Trauma-Focused Psychodynamic Psychotherapy of a Patient With PTSD in a Veterans Affairs Setting

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Objective: This article aims to articulate the use of trauma-focused psychodynamic psychotherapy (TFPP) for a 33-year-old U.S. Army veteran with posttraumatic stress disorder (PTSD) in a Veterans Affairs (VA) setting.

Methods: The patient was treated with TFPP, a manualized brief psychotherapy provided as part of a pilot study. TFPP differs from traditional dynamic psychotherapies in its focus on symptoms of trauma and associated dynamics. The patient was seen for an initial 60-minute intake session and then for 16 50-minute sessions over 5.5 months at a VA medical center.

Results: Follow-up three months after termination of therapy indicated that the patient's panic disorder and PTSD symptoms remained much improved, although some rumination and difficulty focusing persisted.

Conclusions: TFPP appears promising as shown with this patient and others in VA settings who have been treated with TFPP.

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CASE PRESENTATION

Patrick was a 33-year-old African-American U.S. Army veteran who served stateside for four years. One week before his planned discharge from the service, he was returned to active duty as a medic and deployed to Afghanistan for one year ("stop-lossed"). He experienced this involuntary extension of his service as a sudden and complete loss of control. He felt powerless and angry but was able to perform his duties as a medic. After returning to the United States, he developed posttraumatic stress disorder (PTSD), with prominent anxiety, flashbacks, and hypervigilance that were often triggered by loud noises, crowds, and the smell of diesel, which reminded him of sensations he had experienced in combat zones. He experienced a disturbing, recurrent intrusive image of a man he had seen with half his face mutilated. When he recalled the image, Patrick repeatedly touched his own face to make sure it was intact. This intruding image and touching occurred multiple times per day. Patrick also had frequent combat-related night terrors in which he woke up anxiously searching for his weapon.

Patrick had a course of exposure therapy at a Veterans Affairs (VA) facility a few years after discharge, which had partially improved his symptoms. His anxiety was less intense, and although he continued to experience hypervigilance, flashbacks, and night terrors, they had become less frequent and less distressing. However, six years later (two years before his current presentation), he began experiencing frequent panic attacks and an increase in PTSD symptoms, specifically intrusive memories and night terrors. He entered into trauma-focused psychodynamic psychotherapy (TFPP) (1), a manualized, brief psychotherapy being provided as part of a pilot study at the VA New York Harbor Health Care System. He was seen for an initial 60-minute intake session, and he then received 16 50-minute sessions of TFPP over 5.5 months. The therapist was a psychologist working at the VA who received a training course in TFPP and supervision to ensure adherence with the treatment.

When he returned for treatment, Patrick was embroiled in a bitter custody battle over his son, Leo, with his ex-girlfriend, Melissa. His ruminations about his son's circumstances and strategies for his custody case impaired his focus. He had daily panic attacks, with tachycardia, shortness of breath, feelings of loss of control, and racing thoughts lasting approximately two hours at a time, regular night terrors in which he had to rescue Leo from combat, and feelings of helplessness. His panic and ruminations often impeded progress in his custody case because his preoccupations interfered with taking necessary actions.

In therapy, Patrick could not at first identify what had exacerbated his symptoms. As part of the initial focus of TFPP, the therapist identified that Patrick's symptoms seemed to have worsened after he commenced the custody battle for Leo; she communicated this idea to him at the end of the first session. Patrick had not noticed this, and this clarification helped him to gain an early sense that his symptoms carried emotional meaning and thus could be understood. He had begun to challenge the custody agreement when Melissa

attempted to move Leo abroad with her new husband, Matt, without consulting Patrick. After Patrick fought this move in court, Melissa was allowed to move with Leo to the Midwest, but she became hostile toward Patrick. He described feeling powerless over the situation, yet he had not permitted himself to acknowledge how furious he was.

By developing a framework for understanding Patrick's symptoms within the first few sessions, the therapist and patient connected these feelings to having his military service extended involuntarily and being deployed overseas when he was preparing to leave the military. Patrick felt as if the custody battle was harder to accept because it was personal and because he viewed Melissa as vindictive. Additionally, Patrick had concerns about Leo's well-being in Melissa's home because Leo had witnessed Matt skinning and gutting a newly felled deer, Matt had extreme religious beliefs, and Patrick suspected that Leo had been disciplined with a belt. Patrick continued to petition the court for full custody of Leo, although he believed it would never be granted.

Parallel to his feelings of outrage and helplessness at the stop-loss, Patrick revealed that Melissa's pregnancy had been a surprise, and Patrick had not felt ready to become a father at that time. He had not felt committed to Melissa and had thought of the relationship as casual. Patrick's initial ambivalence about the pregnancy induced guilt and raised concerns that he might neglect his son the way he had been neglected by his parents. Devoting himself tirelessly to the custody battle eased Patrick's guilt, allowing him to experience only the desire to be a parent and repress the uncertainty and mixed feelings he had experienced initially about the idea of parenthood.

When Patrick first discussed his emotional experience of the custody battle in therapy, he denied feeling angry and said he believed that anger "is not productive" and that it is "only for primates." The therapist emphasized that anger was a normal response to his situation involving Melissa and Leo. Patrick said he felt numb and unemotional, characteristics of PTSD. The therapist and patient identified that Patrick had a long-standing defensive response to experiencing angry feelings. It emerged that this response to upsetting circumstances had roots in Patrick's childhood and was amplified later in the military. Patrick's difficulty experiencing or tolerating his emotions and facilitation of his gaining better access to these feelings were central throughout the treatment. The therapist suggested that Patrick's difficulty permitting himself to experience anger in these circumstances might be contributing to his panic attacks.

Exploration of Patrick's family background provided additional information. Patrick initially described his parents as "weak-minded and narcissistic." He said they did not provide structure and wanted to be his friends more than his parents. In the next session, he expressed guilt over this statement and requested not to discuss his parents anymore, saying he had "dealt with that part of my life" and wished to focus on the present. The therapist said that while she understood this wish, it was important to understand why he seemed to feel so guilty about saying negative things about his parents. She pointed out that he appeared angry at his parents, as he had with Melissa, but he seemed unable to give voice to this anger. The therapist suggested that guilt about feeling so angry and his fears about needing to control his rage were contributing to his panic attacks and PTSD symptoms and were connected with an anxious, uncomfortable sense that he should protect his parents. He responded by sharing that generally he felt pulled to protect "meek" individuals like "children, animals, someone being bullied." He pitied his parents and said they did the best they could considering they were raised in poverty in a small town and seemed to lack the strength of character to better their situation. The therapist alerted him to angry expressions toward Melissa and his parents as they occurred in the session, but he denied feeling angry. She noted that he probably struggled with addressing anger with her in a similar way, because of guilt or anxiety. Patrick did not comment.

Several sessions later, Patrick shared a belief that he was his parents' favorite child because he was often sick; caring for a sick child was straightforward and had made them feel good. He reported that otherwise they did not provide adequate structure and neglected him. He gave an example of skipping class for an entire year without anyone noticing and without suffering any consequences. These two examples led the therapist to wonder whether Patrick tried to get his needs met by exhibiting provocative behavior or by taking on a sick role (i.e., experiencing physical distress) in part to obtain attention, although he had often still been ignored. The therapist noted that it made sense that he might have attenuated his emotional awareness as a way to manage his profound disappointment about being ignored, and that he probably had struggled with guilt about his anger even when he was young. The physical expression of distress was also connected to somatic aspects of his panic and PTSD in that unconsciously he still experienced them as the only way he could comfortably get people to care for or notice him. Having physical symptoms, as bad as they were, protected him from feeling angry and neglected.

Similar examples of avoiding or dampening feelings pervaded Patrick's discussion of his military service. He described treating bodies as "meat" when he was deployed as his way of coping. Without adequate tools to understand and manage his feelings, he distanced himself from them. The therapist suggested that this tendency disrupted his capacity to understand and integrate difficult emotions and experiences, contributing to PTSD and panic. She emphasized that Patrick seemed to experience a disconnection between his physical experience and his intellectual understanding of his emotions, which contributed to his difficulty understanding the physical manifestations of his anxiety and ruminations.

Patrick's concerns for Leo paralleled his fears during his childhood and military experience. He expressed worries that Leo was being treated as property and that the boy's humanity was not being recognized by Melissa and Matt. Leo

was integrated into Patrick's combat nightmares: Patrick was back in the military and fighting to protect him.

Patrick felt Melissa was trying to erase Patrick's tie to Leo and his identity as Leo's father. She made efforts to change Leo's last name to Matt's name and made Leo call Matt "Dad." The therapist tied Patrick's sense of losing his identity as a father to the meaning of his flashbacks to the man missing half his face. She suggested that these flashbacks and subsequent checking of his face were a way to reassure himself of his identity. Patrick described keeping Leo's toys out after his visits; the therapist said this seemed to provide a physical reminder of their relationship, as though the relationship felt fragile and could be easily lost. Patrick worried about neglecting Leo, because of the distance and his inability to control Melissa and Matt's home environment, as he had been neglected by his parents.

Patrick began to see another meaning of his panic and anxiety: as a method of maintaining his connection with Leo and his identity as a father when they were apart. By endlessly, anxiously ruminating about the custody battle, keeping himself on the edge of panic, he kept Leo in mind and ensured that he did not forget Leo the way Patrick felt his parents had forgotten him, or the way fallen soldiers were forgotten. Although the pain of loss and separation from Leo was unbearable, the realization that he did not have to ruminate to maintain their connection was liberating and helped Patrick to free his mind.

Toward the termination of the therapy, Patrick was able to make a clearer distinction between letting himself feel anger and acting on it, which might interfere with his custody case. His guilt and anxiety about angry feelings diminished. He discussed feeling "pissed" at Melissa and was visibly angry during sessions when he described her efforts to thwart his plans to see Leo. He noticed that his ability to express his anger more openly was associated with improvement in his panic symptoms. He gradually recognized that anger, triggered by specific events, contributed to his panic attacks. He allowed himself to feel furious at Melissa following interactions with her, and he took time to cool down before responding. His new openness to experiencing anger improved his awareness of his tendency to minimize his emotional experiences in general. Following a visit with Leo, Patrick discussed making efforts to help Leo build his own emotional awareness and create a space to help him process his feelings. In the service of helping Leo, Patrick permitted himself to feel his own emotions more.

After this visit with Leo, Patrick's panic attacks ceased. At the termination of therapy, Patrick had not had a panic attack in weeks. He continued to anxiously ruminate for 30–45 minutes each morning while strategizing about the court case, but he was better able to control this rumination. Patrick had held two full-time jobs as a distraction method for years, and he left one a month prior to the termination of therapy, freeing time to do things he enjoyed. One such activity was traveling, which he had avoided because he did not feel he "deserved" vacations because they diverted him from his custody fight. By the final session, he had taken two trips and had enjoyed himself. Saying goodbye to the therapist, whom he described as "a torch guiding me through darkness," he expressed sadness and gratitude. Follow-up three months later indicated that Patrick's panic and PTSD symptoms remained much improved, although some rumination and difficulty focusing persisted.

DISCUSSION

Several psychotherapy interventions for PTSD have been developed, but response without remission and nonresponse rates remain high (about two-thirds of patients retain their diagnosis) (2). Psychodynamic psychotherapy has undergone little systematic study for its use in the treatment of PTSD. For the patient described in this article, a manualized, brief psychodynamic psychotherapy for PTSD, called trauma-focused psychodynamic psychotherapy (TFPP), was used (1). TFPP is adapted from panic-focused psychodynamic psychotherapy–extended range (PFPP-XR) (3), which has demonstrated efficacy as a sole treatment for panic disorder (4–6). The PFPP-XR manual has a subsection describing specific approaches for PTSD; patients diagnosed as having PTSD (but not primary PTSD) were included in studies of PFPP-XR (5–7). The case presented in this article illustrates clinical approaches used in TFPP, which differs from traditional dynamic psychotherapies in its focus on symptoms of trauma and associated dynamics. Below, some clinical approaches used in TFPP that are illustrated by specific aspects of the case are described.

In the initial sessions of TFPP, the therapist works to identify how patients are affected by recent and past traumas to understand and thereby relieve symptoms. The therapist is alert for evidence of mistrust, disruptions in narrative coherence, and guilt and shame about traumatic events that can interfere with processing trauma. Patients may avoid discussing or permitting themselves to think about traumatic experiences and have often distanced themselves from painful emotions and memories. Yet patients are terrified about recurrence of trauma, sometimes unconsciously, and frequently feel unsafe. The therapist should avoid actively pressuring patients to describe uncomfortable feelings or memories they are reluctant to address, because this can be experienced as a repeat of the trauma, reenacted in the therapeutic relationship. The therapist's focus on distrust within the therapeutic relationship can help relieve anxiety and distrust, which can help patients to feel safe enough to tolerate and address these memories and their meanings. Although Patrick's mistrust was not a significant inhibitor of treatment, the therapist was tactful in her efforts to elaborate on his traumatic experiences.

The therapist explores patients' symptoms to identify their origins and relevant conflicts and defenses. Note that the origins of PTSD symptoms often have at least two sources: the traumatic experience itself [seeing the man without the face] and other underlying emotional meanings that heighten the

horror of that event for that specific person. The therapist elicits the context and feelings surrounding symptoms as they occur and links them to the emotions and meanings of the traumatic experience. Identifying patterns of symptom triggers and their relation to traumatic events helps engage patients' interest and curiosity and develop the capacity to reflect on mental states (8), a key element of psychodynamic therapy that produces change. In this case, Patrick's therapist engaged his reflective capacity by identifying that his symptoms recurred in the context of the custody battle and linking the emotional meanings of these circumstances, including his frustration and disappointment, to his stop-loss.

Preexisting feelings of insecurity and separation anxiety create vulnerabilities when experiencing traumatic events and foster development of PTSD in the face of trauma (9). The therapist therefore explores past adverse events, losses, and problematic early attachment relationships. Patients with PTSD typically feel significant disappointment and rage toward close attachment figures, who may have contributed to childhood traumatic events, yet often have difficulty tolerating these feelings. Family management of emotions, including anger, shame, and anxiety, affects how patients tolerate trauma. The therapist identified Patrick's difficulty exploring his rage at his parents for their neglect; his guilt and tendency to dissociate from these feelings magnified his vulnerability to PTSD.

The therapist explores reasons patients continue to relive particular aspects of the trauma, including the context and emotions that trigger these symptoms. Contributors to persistent reexperiencing may include unaddressed guilt, rage, and disruptions in identity or sense of cohesion. Sometimes, reliving can represent an unconscious attempt to undo irreparable loss or to avert intolerable feelings of helplessness surrounding the trauma. Patrick's memories of the man with a disfigured face were related to fears about loss of core aspects of his own identity, including being a father. Patrick's recurrent nightmares represented an effort to rescue Leo, injured soldiers, and himself as a child.

Guilt often accompanies trauma survival, and it is important to explore contributors. Patients often believe they could have done something to prevent the traumatic event(s), obsessively reviewing circumstances. Patients may unconsciously arrange to punish themselves to relieve guilt. They may feel guilty about wishes or fantasies to harm others as they were harmed, referred to as "identification with the aggressor" (10). Inability to access rage can be caused by guilt or anxiety that anger may become out of control and damage others. In this case, Patrick's therapist helped him tolerate and access his rage by articulating his feelings and fantasies, pointing out that these feelings made sense in the context of his traumatic experiences and were normal and not dangerous by themselves.

Within the first few sessions, therapists using TFPP create and share a preliminary psychodynamic formulation regarding the relationship between the traumatic experiences and patients' symptoms. In addition to identifying emotional meanings of symptoms and relevant conflicts and defenses, the formulation in TFPP is particularly important for structuring a more coherent narrative. In the case discussed here, the therapist suggested in session 2 that Patrick tended to avoid his feelings and that his panic attacks in part related to fear of loss of control over his anger. This formulation was further developed over the course of treatment, with additional elements, such as the role of guilt about his separation from Leo, which contributed to his anxious preoccupation and ruminations about the custody case, and its relationship to his feelings about his parents' neglect.

Patients may experience various feelings, fantasies, conflicts, and defenses in the relationship with the therapist; this transference provides an important vehicle to address patients' mistrust and dissociation from therapeutic efforts. The therapist also must be alert to possible countertransference, in which the therapist might avoid painful aspects of the trauma and the patient's feelings of helplessness or rage. In this case, the therapist noted a pattern of Patrick's difficulties in expressing anger toward her that was consistent with his fears of angry feelings and his defense against them. She was alert to her reactions of helplessness and sense of injustice regarding his situation, using these reactions to guide an empathic stance.

The middle phase of TFPP helps to reduce patients' vulnerability to anxiety and PTSD, as various ramifications of central conflicts and contributing factors are explored in different contexts. This process is marked by applying similar interpretations to different manifestations of the same intrapsychic phenomenon. Patrick learned that his struggle with anger and guilt affected a variety of his relationships, contributing to his symptoms and inhibiting his enjoyment of life. He increasingly understood that his difficulty accessing his feelings initially stemmed from his efforts to manage his feelings of disappointment and rage about his parents.

Patients' histories of separations and losses make it important to address emotional responses to the termination of the therapy whenever they arise in therapy. During the termination phase, patients often respond to the impending loss of the relationship with the therapist and feel anger toward him or her as well as sadness. If the treatment has successfully helped improve symptoms, patients learn to cope with the termination by articulating these mixed feelings in therapy. Termination provides additional opportunities to identify painful, conflicted feelings and fantasies in the context of the transference, helping the patient to feel safer and more tolerant of them. For example, Patrick's capacity to acknowledge the therapist's help and his sadness in ending therapy demonstrated his improved access to his feelings, further easing his symptoms and positively affecting his relationships outside treatment. Termination was important for him because the process enabled him to recognize that he could express strong feelings and painful past experiences and the relationship with the therapist could remain positive and intact.

CONCLUSIONS

This discussion represents a single case report that was part of a pilot study of TFPP. As such, there is no clear information yet as to TFPP's effect in particular subpopulations of patients with PTSD. However, the treatment appears promising, as illustrated with Patrick's case and others who have been treated thus far with TFPP.

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REFERENCES

1. Busch FN, Milrod BL: Trauma-focused psychodynamic psychotherapy. Psychiatr Clin North Am 2018; 41:277–287
2. Steenkamp MM, Litz BT, Hoge CW, et al: Psychotherapy for military-related PTSD: a review of randomized clinical trials. JAMA 2015; 314:489–500
3. Busch FN, Milrod BL, Singer M, et al: Panic-Focused Psychodynamic Psychotherapy–Extended Range. New York, Routledge, 2012
4. Beutel ME, Scheurich V, Knebel A, et al: Implementing panic-focused psychodynamic psychotherapy into clinical practice. Can J Psychiatry 2013; 58:326–334
5. Milrod B, Leon AC, Busch F, et al: A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. Am J Psychiatry 2007; 164:265–272
6. Milrod B, Chambless DL, Gallop R, et al: Psychotherapies for panic disorder: a tale of two sites. J Clin Psychiatry 2016; 77: 927–935
7. Milrod B, Shapiro S, Gross C, et al: Does manualized psychodynamic psychotherapy have an impact on youth anxiety disorders? Am J Psychother 2013; 67:359–366
8. Fonagy P, Target M: Attachment and reflective function: their role in self-organization. Dev Psychopathol 1997; 9:679–700
9. Freud A: The Ego and the Mechanisms of Defense. New York, International Universities Press, 1946
10. Silove D, Alonso J, Bromet E, et al: Pediatric-onset and adult-onset separation anxiety disorder across countries in the World Mental Health Survey. Am J Psychiatry 2015; 172:647–656