the mechanism of projective identification (Bion, 1962; Kernberg, 1975; Ogden, 1977) to understand at least some of his or her countertransference reactions as “deposed” intolerable emotional states of the patient. If the therapist has identified his or her own negative emotional and bodily states in such a way, an empathic relationship with the client will often be facilitated.

Therapist: When I consider how I feel myself when I am sitting here with you, I might get an idea of how bad you have been feeling all the time.

Use of resource activation to improve emotion regulation
Actualization of internalized good object relationships becomes the central therapeutic tool for improving emotion regulation. In the following, it will be referred to as “activation of internal resources.” All kinds of positive memories, capacities, thoughts, memories, and fantasies can be utilized as internal resources (as opposed to external resources like helping persons, etc.). Whatever produces a positive feeling state can be considered a resource. Practically, activation of internal resources can include pursuing pleasant activities, remembering positive experiences, and creating positive feeling states by way of imagination. To that end, the therapist systematically teaches the patients to identify, remember, and vividly imagine memories of positive experiences, personal successes, and positive relationships. To cope with current stressors and life problems, patients are asked to identify those coping resources (capacities) needed to solve the problem. In a next step, the patients are encouraged to search for situations in their life history where this resource was available. Finally, the patients are asked to create a vivid imagination of the resourceful scene.

T: Which resource (i.e., personal capacities) do you need to cope with this problem?
P: Courage.

T: Search for the resource “courage” in your life. When in your life did you have this resource “courage” available?

P: In the year 2006, when I said “no” to my boss.

T: Great! Try to create a vivid image of that scene with your boss. Try to relive the good feeling and the body sensation you had at that moment… (After the patient was able to create a positive feeling and a pleasant body sensation:) What other resources (i.e., personal capacities) do you need to cope with your problem?

P: Self-esteem.

T: Proceed the same way as before and search for the resource “self-esteem” in your life…

**Imaginative techniques**

A variety of imagination techniques are used to increase the feeling of safety and well-being and to help the patient distance himself or herself from overwhelming traumatic emotions and traumatic intrusions. The “container technique” is a valuable imagination technique that deliberately activates the defense mechanism of isolation. It requires imagining a container to put all disturbing traumatic material into. It is especially helpful for coping with traumatic “flashbacks.” The “safe place” imagination and the “healing light” technique are other examples of useful imagination techniques that actualize either internalized good object relationships or positive somatopsychic states unconsciously related to internalized good object relationships. In addition, an observing ego is being installed.

**Managing dissociative crises**

If a patient is engulfed in a dissociative state, reorientation techniques should be applied. To manage dissociative crises, the patients are taught “grounding techniques” that help them “to stay present in the here and now” instead of falling into dissociative states as a reaction to overwhelming trauma-related emotions.
When a patient has lost contact with the outer reality because of an acute dissociative state, the therapist teaches the patient how to reorient himself or herself by directing attention toward external visual, acoustic, or bodily stimuli or toward rational thinking. In this way, the therapist fosters the patient’s sense of reality and reality testing (Bellak et al., 1973).

*T:* Look at me. My name is ... It is now the year 2012. You stay in the ... hospital in ... You are safe now. Look at this room. This is the office of Dr. X.

**Strengthening the capacity to differentiate affect states**

Traumatized patients typically are “flooded” by undifferentiated trauma-related emotional states that contain elements originating in the traumatic past and elements originating in the current situation. These undifferentiated emotional states are characterized by feelings of powerlessness and/or abandonment. Therefore, the treatment aims at helping them to use the ego function of reality testing to categorize these affect states into components with respect to their origin in the past or in the present, and to regulate the negative affect arising from the traumatic component. To this end, the patients are educated to use imaginative techniques to separate those parts of the feeling belonging to the traumatic past from those belonging to the present. For establishing distance to the traumatic affect portion, they are invited to use the “container technique” to “pack away” those parts that belong to the past (Allen, 2001).

*T:* Try to imagine this feeling of rage as an object that you can see and grasp.

*P:* I’ll try.... Okay, I got it.

*T:* Now identify that part of the feeling which fits to the real situation and that part of the feeling which fits to the past. What percentage of the feeling fits to the real situation?

*P:* About 20 percent.
Treating depressive comorbidity
Depressive comorbidity requires additional soothing, guilt-relieving, and encouraging interventions if patients suffer from high superego pressure or feelings of failure. Resource-activating techniques can be helpful if they are not experienced as a pressure to stereotypically think positively or as a way to minimize their suffering.

Furthering self-care and self-protection
Poor self-care and self-protection often require insight-oriented work to clarify the impact of internalized object relationships underlying these behavioral patterns, for example, an inner prohibition of self-care and self-protection resulting from the introjection of an abusive and criticizing object relationship. Additionally, several deficient ego functions, including anticipation skills, self-object differentiation, and strengthening of self-esteem, have to be developed according to psychodynamic ego-function diagnostics (Bellak et al., 1973; OPD Task Force, 2001).

Developing mentalization capacity
To foster the patient’s capacity for mentalization, the therapist helps the patient explicate both his or her own and other persons’ mental states. The patient should apprehend his or her and other’s behavior on the basis of mental states, that is, thoughts, beliefs, and intentions (Bateman & Fonagy, 2004). An attachment relationship has to be established in which the patient has a sufficient sense of security to work in a potential space (Winnicott, 1960) that enables him or her to “play with reality” (Fonagy, 1995),
thus strengthening his or her reflective function. Because trauma impairs the process of representation, the therapist especially attends to the mental process of representing relationships.

T: Can you understand why he behaved the way he did? What might have been his motives?

**Protection against vicarious traumatization**

In order to protect himself or herself against being overwhelmed by the patients’ traumatic material, the therapist should discourage the patient from talking about traumatic experiences in detail. The therapist should strive to strengthen rather than weaken the patients’ defenses. If necessary, patients should talk about traumatic experiences in a detached way without activating their full emotional response. Recognizing, understanding, and managing one’s own countertransference reactions can protect against both overidentifying with and overly distancing oneself from the patient (Wilson & Lindy, 1994). The ability to identify negative countertransferential reactions as a result of projected patient states can help the therapist regain a detached, but nevertheless empathic, stance in therapy.

Phase 2: Trauma processing phase

If control over emotional responses and sufficient stabilization have been achieved, traumatic memories can be processed (Steele, Van der Hart, & Nijenhuis, 2005; van der Kolk et al., 1996). Processing of traumatic memories aims at restoring the individual’s capacity to symbolically represent the traumatic experience and at transforming highly stressful intrusive memory fragments that lack symbolic representation (“flashbacks”) into coherent representations of past relationship episodes. In the same way, such processing aims at transforming split-off and distorted self- and object representations into more realistic representations of self and significant others (Clarkin et al., 2001; Kernberg, 1975), thus fostering reality testing and a sense of reality. In neurobiological terms, this processing aims at restoring the function of the limbic structure of the hippocampus to form explicit autobiographi-
cal memories without traumatic stress load (van der Kolk et al., 1996).

“Screen technique”
Contrary to neurotic patients, whose capacity for “therapeutic splitting of the ego” into an experiencing and an observing part (Sterba, 1939) enables them to work through their negative experiences in the transference to the therapist, patients with PTSD are at risk of being overwhelmed by their traumatic memories when they are treated in such a setting. Therefore, instead of working through traumatic memories in the “here-and-now” of the transference to the therapist, a therapeutic technique is needed that provides a dosed or titrated emotional processing of the traumatic experience in the “there-and-then.” A technique that allows the patients to work through the traumatic memories as a distant observer of past experiences is the imaginative “screen technique” (Putnam, 1989). This technique requires a setting where therapist and patient sit side by side and watch the traumatic childhood scenes together like an old film. Repetitive observing of the scenes and the empathic presence of the therapist enable the patient to stepwise create coherent symbolic representations of fragmented traumatic memories, thus integrating them without becoming overwhelmed by them. The technique enhances patients’ capacity to differentiate between experiencing and observing while they are exposed to the traumatic material. A mild positive transference should be maintained, and no reliving of the trauma in the transference should be facilitated. Usually, the work begins with recent traumas and subsequently proceeds to childhood traumas. Childhood traumas are processed only if they are clearly remembered.

For processing traumatic memories by means of the screen technique, the following criteria should be fulfilled:

1. A stable and safe therapeutic relationship is obligatory.
2. Sufficient stability in terms of daily life functioning is required. In particular, the clinician must be sure that there are no signs of serious psychiatric disorders requiring treatment (e.g., severe psychotic depression, substance abuse).
3. The traumatic memories should be clearly remembered as events with onset and end and without “blurring.”
4. Trauma-specific techniques of emotion regulation should be mastered.
5. Persistent offender contact represents a contraindication for trauma confrontation.

As long as these conditions are not met, trauma confrontation should be postponed in order not to harm the patient. Particular caution is advised with patients suffering from dissociative symptoms because of the impending danger of an uncontrollable flooding by traumatic memories.

“Inner child” work
“Inner child” work is a therapeutic technique that aims at modifying the toxic self-representations of traumatized patients and at reducing the stress of traumatic memories by reparenting at the inner stage (Abrams, 1990; Price, 1996; Reddemann, 2004). It is a special form of “ego-state” therapy (Watkins, 1993), which draws largely on the work of psychodynamic authors who described multiple self states in normal development and pathological configurations (Bromberg, 1998; Federn, 1952/1978; Glover, 1932). When using the “inner child” technique, a setting is created in which the therapist forms a therapeutic alliance with the adult part of the patient’s ego to treat the inner traumatized “child.” The patient is encouraged to imagine the child he or she was at the time when the trauma occurred and to give it the utmost parental support and comfort. Thus the adult part of the patient will “contain” the trauma of the “inner child” and provide it with a corrective emotional experience without engaging in a regressive relationship with the therapist.

“Inner child” work is a valuable technique for patients with chronic attachment trauma, a history of emotional neglect, and low resource conditions. It is applicable even if the criteria required for the screen technique are not fulfilled.
Phase 3: Reintegration phase

The third phase of therapy aims at therapeutically addressing the manifold conscious and unconscious conflicts a traumatized patient has to face after traumatic memories have been processed. Now that traumatic memories have lost their importance and ego functionality has improved, interpretive interventions will be more promising. Moreover, with the patient’s improved mentalization capacity, transference interpretations will be used effectively. In the third phase of the therapy, the technique resembles more and more a “normal” type of psychodynamic psychotherapy as it is practiced with neurotically organized patients.

Empirical status of psychodynamic therapy for PTSD

The wide use of psychodynamic approaches in the treatment of PTSD (Schottenbauer et al., 2006) is noteworthy in light of existing research data indicating a substantial lack of empirical evidence to support the effectiveness of psychodynamic psychotherapy for PTSD.

Although psychodynamic psychotherapy has been shown to be effective with a variety of disorders (Leichsenring, 2001, 2009; Leichsenring & Rabung, 2008; Leichsenring, Rabung, & Leibing, 2004; Shedler, 2010), existing meta-analyses (e.g., Bisson et al., 2007; Bradley, Greene, Russ, Dutra, & Westen, 2005) and systematic reviews (Cloitre, 2009; Ponniah & Hollon, 2009) could not find enough evidence in terms of randomized controlled trial (RCT) studies to evaluate psychodynamic psychotherapy as effective for PTSD. Indeed, only one RCT study found psychodynamic therapy to be effective for PTSD (Brom, Kleber, & Defares, 1989). Not astonishingly, international guidelines (e.g., Forbes et al., 2007; National Institute of Clinical Excellence, 2005) do not recommend psychodynamic therapy for PTSD. Instead, they endorse the use of trauma-focused cognitive-behavioral therapy (Foa, Rothbaum, Riggs, & Murdock, 1991) and EMDR (Shapiro, 1995) as the preferred therapies for PTSD.
However, major concerns have been expressed over the validity of these recommendations when applied to PTSD related to childhood abuse. First, these guidelines have been developed on the basis of DSM-IV-TR criteria, which do not formally include the symptoms associated with complex trauma conditions. Second, nonresponse rates averaging 20%–25% have been found in studies investigating the effect of the so-called evidence-based therapies. These findings suggest that persons with comorbid disorders or complex PTSD might not respond to these therapies because deficits in regulation of the self, affects, and interpersonal relations are not sufficiently addressed (Schottenbauer, Arnkoff, Glass, Tendick, & Gray, 2008b). Third, clinical observations show that patients with severe “comorbidities” tend to deteriorate under confrontational therapies without prior work on stabilization and ego functioning (Pitman, Orr, Forgue, & de Jong, 1987). Fourth, these patients typically are screened out of PTSD treatment studies (Spinazzola, Blaustein, & van der Kolk, 2005) or drop out during therapy (McDonagh-Coyle et al., 2005). Consequently, substantial doubt has been raised about whether it is justified to apply international guideline recommendations to PTSD related to childhood trauma.

There are, however, three controlled, although not randomized, studies demonstrating the effectiveness of the psychodynamic approach presented in this article (Kruse, Joksimovic, Cavka, Wöller, & Schmitz, 2009; Lampe, Mitmansgruber, Gast, Schüssler, & Reddemann, 2008; Sachsse, Vogel, & Leichsenring, 2006). The study by Kruse et al. investigated the effectiveness of the approach with patients suffering from war-related PTSD in a Bosnian refugee population, and the studies by Lampe et al. and Sachsse et al. were carried out with complex PTSD inpatients presenting severe psychopathology and broad comorbidity following childhood trauma. Sachsse et al. found a significant and stable reduction of PTSD symptoms, frequency of self-mutilating behavior, and number of hospitalizations in comparison to a treatment-as-usual control group.

Given these encouraging findings, there is a clear need for a study with an RCT design to investigate the effectiveness of the
neurobiologically informed resource-oriented psychodynamic psychotherapy approach presented in this article. We are presently planning to test this approach in an RCT aimed at strengthening the evidence base for psychodynamic psychotherapy with PTSD.

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