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Individual Therapy via the Phenomenon of Hope for Treating Chronic and Complex PTSD

OFIR LEVI

Unit for the Treatment of Combat Stress Reaction, Mental Health Division, Medical Corps, Israeli Defense Forces, Tel Aviv, Israel; Bob Shapell School of Social Work, Tel Aviv University, Tel Aviv, Israel

Evidence-based treatment (EBT) supports different types of cognitive-behavioral therapy (CBT) for treating post-traumatic stress disorder (PTSD). Yet, a growing body of evidence shows a high therapy dropout rate and non-response rate among PTSD patients, especially patients with complex PTSD. A different, short-term therapeutic approach is therefore needed which combines CBT and psychodynamic therapy (PDT) because it is better for patients with chronic and/or complex PTSD to work with clarified stages and an end of treatment in mind. The patient's mental structure is conceptualized as a continuum, and functional problems are regarded as stemming from cognitive structures and unresolved developmental conflict. The five phases of the phenomenon of hope model proposed in an earlier article—a connection phase; an agency and pathway phase (developing a goal-oriented decision-making pattern and learning to plan toward goal achievement); a reconstruction phase; a phase of processing the conflict characteristic of PTSD by utilizing the natural power of hope; and a summary and separation phase—advance a short-term therapy that combines CBT and PDT techniques. This integrated therapy is based on notes that were kept relating to the case study of a chronic PTSD patient.

KEYWORDS hope, phenomenon of hope, PTSD, CBT techniques, PDT techniques

INTRODUCTION

The book *Studies on Hysteria* (1895), by Breuer and Freud, was the first publication on the treatment of trauma. It also marked the birth of psycho-

Address correspondence to Ofir Levi, 20 Nofech St., Modi'in, Israel 71700. E-mail: ofirsiona@gmail.com

analysis and modern psychotherapy. Psychoanalytic psychotherapy was first used in the treatment of trauma survivors and its growth was spurred by the challenges of caring for combat veterans (Kudler, 2007, 2011). During World War I, soldiers suffering from "shell shock" were treated using the same type of psychoanalytical approaches as other psychiatric patients (Kudler, 2011). These approaches have also been described in a novel by Pat Barker, *Regeneration* (1991), which describes the work of W. H. R. Rivers, who worked with British soldiers with PTSD during World War I. During World War II, Grinker and Spiegel adopted a psychoanalytic approach to treating American combat veterans with PTSD, and this led to the growth of psychoanalysis in the postwar years (Kudler, 2007, 2011).

Though no particular therapy method has been identified as superior for patients with PTSD (Bisson, Matthews, Pilling, Richards, & Turner, 2007; Sherman, 1998), the cognitive-behavioral approaches such as prolonged exposure (Foa et al., 2005), eye movement desensitization, and reprocessing (Leiner, Kearns, Jackson, Astin, & Rothbaum, 2012), and classical CBT (Bradley, Greene, Russ, Dutra, & Westen, 2005; Monson et al., 2012) are generally regarded as most beneficial for PTSD patients, including those with chronic and complex PTSD. This is due to evidence-based recommendations (Schottenbauer, Glass, Arnkoff, & Gray, 2008) and a conception of PTSD as a "biological problem" calling for "focused therapeutic intervention" (Kudler, 2007). PTSD can also have physiological implications; for example, people with PTSD may have decreased hippocampal volume. This finding has been inconsistent across studies (Kudler, 2007), generating controversy over the right medication to use for PTSD.

Cumulative evidence on the response of chronic PTSD patients to therapy has shown a high rate of dropout and non-response to therapy, especially in complex PTSD patients (Schottenbauer et al., 2008). One explanation for dropout is that the patient's needs have not been met due to over-focusing of the treatment (Beck, 2005; Kudler, 2007; Schottenbauer et al., 2008). This points to the need for additional therapeutic interventions.

A new short-term therapy approach has been proposed, combining a number of different therapy approaches, which can help to encourage patient focus (and reduce patient "over-focusing" as defined by Kudler, 2007) and may be appropriate for chronic and complex PTSD patients. This short-term therapy approach is characterized by therapy phases linked to aspects of the "phenomenon of hope" (Levi, 2008; Levi, Savaya, & Liechtentritt, 2011; Levi, Fruchter, & Kreiss, in press). The approach utilizes CBT and PDT techniques and stresses the exploration of the patient's life history, including conflicts in the wake of exposure to the traumatic event, conflicts which it seeks to resolve through transference and countertransference (Bergin & Walsh, 2005; Herman, 1992; Kudler, Krupnick, Blank, Herman, & Horowitz, 2009; Snyder, 2000). This idea of combining CBT and PDT together in the same model is similar to the integrative approach to psychotherapy (Stricker & Gold, 2011; Gold, 2005).

This article describes a case study in which the phenomenon of hope model was applied using the five phases set out in the earlier article. The five phases are:

1. establishing therapist-patient contact,
2. the agency and pathway phase (setting goals, exploring how to achieve them),
3. the reconstruction phase,
4. the phase of processing the conflicts which characteristically follow exposure to a traumatic event, and
5. the summary and separation phase.

Some of the phases are universal, some are based on ideas proposed by Herman (1992), and some are unique to phenomenon of hope therapy. The model was applied in the treatment of Yoni (a pseudonym), who has consented to a report of his therapy appearing in this article. But first, let us define the "phenomenon of hope," and how it expresses itself after trauma.

THE PHENOMENON OF HOPE IN THE CONTEXT OF TRAUMA

The concept of hope has been defined in many different ways (Boris, 1976; Dufault & Martocchio, 1985; Frank, 1968; Gottschalk & Calif, 1974; Hopper, 2001; Menninger, 1959; Snyder, 2000; Snyder, Irving, & Anderson, 1991; Stotland, 1969; Winnicott, 1978). Nonetheless, we can identify three central definitions in the scholarly thinking about this concept. One definition characterizes the cognitive-behavioral approach, which sees hope as a desire that leads to the formulation of goals. People achieve their desires by identifying the strategies which they need to achieve them. This process of identifying strategies to realize desires is in fact the process that generates hope (Snyder et al., 1991; Snyder, 2000). The second definition describes the psychodynamic approach, in which hope is conceptualized as a search for psychological space in which the self can make a new start (Mitchell, 1993). The third definition is Jacoby's (1989) definition, which conceives of hope as "an active mental process that is aroused in response to a threat, with the aim of coping with it" (p. 19).

Hope is a complex, multidimensional, experiential, and creative phenomenon that occurs within diverse mental spaces (Levi, 2006, 2008; Levi, Savaya, & Liechtentritt, 2012). Similar to Jacoby (1989), the model presented in this article considers the concepts in Winnicott, Mahler, and Erikson's developmental theories as the key to explaining. Though these theories do not deal directly with the phenomenon of hope their ideas include a theoretical explanation of the "phenomenon of hope."

In order to understand the therapeutic model that this article describes, it should be noted that the conception of the "phenomenon of hope" which was described at length in the previous articles on this subject (Levi, 2008; Levi et al., 2011; Levi et al., in press) stresses the role of hope in the process of human development, from birth throughout the stages of a person's psychosocial development, and the tools that people use to cope with crises and clinical situations during therapy (Bergin & Walsh, 2005; Hopper, 2001). The foundations for an infant's development and adjustment to life are based on the early relationships with the world that are mediated by the mother (Winnicott, 1978). These early relationships with the world should enable infants to cope with the developmental tasks that they encounter in life (Jacoby, 1989; Levi, 2008; Levi et al., 2011; Levi, Savaya, & Liechtentritt, 2012).

The ability to hope is experienced unconsciously during the early stage of an infant's development (Casement, 1995). Unconscious hope helps the infant cope successfully with the stages of growth and developmental tasks they face (Levi et al., 2011). Conscious hope, on the other hand, is generated by the individual's ability to formulate goals and the strategies he needs to follow to achieve them (Snyder, 2000). Conscious hope first appears in childhood, during the initiative versus guilt stage (Erikson, 1963). According to Erikson, this stage occurs between the ages of four and six, and is an important factor that underlies children's initiatives to achieve diverse and independent activities, sometimes based on planning and goal setting.

It has been suggested (Levi et al., 2011) that the development of conscious hope during the initiative versus guilt stage is a response to the imperatives needed for an individual's growth and that unconscious hope allows infants and children to feel confident in their actions while facilitating their inquiry into the world that they experience. Conscious and unconscious hope coexist, therefore, becoming dominant/nondominant at different stages in the developmental process. And, when trying to treat the outcomes of traumatic events, the coexistence of conscious and unconscious hope becomes a very important issue.

Thus, hope has both a conscious and an unconscious dimension and provides a "bridge" (Jacoby, 1989) between childhood time and calendar time (Mann & Goldman, 1982), the latter being considered adult and mature time. The "time" component is also meaningful when working with PTSD patients, as they are prisoners of the horror of the traumatic event. Time stands still for such patients, who find it difficult to do things. It is important, therefore, for therapy duration to be limited in the case of PTSD patients, since overly long therapy can lead to dependence due to non-acceptance of the loss (Brom, Kleber, & van den Bout, 1989).

In terms of the developmental process, trauma is experienced when the environment, in other words, the maternal/main caretaking figure's functioning, fails (Ainsworth & Bowlby, 1991; Kohut, 2005; Winnicott, 1978). Often, this trauma leads to chronic PTSD as defined in the *Diagnostic and Statistical*

Manual of Mental Disorders (*DSM*-IV-TR; American Psychiatric Association, 2000).

It is known that all kinds and levels of trauma significantly undermine the structure of the meaning of life (Janoff-Bulman, 1992; Hopper, 2001). Therefore, therapy should also focus on the unconscious conflicts that follow the various developmental tasks and be restricted in time. It also needs to focus on the impact of unrealistic thoughts on the patient's adjustment behavior (Beck, 2005) and ability to achieve goals (Snyder, 2000). When a traumatic event shatters a patient's hopes he or she needs help in therapy to redevelop his or her hopes and to establish a mature and independent personality with concomitant hopes (Levi, 2008). Mitchell (1993) believed that trauma causes confusion, which can lead to psychological damage, leaving the individual lacking in tools to recognize what is necessary. Hope, then, has the potential to engender transformation and growth, which is why it was found to be significantly related to posttraumatic growth (Ho et al., 2011). Thus, because of its unique function during crisis/distress, hope generates cognitive activity, which leads to concrete plans of action involving goal setting and realization (the cognitive-behavioral component of the hope) aimed at ending the crisis/relieving the distress. Herman (1992) identified two types of trauma: simple trauma and complex trauma, where simple trauma consists of a single, discrete traumatic event and complex trauma is a prolonged, recurring trauma (Schottenbauer et al., 2008). Another description of complex trauma, found in Breuer and Freud's (1895) writing, is "cumulative trauma," namely a series of cumulative traumas that affect the personality and make functioning more difficult (Kudler, 2011). Symptoms associated with complex trauma include difficulties with social and interpersonal functioning, occupational functioning, and general adjustment (Schottenbauer et al., 2008). Finally, recognizing the ongoing nature of hope (Levi, 2008; Hopper, 2001), four hope profiles were identified on a continuum (Levi, 2006) from:

1. hopelessness during severe clinical states, leading to depression/suicidal ideation, apparently due to extended environmental failure,
2. pessimistic hope, which is marked by an orientation toward the future and a desire to develop and advance, though with feelings of anxiety, sadness, and fear of catastrophic crises, making it hard for the person to connect with the emotional product of hope (which is essentially a sense of vitality and happiness),
3. drawing hope from others, where people are inspired in regaining their lost hope by a significant other acting as the preserver or carrier of hope, to
4. independent, mature, realistic hope.

A wide-ranging study of chronic and complex combat PTSD (Levi, 2006) found that hope was perceived as a crucial component in the recovery

from trauma experience and was a key factor in every participant's story. The sense that hope exists and can be reactivated was the main reason participants hung on to life at the time of the trauma, and especially shortly afterward. Since hope springs into action as soon as the traumatic event occurs, the therapist requires a picture of the participant's hopes prior to the event and his or her definition and conceptualization of hope (Levi, Liechtentritt, & Savaya, 2012).

In sum, hope is defined as a continuous phenomenon that accompanies the various stages of human development. It occurs within mental spaces and plays a unique role in completing developmental tasks. It also develops in parallel to the development stages. It is an inner, spiritual feeling which drives people's aspirations of actualizing their uniqueness by lending them meaning to their experiences (Levi, 2008; Levi, Savaya, & Liechtentritt, 2012). The earlier studies revealed that hope is shaped and crystallized into a solid internal nucleus that serves as a personality resource to which people can turn, mainly during times of crisis and stress.

THE MODEL

Therapy using the phenomenon of hope lasts for about one year, which is very important for every aspect of helping PTSD patients. The reason for this is that five-phase model, which requires therapy to be concluded within a set time frame, fits in with Herman's (1992) theory of empowerment and Mitchell's (1993) argument that certain growth areas lie beyond the shared understanding of the therapist and patient and therefore can only take place after therapy has ended. Psychological therapy for patients with chronic and complex trauma has to end since the end of therapy symbolizes the fact that the posttraumatic symptoms have been overcome and signifies that there has been a change in the patient's way of life (people with PTSD have problems persisting with and finishing what they begin because of the difficulties caused by their symptoms).

The summary and separation stages of the phenomenon of hope therapy mark a return of the existential control lost following the traumatic event, to the patient (Herman, 1992; Janoff-Bulman, 1992; Levi, 2008). This control depends on the therapeutic alliance between the therapist and patient (Wigren, 1999), which takes time to develop (and time is usually lacking in the focused treatments).

The PTSD patient needs a secure and protected space within a therapeutic frame (Wigren, 1999) that is based on trust. This can only develop if the therapist enables the patient to use him (Mitchell, 1993; Winnicott, 1978). Therapy must therefore begin with the rehabilitation of a human relationship on an authentic basis (Wigren, 1999). As noted previously, Levi (2008) has advanced a five-phase model in which the phases of

establishing a therapist-patient connection, reconstruction, and summary are all universal—that is, they appear in every therapy; and the third phase, namely the agency and pathway phase, and the fourth phase, the conflict-processing phase, all stem from the concept of hope (Snyder, 2000).

The model demonstrates a combination of cognitive-behavioral and psychodynamic techniques and thinking in a cognitive-behavioral and psychodynamic orientation. For example, in the first phase (contract) of the therapy, the therapist is active as is customary in a cognitive-behavioral orientation (Beck, 2005). This is expressed by focusing on defining the problem, which according to Herman (1992) is the basis for establishing the therapeutic alliance, taking mutual responsibility for the therapy, and together overcoming the unconscious wish to avoid touching the horror of the traumatic experience.

Although cognitive-behavioral techniques are used in the first three phases, which are active phases for the therapist, the thinking behind these phases is dynamic and addresses unconscious feelings associated with the desire to remain in a static, familiar state and avoid all change (Mitchell, 1993), which might lead to problems with cognitively formulating the problem. This is not a technical definition of the kind we are accustomed to in cognitive-behavioral therapy, and therefore in most cases, during this phase, it is all right for patients to discuss past experiences and relationships with significant figures in their lives. In this case, the therapist should listen in order to learn more about the patient's life history, and avoid interpretation. At the right moment, he should direct the patient, showing empathy and sensitivity to the phase he and the patient are in. During the fourth phase, the orientation is dynamic, which is why the therapist is passive and uses the interpretation technique. In the fifth phase, the therapist becomes active again, as in the first three phases (Levi, 2008). In every phase, the therapist must try to strengthen the therapeutic alliance and make the patient a full partner in the therapy and try to engender a deep desire to deal with the problem (Wigren, 1999; Levi, 2008).

In this model, the transition through the first three phases is linear, which means that each phase must be completed before moving on to the next phase. In contradistinction, the fourth phase is characterized by a back-and-forth or "spiral movement that is constructed and disappears and is reconstructed" (Florsheim, 2008, p. 43), which ultimately improves the integration of content raised during therapy. It is possible to move among different hope profiles during all phases of therapy until an independent, mature, realistic hope emerges. Successful therapy via the phenomenon of hope depends on the patient's capacity to trust the other and establish relations of trust with him (Bleiberg & Markowitz, 2005). This helps the patient to reintegrate into different aspects of life.

In the next section we examine the therapy phases of a patient, Yoni (a pseudonym), who was counseled in therapy with the author for about a

year. The case study relates to complex combat-related PTSD trauma—the author's clinical and research specialization in recent years. However, the model has been successfully implemented with other trauma victims such as rape victims, who have been treated in clinics for the general public as opposed to clinics serving Israel Defense Forces cases. The model is consequently valuable for treating chronic post-traumatic stress disorder (C-PTSD).

Phase One: Connection

The connection phase is the phase in which an attachment is formed between the therapist and patient. The phase lasts for six to eight sessions and is an important stage in developing hope in therapy. During this phase, the patient observes the therapist's mannerisms (body language) and verbal expressions. This helps to reinforce vague and unprocessed feelings the patient may have relating to the therapist's capacity to help him. According to Ogden (2001/1989), the patient views the therapist even before their first meeting so that the small gestures the therapist makes and the things the therapist says or does not say are important. Hence the significance of "the formal presentation" (Ogden, 2001/1989, p. 131), during which the patient, who is in a state of crisis that led him to seek therapy, consciously and unconsciously registers aspects of the therapist's behavior which directly affect his hope. Here, we are talking about the therapist's ability to emanate warmth, acceptance, and respect during the early connection phase, and whether he can communicate an honest belief in his own willingness and ability to help the person before him (Frank, 1968). This is very crucial when working with C-PTSD patients because they are generally suspicious and hesitant about making commitments, owing to their feeling that all their basic security networks have been destroyed (Herman, 1992). Thus, the therapist's first step toward restoring the basic confidence which the traumatic event killed is to communicate an aura of professional confidence and empathy while establishing a therapeutic frame with clear boundaries.

It is very important for the therapist to discuss all aspects of the therapeutic contract in the connection phase. The first session should involve the following: discussion of payment, frequency of sessions, times and place of sessions, total duration of therapy, therapy approach, confidentiality, mutual commitment by both therapist and patient, and possibilities for amending the contract in the future (Green, 2003). As part of the contract framework, the therapist should also explain his therapeutic orientation and his expectations from the therapy process. This gives the patient a sense of human dignity, which is requisite for strengthening the bond and establishing trust between the therapist and the patient (Frank, 1968; Wigren, 1999), which is very important for a PTSD patient, who has difficulty establishing relations of trust with others (Levi, 2008).

Having completed this phase, the therapist and patient begin to define the problem. Defining the problem reveals different PTSD features (such as depression and communication difficulties) and acquaints the therapist with the patient's life history, including developmental conflicts, and affords both patient and therapist a sense of control. A PTSD patient who seeks therapy and feels that his therapist understands his problem gains legitimization for the fact that his response to situations that threaten his life and physical intactness are normal human reactions. More importantly, the patient begins to take responsibility for his problems and their treatment (Herman, 1992), and feels hope that therapy can "correct" the problem and provide a new beginning (Mitchell, 1993). Defining the problem leads to a process of separation from the posttraumatic identity and its associated hidden representations (which sometimes accompany the PTSD patient for many years), thereby reinforcing the significance of the development of hope during therapy.

It is important to formulate the problem in terms of function with the understanding that this makes it distinguishable from symptoms ("I do not sleep well at night"), especially since the therapeutic goals for the next phase (the agency and pathway phase) should be derived from the problem's definition. Defining the problem in functional terms is also compatible with the F criterion in the *DSM*-IV-TR (American Psychiatric Association, 2000). The therapist should, at this juncture, help the patient actively to recognize and define the problem. Herman (1992) suggested that this active help should give the patient courage to acknowledge those problems he tends to deny (avoidance). Furthermore, by encouraging patients to engage with their problem directly by defining it, the patient is given a message of hope that says, "You have been through something terrible but now hope has the power to relieve your pain and help you to move forward toward a better quality of life." Note, too, that in this phase the dominant hope profile is "drawing hope" (Levi, 2008), which refers to a person's need for an other to provide a special quality of contact which is calming, inspiring confidence, containing, attentive, and especially, one that involves sharing and willingness; this, for the renewed connection between the horror of the event from the past, and the present, and from there growth to a future filled with satisfaction and hope.

The following account of the first meeting with Yoni describes this phase:

> I met Yoni at the door to the therapy room. We sat down and I introduced myself and explained the therapeutic model I would be using. As we talked I made sure to maintain eye contact, and wanted to project gentleness and acceptance through my body language and intonation. I asked Yoni to talk about his distress and when it began. I learned he had been feeling sadness for the past two years, following

a combat operation in Gaza in which he participated as a combatant. I understood the sadness was because of a comrade who had been injured and that Yoni felt especially ashamed of how he had functioned at the time. As a result, he avoided meeting his comrades from the unit and did not attend the unit's gatherings each year. He also said he avoided movies and news about war and had frequent outbursts of crying. He added that he had undergone a profound change since the event, which was different from the sadness, and involved asking "philosophical" questions about the meaning of life. As he told his story, I reflected back to him, echoed points I thought were significant, asked clarification questions as needed, and provided empathic confrontation. I used these techniques to try to establish the preliminary basis for hope. During the early sessions, Yoni asked if it would be possible to hold our sessions in a café or some other neutral place. He said that sitting in a less formal place would make it easier for him to talk about the deeper emotional issues. I reflected that he had made a difficult decision to enter therapy, and added that it was important to preserve the therapeutic frame because that would help preserve and maintain the therapy. I added that his request to meet in a neutral place could reflect fear and anxiety at the prospect of the therapeutic process and its outcomes, which had prompted a need to control the therapy environment conditions of the therapy by controlling the therapeutic frame. In response, he explained that he just was just trying to create more comfortable conditions and atmosphere, and that if I insisted he would understand and accept it. At this point I thought about the "surrender" that had taken place during the transference process which might reflect an unconscious hope on Yoni's part for containment, understanding, and maintenance. Following this thought about unconscious hope, I told Yoni that I reckoned that if a relationship of trust developed between us, he would come to trust the therapeutic frame and me and things of this type (meaning the surroundings) would become less bothersome. Then he became silent, and when I reflected this, he asked me to guide him on what to say and where to focus. This continued for several sessions and I detected an internal battle within Yoni over the therapeutic frame and the contract itself. This lessened as the therapy advanced and I invited him to try to define the problem (which he had initially defined as mild; ". . . Look, I'm not sure I am like your other cases. In all, I function and manage. . . . I don't even know if I should be in therapy. . ."). Yoni's early attitude may be ascribed to his difficulty acknowledging that a problem existed and that he needed a therapist. This can be viewed as an unconscious hope that I would confirm that he was not in the kind of distress that requires therapy. It was an expression of the sense of shame and guilt from which Yoni suffered and stemmed from a sense of failure over the event in Gaza. It can also be related to personality traits such as low self-worth, and his life history (developmental process), which raised the following: Yoni is the middle child of three children. His mother is a teacher and his father has an academic education, a senior management position, and is a former

combat officer. His older brother has an academic education and a job and also served in a combat unit; his sister is in high school. He described relations with his parents as generally tense, especially with his father whom he saw as self-centered and who pushed him to study something "with a future" and to volunteer for a combat unit. He described having a polite relationship with his brother, whom he said was perceived as "the successful and obedient child." He had a close relationship with his sister. At the time of therapy, Yoni was working in an area linked to his degree studies. Attempting to define his problem, he stated that parallel to functioning satisfactorily in his studies and work and to his dedication, caring/generosity (toward his fellow students), and his diligence (at work), and compassion, he experienced feelings of sadness and shame and found it hard to pinpoint the problem (function) underlying these difficulties. He answered every attempt on my part to understand what had led him to seek therapy (the problem) by indicating that he was suffering and that he seemingly did not understand what I wanted of him (regarding the question of what led him to therapy). I felt that Yoni's "lack of understanding," his hope for change, was rooted in a set of old, familiar, static hopes that were expressed in the familiar symptoms of his suffering alongside his functioning. Through these descriptions, I learned about the sense of frustration that accompanied his process of maturation, which stemmed mainly from messages his father conveyed of not being satisfied with him (but being satisfied with his brother), so much so that it harmed his sense of confidence and self-worth. He therefore perceived military service as an opportunity to prove how much and what he was worth. As mentioned, during the process of defining the problem Yoni questioned his eligibility for therapy ("I'm not sure I am like your other cases"). I asked Yoni what he had heard about these so-called other cases, and he replied, "... I suppose that by mentioning others who I don't really know I am actually looking for a way out or perhaps confirmation that I don't need therapy because my case isn't so serious...." This point marked the beginning of Yoni's recognition of his distress. The consistency of my message to Yoni about having to define the problem led to his realization that our path in this shared process of creation (the potential space) needed to pass through "direct contact" with the distress. This represented one of the central components of the phenomenon of hope, that distress should be confronted in an actively cognitive way. After sharing with Yoni my thought that he was belittling his value and abilities compared to the "others," he indicated that others in Gaza had also been afraid, as indicated by some volunteering to help move the injured to the rear. When I showed him this he said, "... But this is the drama of my life. Others are always better." This revealed Yoni's feelings of shame and helplessness over the event, but also that he experienced these feelings throughout his development process and in his relations with significant figures (father) in his life. Based on these insights Yoni was able to define his problem as "social reduction and avoidance of new interpersonal relations due to lack of confidence and

> the shame I have always felt, which intensified after the Gaza military operation. . . ."

This definition, which pertains to the symptoms of his problem (reduction, shame, frustration, sadness), enabled Yoni to recognize his problem (which existed on a functional level) and acknowledge his need for help. The process of defining the problem strengthened the shared understanding of the therapy focus and deepened the "therapy identity" (which, according to Herman [1992], arises from the definition of the problem).

Phase Two: Agency and Pathway Phase

Phase two, which involves defining therapy goals and how to achieve them (strategies), and the next stage, namely reconstruction, represent the cognitive-behavioral component of the model. This phase complements phases one and four: the dynamic perception phases.

During phase two, the patient and therapist decide on goals arising from the problem definition of the previous phase and discuss how to achieve them. This discussion of goals and strategies introduces practical hopes into the patient's mind, increasing his or her sense of efficacy, confidence, and control. Chronic PTSD patients come to therapy with a feeling of internal chaos that stems from the fact that their world has changed. Following the traumatic event they experience a lack of confidence and sometimes hopelessness. Setting goals in therapy is an additional tool for helping to restore the patient's confidence, control, and hope. This is because goals engender the feeling of a clear plan and strategy for change. That is, they bring a hope of change into the person's life. Frank (1968) and Menninger (1959) believed that therapists' goals for their patients should be defined *with* the patients, since at the right dosage goals create hope. Frank (1968) felt that this process should be clear to both the therapist and patient. Goals inspire the patient with hope and confidence in his ability to recover. Three goals were formulated in Yoni's case: (1) to understand the patient's interpersonal relationship problems and the cause for their reduction, to initiate relationships and cultivate existing ones; (2) to understand the origins of the patient's feelings of shame and fear and to try to overcome them; and (3) to investigate the reasons for the patient's poor self-image and why the Gaza event increased its vulnerability. These goals express both a conscious hope of being able to set goals and find ways to achieve them (Snyder, 2000) as well as an active hope of learning to cope with the outcomes of the event.

In this phase, too, the dominant profile appears to be drawing hope, and points to the patient's need to draw hope from the therapist that he can cope with goals that symbolize both the distress and the return of control and ability to cope with the horror of the traumatic event. In this phase, a

tendency toward pessimistic hope was apparent, following his anxiety that the relationship with the therapist would fall apart and the therapy would fail.

After formulating the goals, the therapist and patient then have to determine the practical steps needed to achieve them. For example, in Yoni's case, in order to achieve the second goal, we discussed several possible strategies for establishing trust between us that would enable us to address the problematic feelings without fear or anxiety. The successful achievement of this goal enabled Yoni to contact representatives of the environment that symbolized the shame (the meeting with his comrades from the army).

Phase Three: Reconstructing the Event

Reconstructing the event is a key stage in treating PTSD patients. This is because patients need to directly confront the traumatic event, as this sends them both a symbolic and practical message that they can cope with the avoidant cluster. It is also part of the process of reducing the patient's anxiety. For patients who need "active help" from the therapist, confronting the event offers proof that the therapist can contain the horrors of the trauma (Ehlers & Clark, 2003, p. 823). Active help is required because the event may arouse mixed feelings in the patient and the therapist (Levi, 2008; Herman, 1992).

Reconstruction should be spread over one to three sessions. Its goal should be to establish a coherent and organized narrative that will allow an attempt to locate foci of meaning of possible importance for the fourth phase, when conflicts are processed. This is because reconstruction can expose dilemmas that preceded the event, such as dilemmas associated with relationships with significant figures in the patient's life (Schottenbauer et al., 2008).

The therapist and patient can often learn about the meanings the patient attributes to the event through the therapeutic reconstruction process. The same is also true for the patient's intonation, nonverbal expressions, and, of course, the words and sentences that the patient chooses. Here, we should recall Ehlers and Clark's (2003) suggestion that patients may find it difficult to reappraise certain problematic meanings connected with the event, without help: for example, they may find it hard to challenge ideas that they could have died in the event. Ehlers and Clark also proposed that these problematic meanings may be related to ruminations about the event (which are considered good predictors for the development of PTSD) in the form of questions such as, "Why did this happen to me?" and "How could it have been prevented?"

The problem that the patient and therapist define and the therapy goals must be examined with reference to these meanings. For example, the approach used regarding Yoni's second goal, "To understand the sources of

the patient's shame and fears and try to overcome them," was to address the catalyst for the arousal of his feelings of shame and fear during the event itself, focusing on the point in time when the feelings occurred, the specific trigger within the event that provoked them, and whether this trigger was linked to familiar fears and emotions from Yoni's past.

One of the central aspects of the phenomenon of hope (Levi, 2008; Levi et al., in press) and "work of hope" (Jacoby, 1989) is also included in the reconstruction phase, and that is direct contact with the cause of the stress, even if it arouses horror and fear. Direct confrontation is a key to rehabilitating the damaged self, because it is from there, the damaged self, that hope can arise (Levi, 2008). Note, too, that the drawing hope profile is dominant in the reconstruction phase since the problems of reengaging with the event lead to a need for a significant other (the therapist) who can both inspire the patient to regain his or her lost hope and carry the hope.

During the reconstruction phase it is advisable to establish a clear distinction between the facts and the thoughts and feelings associated with the event (Levi, 2008). This creates a sense of structure and control over the boundaries of the event and enhances the patient's confidence (which has been weakened by the anxiety that usually exists prior to the reconstruction), and the chances of successfully coping with the reconstruction.

The following was the narrative of Yoni's event produced by the reconstruction:

> "... Very shortly after receiving our gear, I found myself under fire. A piece of shrapnel brushed past my helmet, increasing my fear. When I realized that Haim [a pseudonym] had taken a hit, the shaking, palpitations, and crying greatly increased. I did not want to die. I thought of my mother breaking down when she receives the news, and about Haim's mother. In spite of it all I crawled towards him and began to treat him.... All the while I did not stop talking to him and asking God to watch over him. I was encouraged by the fact that despite the crazy fear, I somehow managed to help him. I thought this was because of how close we were, I thought.... After he reached the hospital I felt relief. And when they told us he would be all right I broke down.... It seems that only at this point did I reconnect to what I went through.... I cried and shook and could not control myself and this is probably why they sent me to the mental health officer."

Phase Four: Processing Internal Conflicts Linked to the Traumatic Event Using the Phenomenon of Hope (Dynamic Tools)

Horowitz (1974) suggested that C-PTSD patients are characterized by unconscious denial (avoidance) of the significance of the traumatic event and its outcomes. Herman (1992), Levy (1999), Schottenbauer and colleagues

(2008), as well as Winston and Winston (2002) indirectly, identified several more conflicts in C-PTSD patients which are expressed during the therapy process and may stem, among other things, from a denial of the event and its outcomes. Symptoms of these conflicts included difficulty in establishing trust versus the basic need to have trust in therapy, the need to disengage from the posttraumatic symptoms and on the other hand preserve them due to their assimilation within the identity (the self), and the desire to return to normal functioning versus avoidance of return to functioning because of unconscious shame and guilt and/or unresolved conflict linked to one of the significant figures in the patient's life (Levy, 1999).

During psychotherapeutic therapy with PTSD patients, conflicts that arise in response to confronting the traumatic event are generally processed by examining the patient's development (life history) while focusing on conflicts with significant figures in their life. The interpretation technique is used to process the interaction between the patient and the therapist during transference and countertransference (Bergin & Walsh, 2005; Herman, 1992; Kudler et al., 2009; Kudler, 2011; Lindy, 1989; O'Hara, 2011; Snyder, 2000). This allows a new personal meaning to evolve that symbolizes the emergence of new hopes, the processing of old hopes (Mitchell, 1993), and the construction of a new posttraumatic identity (Herman, 1992).

Though the phenomenon of hope continuum is indeed broken by the traumatic event, it does not cease to play a central role in the process of adjustment after this event (Levi, 2008; Levi et al., in press). Groopman (2006) said of this, "... Hope gives us the strength to stand straight versus the circumstances and the ability to overcome them..." (p. 12). Hope's capacity to do this can help us resolve internal conflicts within the patient which were created and developed as a result of the traumatic event, on the way to assimilating the trauma within the self and adapting it to the person's new life reality.

For this process to occur the patient and therapist must "move back and forth" from the present to the recesses of the event, and the patient's developmental process. The process is needed so that the patient's feelings can be revisited and insights gained into the positioning of the event within the patient's identity (Herman, 1992). For all this to happen, the patient must feel that the therapist can afford unconditional empathy and support (Frank, 1968; O'Hara, 2011).

Due to the horror and fear that the patient revisits and experiences while processing the conflict, he can experience the unconscious hope that a significant other (the therapist) feels and experiences the horror of the event, albeit in a differentiated way. The therapist therefore functions as a preserver and vessel of hope (drawing hope profile). As a result it is critical for the patient to feel confident in the therapist and the analytical interpretation that the therapist brings, that the therapist will be a continuous presence in his life (Mitchell, 1993). Due to the ultra-sensitivity of PTSD patients to

unconscious messages (Herman, 1992), the patient unconsciously probes the therapist's trustworthiness by means of unconscious tests. This can be seen in the following extract from Yoni's therapy:

> Throughout and after the reconstruction process, Yoni said it was very difficult and complex to revisit the traumatic event. But, he also indicated that the structured process, protective therapeutic frame, and feeling that he had someone nonjudgmental who would listen to him gave him a sense of relief (less anxiety) that developed after the reconstruction phase. After I echoed his word "non-judgmental" it turned out that for years Yoni had felt judged by his environment, especially his father, who wanted to understand, for example, why he did not participate in the 2006 Lebanon War (at that time Yoni had been a reserve soldier for over a year and it was about two years after the traumatic event in Gaza). We then dealt with his attitude toward his father in therapy. We could do this because Yoni relied on the space that therapy created to help him expose internal conflicts evoked by the traumatic event.

The second major conflict confronted in PTSD patients is their need to both separate from the posttraumatic symptoms and preserve them because they have been assimilated within their identity and because they have secondary unconscious (and non-adaptive) psychological benefits (Herman, 1992; Levy, 1999). As a rule, all therapies seek to help patients separate from their symptoms, during a slow and gradual process in which hope develops in a "spreading and continuous" way (Boris, 1976, p. 147). The change that Boris described is a quiet change that matures and spreads during and after the therapy. It is the slow and complex change that chronic PTSD patients go through. Along with this change, however, the patient has difficulty separating from his symptoms, preferring to preserve them, using different defenses. The therapist must therefore offer containment and empathic coping in order for a realistic, mature, and independent hope to be established (Levi, 2008).

Many times, symptoms are assimilated into the self as a result of the unprocessed guilt and mourning arising from the structured loss that occurs whenever a person experiences a traumatic event (Brom, Kleber, & van den Bout, 1989). Feelings of guilt over inadequate/unsatisfactory functioning, perhaps associated with someone's death, are a persistent and intractable problem to treat (Shalev, 1994). Trauma also carries with it an inevitable loss, which damages the individual's feelings of the continuity of his or her self and the phenomenon of hope (Levi, 2008; Levi et al., 2011). It is therefore essential to process the conflict by touching on the losses (psychological/existentialist/mental) that the patient suffered so that hope in general can develop and for the therapy to succeed. During this phase, we expect to see movement between the pessimistic hope profile, which above all is an expression of the patient's losses, and the drawing hope profile (Levi, 2008;

Florsheim, 2008; O'Hara, 2011). It seems that processing the traumatic event allows the patient to find a path that will reconnect him with his hope.

At this stage, the therapist should encourage the patient to confront his losses, and explain that this can reveal insights that will help to connect him with his unconscious internal processes. Processing losses helps to remove defenses that were a major part of the patient's functioning prior to therapy. These defenses were part of the PTSD patient's identity, sometimes for many years (Herman, 1992), and processing them symbolizes the change the patient has undergone.

Processing the patient's loss(es) usually leads to a search for meaning and, in the present case, to the meaning of hope being exposed during the recovery process. Hope leads to an uncompromising, consistent, and successful battle with crisis states, and uncovers ego strengths and personal power. Revealing this meaning is meant to bolster the patient during therapy. It should also be recalled that both the traumatic event and hope are part of the patient's subjective experience and the meaning he attributes to it (Levi, Savaya, & Liechtentritt, 2012). It is important, therefore, for a patient to perceive the changes in his personality, changes which he can see more clearly if he realizes the meaning he has ascribed to the event (Herman, 1992). The fact that the patient can find meaning in the traumatic event will help him to accept that some experiences will not be realized, by cataloguing them as "experiences that will not be realized." This is one of the important aspects of the phenomenon of hope.

The next description of Yoni's case illustrates this well:

> Yoni perceived his father as a harmful and destructive person in his life, someone who never accepted Yoni as he was. In recent years, Yoni had started feeling a growing anger with his father, and a desire and need to distance himself from him. Yoni's mother, on the other hand, was warm and supportive, though she was not perceived as protecting Yoni from his father's criticism and emotional remoteness. This was the emotional climate at home when Yoni was drafted into the army. In therapy, he realized that for him the military represented an attempt to prove himself and show his father that he was worth something. He especially sought to try to express parts of himself that had been hidden for many years and had not found acceptance within the life systems around him. He was accepted into an elite unit, which symbolized to him that he was worth something. He successfully graduated from the unit's training course, despite feeling that he was less strong than the others. From the point of view of hope, he felt less hopeful than his friends in the unit. In the context of his army service, we learned during therapy that his father's lack of acceptance affected his confidence in relations with his comrades. However, as Yoni's grueling combat training progressed and his bonds with his comrades deepened, "his father's presence receded." But the traumatic event caused the shadow of Yoni's father to loom

up once more. Yoni's subjective feeling at being afraid, and his sense of inadequate functioning, redoubled his sense of shame, which was also linked to his father. During the therapy, his sense of shame and guilt at his inability to join his comrades in the unit and fight at their side in the Second Lebanon War became linked to and heightened by his father's demand to "understand" his lack of participation in this war against Hezbollah.

Yoni thus felt conflicted: on the one hand he wanted to get rid of his shame, anxiety, and, fears; on the other hand it was easier to surrender to them and assume the identity of the symptoms, in an unconscious process of punishing the father. When Yoni realized that he had an unconscious hope of maintenance, recognition, and acceptance by me as the "keeper" of hope, his confidence and trust in me increased. However, later, during this phase, Yoni did not turn up at one of our appointments, which was uncharacteristic of him. He did not return any of my calls or messages but rang after three days to explain that he had not come because of studies and work constraints. He did not refer to my attempts to find him. He was not in acute distress and did not need an urgent session so I told him I would see him at our next appointment. That session opened with silence and a declaration by Yoni that he does not really have anything to say. He asked me to help him. When I reflected that this was an unusual request (for help) at this stage of therapy (about seven months in), he agreed, adding that something unclear was happening to him. He said that after our last session he had been distressed and experienced feelings of sadness and anxiety, frustration and helplessness. He said he didn't know where those feelings came from, since his general feeling was that the therapy was very helpful. Later on in the session, Yoni connected the negative feelings he had experienced after our last appointment—anger toward me expressed as not keeping our appointment—and our interpretations regarding his fear and horror over Haim's injury (encounter with death) and after it—as a "loss of innocence." Also linked to the theme of his loss of innocence, Yoni said that the special unit taught its soldiers they were an elite group and that nothing would happen to them, a belief which "blew up in his face" when Haim was injured and was further shattered by the interpretations in therapy which revealed the truth about the protective psychological shield that he constructed. This produced negative feelings toward me because the interpretations left him without defenses. He also felt that the event had radically changed his life. He felt transformed from a brave, self-confident, vital person, into a frightened, avoidant person, who also avoided social contact. In this context he explained that he had not been in a couple relationship since the event (prior to which he had several significant relationships with women). However, he immediately contradicted this, saying that he was far too busy for such emotional experiences. On hearing this I questioned whether his avoidance of a relationship could be due in the main to an impaired sense of self-worth and confidence. This was linked to his sense of shame, and especially to his sense of guilt, which he had been

> plagued by since the event. During the sessions when we processed this guilt, Yoni began a romantic relation with a woman he met. He liked her, but every time they met he had a sense of being unworthy and of hiding something (his paralyzing fear during the event and the fact that because of it he did not enlist for the 2006 Lebanon War), which would sooner or later come out. This led him to cancel dates on the pretext that he was too busy studying. Since he felt guilty for avoiding her, even though he had a romantic interest in the relationship, he began avoiding phone conversations with her. When he raised these issues in therapy, Yoni realized that his avoidance behavior was aimed at "preventing a problem." After processing these points in therapy he decided to talk with her and the relationship consequently stabilized. When the bond between them deepened, he shared the details of the traumatic event with her. Their relationship grew and continued after his therapy ended. Therapy helped Yoni to understand that his social reduction affects many aspects of his life, and he even acquired insights into how the symptoms of the event (guilt, shame) affect his (unconscious) behavior. The processing of his guilt by examining his emotional values and the gaining of insights into the effect of his unconscious behavior on the different spheres of his life helped Yoni to achieve a deeper understanding of the meaning of the event he experienced. In turn, this led to symptomatic relief (less guilt and shame) and an improvement in his functioning (establishment of a couple relationship).

This process shows that the active aspect of the phenomenon of hope helped to improve the patient's ability to choose, and created internal degrees of freedom. In other words, active behavior generated an active and adaptive form of hope, and goal-centered activities allowed the patient to process the conflict (between his difficulties in resuming normal functioning stemming from an unconscious desire to punish his father and his need to resume normal social functioning) and expose repressed traumas by achieving insights that transformed his reality:

> Following his acceptance and understanding that contrary to his beliefs, his comrades did not judge him as a coward (because of his functioning during the event and the paralyzing fear which prevented him from participating in the 2006 Lebanon War), Yoni decided to take the initiative and invite the members of his unit to his home. The reunion went well and taught Yoni that his comrades valued him highly for his honesty and willingness to help. After the event Yoni felt great relief. His shame and guilt was vastly reduced, but more than anything he felt a renewed sense of vigor. He said that for the first time in years he was feeling the way he had at the start of his military service: confident, proud, and full of ambition to succeed.

As the case study shows, at this point in the therapy, the patient can perceive that the posttraumatic symptoms are under control, and is confident and strong enough to directly fight the fears and anxieties arising from the event (Herman, 1992; Levi, 2008). The patient can now activate his imagination and fantasy (Hopper, 2001), which were previously overshadowed by the trauma. This is also evident from the patient's renewed confidence in himself and his own abilities, and from the way he coped with the emotional symptoms of regression generated by his anticipation of separation from the therapist.

Toward the end of his therapy, Yoni felt less guilt and shame and greater self-confidence, and he had successfully completed his third year in college, reestablished contact with his friends, and maintained the couple relationship begun during therapy. Therapy taught Yoni about the unconscious processes which had accompanied the drama of his life after the traumatic event. The Yoni we meet after therapy seems confident in his ability to cope with the development tasks in store for him—by himself.

Phase Five: Summary and Separation

Mitchell (1993), but chiefly Herman (1992), stressed how important it is to conclude therapy for PTSD patients in the right way so patients can deal with their posttrauma reality by themselves. The fact that there are always psychological areas to be dealt with, especially when a person is coping with a trauma that will stay with him or her throughout life, means that recovery after a trauma cannot probably ever be full or complete (Shalev, 1994). It also means that trauma-related symptoms can persist, even to a serious degree, and perhaps return to haunt them as they face future development tasks in unique stress situations such as birth or death in the family. Separation is therefore essential and meaningful and three to four sessions should be devoted to it in order to summarize the therapy process and process the separation.

According to the phenomenon of hope model, the summarizing and separation process should be structured in this way: (1) One session should be devoted to the patient presenting his summary of the process, including a description of the development of the therapy over time, the challenges encountered during the process, and how they were handled. In addition, this session should cover the development of the relationship with the therapist, and the meaning of separation from the therapist, touching upon other separation events in the patient's life. (2) One session should be devoted to the therapist summarizing the process, touching on the same points the patient referred to. (3) One session should be devoted to identifying the tools gained during the therapy and their importance for coping with any future crises.

In the fifth and final phase, the therapist once again plays an active role in the therapy (similar to the first three phases), in this stage sometimes taking the lead. The rationale for structuring the summary and separation process is that it helps to strengthen the patient's sense of regaining the control lost through the traumatic event—especially when the process focuses on and identifies the tools acquired in therapy (Levi, 2008). These tools help to boost the patient's confidence in his ability to separate from the therapist, a figure he sees as the sole reason for his renewed trust in interpersonal relations and ability to cope with the conflicts typically found in PTSD patients. In addition, the finality of the therapy reflects the nature of the model in that it combines techniques drawn from both the structured cognitive-behavioral approach and the psychodynamic approach. It also symbolizes the conclusion of the control that the traumatic event exerts over the patient's life.

CONCLUSION

Chronic PTSD is considered difficult and complicated to treat, and there are ongoing efforts to propose and structure techniques and methods for treating PTSD patients and meeting their needs. These efforts address all levels of the syndrome (Kudler, 2011). The five phases of therapy via hope employ an integrative approach to psychotherapy, with a combination of cognitive-behavioral and dynamic techniques and short-term therapy frame (Stricker & Gold, 2011; Gold, 2005; Winston & Winston, 2002). The goal of this approach is to improve the therapist's response to the needs of PTSD patients by extending our focus beyond the narrow boundaries of just the traumatic event (Kudler, 2007).

The PTSD therapy discourse on PTSD presents numerous attempts at combining cognitive-behavioral and dynamic techniques. These discussions also include proposals for combinations of different approaches (Peri, 2008; Winston & Winston, 2002). The boundaries between different methods are blurred, however (Kudler et al., 2009), to the extent that it is not only possible to combine them but it may be vital to do so to treat PTSD patients. All therapies nowadays require scientific proof of their usefulness, including the model of therapy via the phenomenon of hope, which has only very partially been formulated. Future research should therefore seek to determine the usefulness of the model and any limitations of its use by the administration of appropriate questionnaires.

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