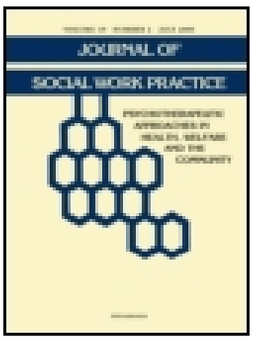

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The role of hope in psychodynamic therapy (PDT) for complex PTSD (C-PTSD)

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ABSTRACT

Psychodynamic therapy (PDT) for complex PTSD (C-PTSD) focuses on the interpersonal relationships of sufferers with difficulty forming trust-based relationships. By focusing on the relationship with the therapist, PDT helps sufferers gain insights into other interpersonal relations. Hope plays an important role in the process, as described by Stephen A. Mitchell, and it could be useful to utilize this concept's uniqueness in order to understand PDT processes. The article describes the process in which my hopes as the therapist drew closer to those of Daniel, the patient, within the potential space built by therapy. Inner change arose when the client 'lived' the new words suggested by me during the interpretation work, which broke down the old familiar awareness states while symbolizing new hopes and states of awareness. This article is important for clinicians by indicating the salience of PDT for treating C-PTSD sufferers, while introducing clinicians to the concept of 'Hope'.

KEYWORDS

Hope; complex PTSD; psychodynamic therapy; interpersonal relationships

What is psychodynamic psychotherapy for PTSD

Psychodynamic therapy (PDT) for PTSD in general and complex PTSD (C-PTSD) specifically, typically focuses on techniques that increase patients' awareness of the content and process of unconscious thoughts and feelings associated with a traumatic event (Horowitz, 1973). PDT for C-PTSD victims is based on Sigmund Freud's approach, which indicated the role of the therapeutic relationship and preceded the development of modern exposure therapy treatment (Gold, 2011).

PDT addresses maladaptive defense mechanisms that are believed to fuel the symptoms of C-PTSD by helping patients come to terms with the idiosyncratic meaning of their traumatic event (Horowitz, 1973). Specifically, therapy can help the patient understand the effect of the traumatic event on their personality while embedding it in the context of their current experiences. It allows patients to gain insight into their present life (Schottenbauer, Glass, Arnkoff, & Gray, 2008). PDT delves into the construed meanings of the traumatic event and the behaviors that subsequently developed. PDT helps patients to master their internal experiences through more effective coping (Kudler, 2011).

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Efficacy of PDT for PTSD

There are fewer studies on the efficacy of PDT for PTSD than on the efficacy of other therapies (Leichsenring & Klein, 2014). In a randomized control trial (RCT) for PTSD, Brom, Kleber, and Defares (1989) compared the effects of PDT, behavioral therapy, and hypnotherapy. All treatments appeared equally effective. This is consistent with similar efficacy comparisons when these therapies are delivered by routine mental health care (Stiles, Barkham, Clark, & Connell, 2008). According to other studies on the effect of PDT on PTSD, PDT enhanced patients' ability to resolve emotional reactions to trauma by increasing their reflective capacity. Studies in real-world settings, not RCT's, demonstrate that PDT can benefit patients with multiple interpersonal/personality issues (Levi, 2017b; Levi, Bar-Haim, Kreiss, & Fruchter, 2016). This supports the claim that comparative efficacy research aimed at directly comparing interventions for PTSD in real-world settings is particularly important (Steenkamp & Litz, 2013).

Complex posttraumatic stress disorder (C-PTSD) and PDT

It is now well established that the majority of people who report exposure to trauma have undergone multiple exposures to trauma over critical developmental periods and not a single incident or event (Kessler, 2000; Levi, 2017a; Van der Kolk, 2017). Knefel, Lueger-Schuster, Karatzias, Shevlin, and Hyland (2019) suggest that trauma during the developmental period causes attachment disorders marked by persistent fears and hopelessness about themselves. Trauma of this type, which we call complex trauma, establishes a risk for a symptom profile commonly termed complex PTSD (Herman, 1992), which is distinguishable from posttraumatic stress disorder (PTSD) (Hyland et al., 2017). Herman identified two types of trauma: simple trauma (simple PTSD) and complex trauma (complex PTSD). Simple trauma is the term used for a single, discrete traumatic event (e.g. a car accident). On the other hand, complex PTSD (C-PTSD) entails repeated, prolonged, extended, and recurrent stressors. These stressors include difficulties with social, interpersonal, and occupational functioning, and general adjustment, and affect the personality (Kudler, 2011; Schottenbauer et al., 2008). It is therefore argued that C-PTSD is outside the current definition of PTSD (Resick et al., 2012) since patients with C-PTSD typically present long-term symptoms including key symptoms like self-organizing disorders (Hyland et al., 2017).

Studies of different treatments for C-PTSD suggest that supplemental affect management groups can be somewhat effective in alleviating C-PTSD symptoms(Resick et al., 2012). Another study of psychodynamic therapy (PDT) for C-PTSD indicated reduced PTSD and depressive symptoms by the end of therapy and follow-up assessment, with significantly improved patient functioning by the end of therapy and at the 12-months follow-up point. Patients' hope had also improved (Levi et al., 2017). Generally, however, studies offer no clear evidence of effective treatment for individuals specifically diagnosed with C-PTSD and no explanation for the high rate of dropout and non-response to therapy, especially with C-PTSD patients (Resick et al., 2012; Schottenbauer et al., 2008).

The therapeutic response to C-PTSD should address subjective experiences while touching on relationships with significant figures from the past and their effect on the

assimilation of the traumatic event in the present (Knefel et al., 2019). This requires a variety of psychodynamic techniques (Kudler, 2011).

The concept of 'hope' and the role of hope in PDT for C-PTSD patients

While there are several definitions of the concept of 'Hope' (Dufault & Martocchio, 1985; Menninger, 1959; Snyder et al., 1991; Stotland, 1969) two stand out in particular. The first is advanced by the cognitive-behavioral approach that sees hope as a desire that leads to the formulation of goals. Namely, people actualize their desires by identifying strategies to achieve them and this process generates hope (Snyder et al., 1991). The second definition of Hope is consistent with the psychodynamic approach where hope is conceptualized as the search for a psychological space in which the self can start anew (Mitchell, 1993). Hope has also been discussed by philosophers (e.g. Immanuel Kant), who argued that hope is a desire for an end perceived to be good and a belief that the end is possible. Philosophers have amplified hope in various ways, mainly by regarding it as a passion, and situating it within a nexus of other passions. Some regard hope as an emotion related to other emotions either through similarity or contrast (Callina, Snow, & Murray, 2018). But whatever the definition, hope is a complex, multidimensional, experiential, creative phenomenon residing in different mental spaces (Levi, 2013).

For its part, the PDT approach conceptualized hope through developmental trauma victims (Mitchell, 1993). It describes Hope as a search for a psychological space that will enable the self to start afresh. Mitchell (1993) believed that trauma causes confusion that can lead to psychological damage, leaving the individual without tools for recognizing what is necessary for his or her daily function and quality of life. This may produce dysfunction, especially at the level of interpersonal relationships. C-PTSD is also the result of a life changing trauma that can temporarily affect the sense of hope of those struggling with its symptoms. C-PTSD is disorienting and may disrupt the patient's understanding of the world and block their basic desire for security and well-being (see more in Gallagher & Long, 2018; Levi, 2013). Hope, on the other hand, can potentially promote their transformation and growth. Mitchell specifically found that C-PTSD sufferers saw hope as a crucial part of their recovery from their trauma experience. He observed that hope was a key factor in each participant's story. When a traumatic event shatters a patient's hopes, therapy can help to develop their hopes and establish a mature and independent personality with concomitant hopes. Hope, then, can potentially engender transformation and growth. That is why it is significantly linked to posttraumatic growth (Ho et al., 2011).

The PDT technique described below, which was used with the patient in this article, consisted of three broad stages: a) establishing a therapeutic alliance and interpersonal relationship with the patient; b) exploring the patient's unconscious conflicts arising from the effect of the traumatic event (including: addressing the therapist-patient relationship while carefully noting unresolved conflicted feelings linked to significant figures in the patient's past and analyzing how these feelings shield the patient's awareness from threatening thoughts, feelings, and impulses), c) termination and summary. The last stage of PDT includes the sense of loss inherent to any trauma case, but particularly the loss of therapy and the therapist from the patient's life. Because these losses are also linked to losses associated with the trauma and other endings in the patient's life hope is considered a vital component in the recovery from the trauma experience. As noted

above, past studies have identified hope as a key factor in their participants' stories and the sense that hope exists and can be reactivated has proved the main reason that participants hung on to life at the time of the trauma and particularly shortly afterwards. Since hope springs into action with the traumatic event, the therapist needs a picture of the participant's hopes before the event as well as their definition and conceptualization of hope (Levi, 2013). Therapy must thus begin with the rehabilitation of an authentic human relationship. In each phase of the therapy, the therapist must endeavor to strengthen the therapeutic alliance and draw the patient into a full partnership in therapy, while engendering a deep desire to deal with the problem (Wigren, 1999).

Moreover, as suggested by Stephen A. Mitchell (1993), these phases represent a critical process in which the hopes of the therapist and patient 'draw closer' to one another within the potential space that builds up in therapy. The therapist plays a crucial role in this framework through his complex meaning-generating subjectivity. The therapist's task is to offer a complex reorganization of the patient's new hope along highly personal (patient-oriented) lines. Mitchell discusses the reciprocity between the therapist's hopes and fears and those of the client. Therapists' hopes relate to their choice of becoming a therapist, the service they offer, their sense of self-worth, and what gives their life meaning. These factors affect their sense of their ability to help – and if they do not help, they may experience paralyzing anxiety.

The clients, however, unconsciously hope to stay 'stuck' in their old, familiar hope under the therapist's protective, omnipotent care. However, they enter therapy because they are distressed which implies a desire (and hope) of improving their situation. Thus, a dialectic relationship develops between the static and familiar (old hopes) and the longing for something fuller and more satisfying (hope of change). Inevitably, a crisis stemming from the gaps between the therapist's hopes and the client's hopes will arise which includes the dialectics between hope and despair (O'Hara, 2011), where each supports the other. Hope and despair often coincide, and O'Hara suggests that these states are expressed in action and reflection during therapy. The therapist's goal is to achieve a balance between them. Essentially, action and reflection are needed to rediscover hope once the right balance of despair has had its effect. Excessive action or reflection minus the tempering influence of the partner factor will thrust back the client back prematurely into a life of frantic, instrumental action or else drowning in a pool of interminable navel gazing. The correct balance will mean that the work of nurturing hope can ground a new and realistic hope in an awareness of which of the patient's goals are feasible and attainable.

Mitchell maintains that this balance is a natural part of the therapy process and that is expressed by the patient's attack on the therapist's belief in change, and what attracted him to the profession (i.e. the attempt to understand, interpret, and produce change). This brings the therapist face to face with his or her fears. Furthermore, the therapist's understandings are expressed in the analytical interpretation which they suggest, which ultimately engenders the development and intensification of hope in therapy. For the client to accept the analytical interpretation, which is part of the new hope and an expression of the power invested in the therapist through the transference, he or she has to see the therapist's interpretation as different from anything else he has known. This 'light' (the interpretation) that the therapist sheds upon the 'prism' (subjective world of the client) will not diffuse into familiar experiential categories: old fears, old longings, old

hopes. Rather the interpretation, which normally brings new hopes, will increase the client's fears. On the unconscious level, the client senses an imposition of the analyst's values and personality. Therefore, Mitchell suggests that hope requires great courage and develops through the ongoing therapist-client presence.

As noted, Mitchell also addressed the case of trauma casualties, who he argues are characterized by a deep confusion between wishes and needs and so lack the tools to identify what is required to improve their quality of life. In order for their hopes and wishes to provide the basis for personal meaning-creation, old hopes must change within the framework of the client-therapist interaction. According to Mitchell, since we all possess the potential to organize ourselves in numerous ways, opportunities must be found for new hope to grow. This hope takes shape through the new words that the therapist employs that the client internalizes and which serve to dismantle old familiar states of consciousness/mind. This in turn makes room for new states of consciousness/mind. Mitchell also believes it important for therapy to end so that the client learns he is responsible for his own life. This prevents therapy becoming a substitute for life. Ending therapy frees the client from the therapist's influence allowing them to find their own unique path.

The present article describes how, after years of struggling with C-PTSD symptoms, the PDT approach helped the patient to master his inner experiences and reestablish the integrity of his life while focusing on interpersonal problems. It should be stressed that this clinical example presents the treatment of a man by a male therapist, which involves different countertransference transfer processes to a male-female therapeutic dyad. The patient in our case consented that his therapy details should be used.

Clinical example

Daniel (not his real name) is the oldest of three siblings with both parents Holocaust survivors. He is married with children and grandchildren and is presently retired. I treated him for two-and-a-half years following complaints of complex PTSD symptoms, apparently the result of fighting in the Yom Kippur War (1973) and childhood traumas. Daniel was treated by the Unit for Treatment of Combat-Related PTSD (UTC-PTSD) of the Israeli Defense Force (IDF) Medical Corps. The unit provides weekly therapy free of charge to soldiers who fought in Israel's wars/combat operations. Patients can apply for and be accepted for treatment by various means including over the phone. Therapists (psychiatrists, clinical psychologists, and social workers) in the unit have extensive experience in PTSD diagnosis and treatment. All therapists have completed mandatory IDF service and are cognizant of Israel's military culture, language, conduct, behavioral norms, system, dress code, and rituals.

During our initial phone conversation Daniel explained that he was considering therapy and wondered if he actually had a chance of feeling better so long after the traumatic event. I replied that our experience showed significant success with helping casualties of the Yom Kippur War.

We can understand Daniel's approach as a combination of an unconscious hope of being held coupled with a fear and despair of exposing himself after so many years. The position that I presented in our phone conversation was based on the solid hope that therapy could help.

In an early therapy session, Daniel recalled that our phone conversation had removed his emotional block and given him the confidence to enter therapy. These sentiments were identified by Jerome Frank (1968) who argued that the therapist plays an important role in instilling hope (and confidence) in the client.Daniel described sadness, self-destructive behavior (heavy smoking despite heart disease), crying episodes over the suffering of others, shame over his combat performance, guilt relating to his wife, sensitivity to smells that reminded him of the war, and frustration over the quality of interpersonal relationships in different areas of his life – which corresponds to complex PTSD. He explained that he was seeking therapy in the hope of feeling better, which appeared consonant with my own hopes as a therapist. However, this hope-expectation, which was mentioned in relation to complex symptoms (shame and guilt) exacerbated my concerns over my own ability to help him. This feeling intensified when I discovered that Daniel had control needs, evidenced by his volubility and the emphasis he put on his abilities and merits.

Daniel often described his suffering in the same breath as his devotion, dedication, and giving as a family man. I identified this as both a need to impress me and a need for 'recognition'. My efforts to understand what brought him to therapy were fruitless. Daniel failed to understand my probing. This indicated that Daniel's hope of change was still linked to his old, static, familiar hopes with their familiar symptoms of suffering (and functioning) and/or related to his perceived risks of hoping (risk of disappointment, failing to reach the hoped for goal) (O'Hara, 2011). In therapy, these hopes need to be converted into new hopes in therapy, in a process that among other things occurs during a special state in which the client's hopes are held by the therapist (Levi, 2013).

At first, I listened empathically to Daniel's narrative and reflected and empathized with his statements. I realized that the only way to establish the kind of relationship that Daniel needed was to protect the delicate, fragile intermediate space (Winnicott, 1975) which I could see emerging. Only this therapeutic alliance (Wigren, 1999) combined with a deepening of Daniel's confidence and trust would enable the vital 'shifts' and a consonance between our hopes to arise. Therefore, despite the growing threat and fear of that the therapy might fail, I reminded myself that the long process of passage from the hopes of the past to another existence in the present (the dawn of the new hope) and to future growth and development, was by allowing Daniel to stay in the states of hope with which he arrived to therapy.

This is what I learned from Daniel's description of his life and relationships. His parents and teachers, apparently unaware of his learning difficulties, expressed dissatisfaction with his work and warned that he would never succeed academically. He swore that he would 'show everyone what I am worth'. I also learned about the fears he had inherited from his parents, two Holocaust survivors (a demanding and controlling mother and an avoidant father who drummed into him that, 'he must never let Hitler rest in peace' and needed to have as many children as possible"). He was driven by his parents' expectations of him as the eldest son and by his need to feel talented, special, and masculine. This led to multiple relationships with women and problems adjusting to his military service (early in basic training there were confrontations with his officers). He also recalled that if he had not been promoted to a special position which granted him status, but above all close personal interactions with an individual at the top of the 'pyramid', he would not have survived the army.

These descriptions highlighted the C-PTSD underlying his stagnant and survivalist approach to life. His stagnation and fear of emotional pain made parting from his old hopes (i.e. the safe place which protected him from pain, but also caused him suffering and sadness) more difficult.

Daniel said once that he was concerned that my responses were too low-key and that I did not take the lead and 'show him the way'. This remark expressed the gap between our hopes: his disappointed infantile hope of being held, contained, and understood (needs not met by his parents) with its resulting aggression, anxiety and despair, and the hope of a quick cure. On the other side of the gap was my hope of forging a trust relationship and a potential space for nurturing the process of converting the old hopes into new hopes. I also felt and understood the origins of Daniel's detached experiences: the failure of others to recognize his abilities in childhood (poor student), and his efforts to prove his 'value'. Likewise, I could feel his yearning 'for rebirth', his hopes of making a new start and returning to the points of the failure which had disrupted his development and sabotaged his unconscious hope of actualizing his growth and development needs (Casement, 2013). I needed to survive Daniel's attacks in order to return to these points. This included dealing with the sense of hopelessness which scholars suggest is a support link between hope and trauma (Gallagher & Long, 2018). In other words, I hoped that Daniel and I could go back as far as needed, to his early emotional development before the traumatic damages had accumulated and become intolerable. I postulated that if this led to his confusion and despair it would engender an opportunity for change in perception and meaning (O'Hara, 2011).

As therapy advanced, the mutual sense that our hopes were drawing closer grew perceptibly. Daniel shared his complex relationship with his wife with me. They had met when they were young and their eldest daughter arrived in their early twenties. Daniel was still a student. After his daughter's birth, he felt he was carrying the burden of two children – his wife and daughter – while trying to study for a difficult degree. He described (and hastily retracted) his wife as a sweet and 'stupid girl in some ways' and accepted her failure to function as a mother after their daughter's birth as a result of her immaturity. Daniel has engaged in complex long-term relationships with other women, sometimes under his wife's nose 'who asked not to know'. When he attempted to confess, his wife prevented him by saying that he was a wonderful husband and father and this was all that mattered. He was silent when I mirrored that he was describing his sense of guilt and that he had a conscious cognitive perception that his wife had nothing to complain about. Later, Daniel disclosed that he was in a long-term relationship with a woman who had lost several first-degree relatives in the Yom Kippur War and other wars. To justify the affair he argued that as the son of Holocaust survivors he was 'obliged' to give himself to this woman to fill what he described as the emotional hole caused by her loss. He stressed that he had a duty to help her, to devote himself to her, and to provide what he felt sure no one else could. I said that I associated this with being 'the good angel.' I also commented that the affair could be linked to his functioning during the Yom Kippur War, which he rejected and (reiterated) angrily that he would rather I was direct and did not beat about the bush. On this occasion, I felt a different emotionality in his response: increased willingness to expose unconscious layers related to his old hopes. I therefore told him that perhaps his response represented an unconscious fear of a connection between the affair and his performance

in the war. His answered 'perhaps' and then was quiet and began weeping restrainedly. Later he recalled in anguish that he had used the cover of evacuating wounded soldiers to a field hospital remote from the battlefield in order to avoid further fighting. This was in stark contrast to his lover's family members who sacrificed their lives and fought until they fell. I answered that his relationship with this woman seemed related both to his sense of guilt over his combat behavior and to his need to be connected in a personal way to the Israeli ethos of bereavement. Daniel then confessed his fantasy of settling down with this 'noble' woman despite his deep sense of commitment to his wife and daughter. He described a dream in which his wife was removed by an angel for a while to develop her emerging artistic skills. I suggested that this dream expressed an unconscious wish for his wife to disappear from his life (i.e. die). I proposed that the guilt related to this wish led him to compensate 'with unending devotion and giving'. Daniel denied having such thoughts, possibly indicating that my interpretation came from the zone of reciprocal influence: a containing space where his primary needs were recognized. The space which was created in this therapy expressed the faith and unconscious hope that therapy would help Daniel to realize that the failures of others were responsible for the fact that his earliest needs had remained unsatisfied and for the development of his current patterns of psychological distress. Daniel rang the clinic after this meeting and said that our last conversation had shown he had been 'pushed' into doing things. He said this insight took a heavy emotional toll and made him feel worse. This stemmed from the new insights which he had reached, especially the agonizing realization that he would like his wife to 'disappear.' Daniel did not keep his next appointment. He left a message that he was sick. I saw his absence as a reaction to my interpretation of his dream. Apparently, the interpretation included both desperation and hope: on the one hand a despair of hope and on the other a possibility for growth (new hope). In Daniel's case, the potential for change had been achieved by my self-positioning as a containing, holding, and present parent who weakened the old defenses to the extent that Daniel entered a pre-balanced, unbearable state (Mitchell, 1993), expressed in his physical collapse (illness). Daniel now took his first steps towards 'exiting' a schizoid paranoid position and entering a depressive position. The schizoid paranoid position is defined as a longing for a magical, omnipotently controlled, easily exchangeable object, where the environment is seen as objects in need of supernatural solutions. The depressive position demands great courage; it is a longing for an all too human, irreplaceable object that is outside one's control, and includes an understanding that the environment is a complex generality of 'good' that is beyond his capacity to control (Winnicott, 1975).

At our meeting two weeks later, Daniel told me how important our last conversation had been and that he had discovered his unconscious layers. He talked about his painful emotions after the conversation and how he realized that the pain also signaled an opportunity for something different and new (growth). Having perceived that he had this opportunity for change he now asked me to extend our sessions by half-an-hour to expedite the process and 'because opening things' after so many years was challenging and complex. He felt that our sessions were curtailed prematurely.

I assented that, yes, it was difficult to address issues that had been locked down for years and that exposing the unconscious layers of his mind was a complex challenge. But I also explained that seeking to extend our meetings could show an unconscious

desire to regain control after exposing the unconscious layers in the last meeting, and that this caused fear and anxiety (also expressed in his illness). He said 'I had taken it too far,' explaining that his whole life had been dedicated to giving, sacrifice, and caring for others, and now, under such sensitive circumstances, when he finally allowed himself to ask for something for himself, his request must be taken seriously. His reaction was typical at moments of crisis. Daniel was essentially protesting against what had happened in our previous meeting – the interpretation which had been 'forced on him' and which embodied my own values, insights, and 'claim' that I could help him to change (Mitchell, 1993). He was 'attacking' the framework (the duration of the therapy session), which he identified with me, and which signified the static, familiar state outside the room (his life). This indicated development, including progress in the process of our hopes of moving closer within the space created between us.

Over the years of therapy there were many moments of crisis relating to numerous contexts (e.g. when dealing with his shame and guilt at fleeing the battle under the cover of evacuating wounded soldiers). After approximately two years in therapy, characterized by my 'continuous presence' and Daniel's tremendous courage and desire for continuity, Daniel arrived at insights into his fantasies (regarding success, power, beauty) and into his vulnerability due to his poor self-esteem. I also examined the meaning of his relationships with significant figures in his life on the conscious and unconscious levels, linking them to the combat events (e.g. we dealt with the fact that after his breakdown he went home, and his father reproachfully asked him why he was home when everyone else was fighting).

Daniel worked to construct an experience of his self and his inner object experience as an expression of more mature and adaptive mechanisms which reflected his change, namely his 'new hope.' After more than two-and–a-half years we both felt that ending therapy would show us whether Daniel could handle his life without my professional influence (Mitchell, 1993) and if he could forge his own path.

In the follow up meeting, Daniel said that it was difficult for him to express how his change had occurred. But he knew that it was a fact. The ability to hope, knowing that hope may not necessarily be realized, and being prepared for disappointment, pain, and frustration – these factors are the essence of hope.

Discussion and conclusions

PDT for C-PTSD focuses on the interpersonal relationships of the sufferer, who as a rule has difficulties in forming trust-based relationships (Levi, 2013). Daniel's case demonstrates that for C-PTSD casualties new growth arises from: establishing trust, boosting client confidence, creating a potential space for complementary, competing, and opposing ideas to coexist in the same reality, and facilitating the development of ideas, thoughts, and feelings (Wigren, 1999). To achieve new growth, the therapist must offer unconditional acceptance and enable the client to use him or her, while keeping the flame of hope alive (Levi, 2013). The therapist must also survive the dread and despair experienced by the patient (and the analytic process) without withdrawing (Mitchell, 1993; O'Hara, 2011). The therapist must continue to provide support until the conditions are ripe for converting the old hopes into more satisfying patterns of living. In Daniel's case, my ability to hope and hence be continuously and consistently

present while protecting Daniel's suspended hope in the intermediate space we created is what enabled the change. Daniel had been disappointed by significant others in the past and had to experience trust and confidence so that his suspended hope could reach out and grow. By functioning as a containing, holding, present object, I enabled him to feel another way of being, emotional and deep. This was especially relevant during moments of crisis when there are no words, or when words (the interpretation) give rise to 'another way of being.' At these junctures, old defensive organizations reflecting the conflict inherent in the movement between old familiar hopes and new hopes are expressed. It is only then that the potential of hope can emerge as a life force that motivates and brings forth change.

When C-PTSD casualties decide to seek therapy after years of existing in the shadow of their traumatic event they unconsciously generate a powerful process in therapy, founded on the infantile hope that the therapist can help them recover quickly. This process can lead to the expectation that the therapist will function as a 'savior'. It is important to avoid this (Herman, 1992). If the therapist adopts an overprotective attitude towards the client (this being basic to the role of 'savior'), it will undermine the transference between the hope of the paranoid-schizoid position and the hope of the depressive stage, which is crucial for recovery (Mitchell, 1993). It is extremely important therefore for the therapist to recognize these conditions through the countertransference process and reduce the risk of therapy discontinuation by: (a) forming a quality alliance, (b) exploring fear and pain whilst retaining an energized, hopeful orientation, and (c) by providing an inspirational therapeutic process which grapples with life yet finds the balance between possibilities (hopes) and limitations (realistic hopes.)

Finally, C-PTSD can be disorienting and limit the client's understanding of the world while obstructing their basic desires for safety and well-being. In the face of these challenging problems, hope is considered an important resource during the long process of moving towards emotional and psychological healing. While this article has endeavored to demonstrate this process, further study of the relationship between hope and C-PTSD is also recommended.

On the basis of my Ph.D. dissertation and my wide-range experience as post-trauma therapist (in my capacity as Commander of the Unit - Post Traumatic Stress Disorders Treatment Unit, IDF) my research naturally deals with the following two main issues: hope and diagnosis. Likewise it focuses on treatment and prevention of chronic Post Traumatic Stress Disorder. My original Ph.D. thesis was formatted and arranged as a Five-Step Therapeutic Model. This Model is based on short-term dynamic orientation which combines dynamic and behavioral tools aimed at treating chronic post-trauma.

I have retired from my IDF service and opened a private clinic. As a therapist I treat PTSD and anxiety disorders using the patients' hope according to the protocol I developed and give workshops to groups in different organizations. In addition, I carry out teaching, researching and publishing my findings. The focus of my work is all levels of trauma, positive psychology, hope, prevention of post-trauma, cognitive-behavioral therapy, dynamic individual and group treatment, diagnosis and analysis processes.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Ofir Levi, Ph.D., On the basis of my Ph.D. dissertation and my wide-range experience as post-trauma therapist (in my capacity as Commander of the Unit - Post Traumatic Stress Disorders Treatment Unit, IDF) my research naturally deals with the following two main issues: hope and diagnosis. Likewise it focuses on treatment and prevention of chronic Post Traumatic Stress Disorder. My original Ph.D. thesis was formatted and arranged as a Five-Step Therapeutic Model. This Model is based on short-term dynamic orientation which combines dynamic and behavioral tools aimed at treating chronic post-trauma. I have retired from my IDF service and opened a private clinic. As a therapist I treat PTSD and anxiety disorders using the patients' hope according to the protocol I developed and give workshops to groups in different organizations. In addition, I carry out teaching, researching and publishing my findings. The focus of my work is all levels of trauma, positive psychology, hope, prevention of post-trauma, cognitive-behavioral therapy, dynamic individual and group treatment, diagnosis and analysis processes. Address: Department of Social Work, Ruppin Academic Center & The Bob Shapell School of Social Work, Tel- Aviv University.

References

Brom, D., Kleber, R., & Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorders. *Journal of Journal of Consulting and Clinical PsychologyTraumatic Stress*, (57), 607–612.

Callina, K. S., Snow, N., & Murray, E. D. (2018). The history of philosophical and psychological perspectives on hope: Toward defining hope for the science of positive humman development. In M. W. Gallagher & S. J. Lopez (Eds.), *The oxford handbook of hope* (1 ed., pp. 9–26). New-York: Oxford University Press.

Casement, P. (2013). *Further learning from the patient: The analytic space and process*. London and New-York: Routledge.

Dufault, K., & Martocchio, B. C. (1985). Symposium on compassionate care and the dying experience. Hope: Its spheres and dimensions. *The Nursing Clinics of North America*, *20*(2), 379–391.

Frank, J. (1968). The role of hope in psychotherapy. *International Journal of Psychiatry*, *5*(5), 383–395.

Gallagher, M. W., & Long, L. J. (2018). Hope and posttraumatic stress disorder. In M. W. Gallagher & S. J. Lopez (Eds.), *The oxford handbook of hope* (pp. 233–242). New-York: Oxford University Press.

Gold, J. (2011). An attachment based integrative psychotherapy for anxiety disorders. *Journal of Psychotherapy Integration*, *21*(4), 382.

Herman, L. J. (1992). *Trauma and recovery*. Israel: Sifriyat Ofakim Am Oved.

Ho, S., Rajandram, R. K., Chan, N., Samman, N., McGrath, C., & Zwahlen, R. A. (2011). The roles of hope and optimism on posttraumatic growth in oral cavity cancer patients. *Oral Oncology*, *47*(2), 121–124.

Horowitz, M. J. (1973). Phase oriented treatment of stress response syndromes. *American Journal of Psychotherapy*, *27*(4), 506–515.

Hyland, P., Shevlin, M., Elklit, A., Murphy, J., Vallières, F., Garvert, D. W., & Cloitre, M. (2017). An assessment of the construct validity of the ICD-11 proposal for complex posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(1), 1.

Kessler, R. C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. *The Journal of Clinical Psychiatry*, *61*(5), 4–12.
Knefel, M., Lueger-Schuster, B., Karatzias, T., Shevlin, M., & Hyland, P. (2019). From child maltreatment to ICD-11 complex post-traumatic stress symptoms: The role of emotion regulation and re-victimisation. *Journal of Clinical Psychology*, *75*, 392–403.
Kudler, H. (2011). Psychodynamic psychotherapy. In B. A. Moore & W. E. Penk (Eds.), *Treating PTSD in military personnel* (pp. 107–124). New York - London: The Guilford Press.
Leichsenring, F., & Klein, S. (2014). Evidence for psychodynamic psychotherapy in specific mental disorders: A systematic review. *Psychoanalytic Psychotherapy*, *28*(1), 4–32.
Levi, O. (2013). Individual therapy for chronic and complex PTSD via the phenomenon of hope. *Psychoanalytic Social Work*, *20*, 150–173.
Levi, O. (2017a). From traumatic language to posttraumatic language: The development of language in therapy according to the "phenomenon of hope" model. *Psychoanalytic Social Work*, *24*(1), 54–74.
Levi, O. (2017b). In depth psycho-sociological interview (intake) and placement for treatment in case of combat PTSD. *Addiction Medicine & Therapy*, *3*(5), 1–5.
Levi, O., Bar-Haim, Y., Kreiss, Y., & Fruchter, E. (2016). Cognitive–behavioural therapy and psychodynamic psychotherapy in the treatment of combat-related post-traumatic stress disorder: A comparative effectiveness study. *Clinical Psychology & Psychotherapy*, *23*(4), 298–307.
Levi, O., Shoval-Zuckerman, Y., Fruchter, E., Bibi, A., Bar-Haim, Y., & Wald, I. (2017). Benefits of a Psychodynamic Group Therapy (PGT) model for treating veterans with PTSD. *Journal of Clinical Psychology*, *73*, 1247–1258.
Menninger, K. (1959). Hope. *The American Journal of Psychiatry*, *116*, 481–491.
Mitchell, S. A. (1993). The dialectics of hope. In *Hope and dread in pychoanalysis* (1., pp. 202–232). New York: Basic Books.
O'Hara, D. J. (2011). Psychotherapy and the dialectics of hope and despair. *Counselling Psychology Quarterly*, *24*(4), 323–329.
Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., Mitchell, K. S., … Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: Implications for DSM-5. *Journal of Traumatic Stress*, *25*(3), 241–251.
Schottenbauer, M. A., Glass, R. G., Arnkoff, D. B., & Gray, S. H. (2008). Contributions of psychodynamic approaches to treatment of PTSD and trauma: A review of the empirical treatment and psychology literature. *Psychiatry Research*, *71*(1), 13–34.
Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., … Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology*, *60*(4), 570–585.
Steenkamp, M. M., & Litz, T. B. (2013). Psychotherapy for military-related posttraumatic stress disorder: Review of the evidence. *Clinical Psychology Review*, *33*, 45–53.
Stiles, B. W., Barkham, M., Clark, J. M., & Connell, J. (2008). Effectiveness of cognitive-behavioural person-centered and psychodynamic therapies in UK primary-care routine practice: Replication in a larger sample. *Psychological Medicine*, (38), 677–688. doi:10.1017/S0033291707001511
Stotland, E. (1969). *Psychology of hope*. New York: Jossey-Bass.
Van der Kolk, B. A. (2017). Developmental Trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, *35*(5), 401–408.
Wigren, J. (1999). As hardly killed, as easily wounded: Posttraumatic challenges to the working alliance. *Contemporary Psychoanalysis*, *35*(2), 253–269.
Winnicott, D. W. (1975). *Through paediatrics to psycho-analysis: Collected papers*. London: Brunner/Mazel.