Psychoanalytic Approaches to Treatment-Resistant Combat PTSD

8

Joseph E Wise

Brothers in Arms, by MSG Christopher Thiel, courtesy of the Army Art Collection, US Army Center of Military History.

J. E. Wise (✉)
Department of Psychiatry, Walter Reed Army Institute of Research, Walter Reed National Military Medical Center, 8901 Wisconsin Ave, Bethesda, MD, USA
e-mail: joseph.e.wise.mil@mail.mil

E. C. Ritchie (ed.), *Posttraumatic Stress Disorder and Related Diseases in Combat Veterans,* DOI 10.1007/978-3-319-22985-0_8

Since September 11, 2001 to the beginning of 2015, approximately 2.5 million service members have deployed in support of the wars in Iraq, Afghanistan, and related activities [1]. Early on in the current wars, surveys determined that an average of 15% of deployed soldiers had symptoms of posttraumatic stress disorder (PTSD) [2]. Additionally, many of those who screened positive for behavioral health (BH) symptoms were hesitant about getting care [2]. Moreover, those who were identified as having symptoms did not seek care in traditional ways or as a result of a positive screen [3, 4]. More recently, in active duty soldiers with PTSD, about half dropped out of care prematurely or got an inadequate number of sessions [5].

The historical connection between military and psychoanalysis runs deep. Notably, many of the early psychoanalysts were conscripted in World War I [6]. Freud experienced World War I personally, living in the capital Vienna and having his children drafted. It was partly due to these experiences that Freud elaborated on his theories. For Freud, trauma was when excitation overwhelmed the protective ego shield of the psyche [7, 8]. Moreover, the early analysts such as Sandor Ferenczi described cases of what would be considered PTSD, in modern psychiatric nosology [9, 10].

In World War II, many psychiatrists came back from the military expecting to apply psychodynamic concepts [11]. Across the Atlantic, the British psychoanalytic experiences in World War II were monumental. For example, Wilfred Bion and collaborators at Northfield Military Hospital developed what was to evolve as group psychotherapy and an understanding of unconscious forces in groups [12]. Fairbairn, as early as 1943, posited a "military neurosis" whereby a patient may project his internal object relations in the military organization [13].

For PTSD, the Department of Defense/Veterans Affairs (DoD/VA) Practice Guidelines identify psychotherapy with cognitive restructuring and/or exposure and selective serotonin reuptake inhibitor (SSRI) medications, as first-line treatment [14]. The American Psychiatric Association (APA) Guidelines, including updates, have similar recommendations but do recognize the need for psychoanalytic approaches as well [15]. Recognized manualized evidenced-based psychotherapies for PTSD include prolonged exposure (PE) [16], cognitive processing therapy (CPT) [17], and eye movement desensitization and reprocessing (EMDR) [18]. Core principles from these treatments include narration, cognitive restructuring, in vivo exposure, stress inoculation/relaxation skills, and psychoeducation [19].

Limitations of the manualized treatments include concerns that many of these were tested in civilian, not active duty military populations. Moreover, although generally efficacious for those patients who complete the protocol, there are a significant proportion of patients who drop out of the treatment. Many DoD providers self-identify as using evidence-based psychotherapies, but likely less than half report fidelity to the researched manualized protocol [20]. For those who cannot tolerate medications or do not respond to initial trials of psychotherapy (i.e., treatment-resistant), additional interventions are needed. As mentioned in the APA Guidelines, a psychodynamic/psychoanalytic approach may be helpful for these patients (here, the terms psychoanalytic and psychodynamic are used synonymously).

There is increasing evidence of efficacy of psychoanalytic psychotherapy in randomized controlled trials for a variety of psychiatric disorders. Milrod has demonstrated efficacy in panic disorder, where there was 73% response rate compared to 39% for a type of relaxation training [21]. Bateman, Fonagy, and collaborators, using mentalization-based therapy in the UK, have demonstrated good effect in borderline personality disorder (BPD), including in long-term follow-up [22–25]. Kernberg and collaborators with transference-focused psychotherapy (TFT) have shown efficacy, even compared to the well-known dialectical behavioral therapy (DBT) in BPD [26]. Gunderson, who developed "good psychiatric management" for character disorders, has shown efficacy with this approach, which is easily adaptable to routine psychiatric practice in many clinics, rather than specialized BPD units [27]. A meta-analysis for long-term psychodynamic psychotherapy (LTPP) showed superior efficacy, especially in patients with complex mental disorders [28]. Gerber and colleagues reviewed trials from 1974 to 2010 and found psychodynamic psychotherapy to having "promising" results and "mostly show superiority of psychodynamic psychotherapy to an inactive comparator" [29]. Finally, in a recent widely disseminated article, Shedler reviews the efficacy of psychodynamic psychotherapy, and he finds these psychotherapies to have effect sizes as large as those reported for other psychotherapies [30].

Psychoanalytic psychotherapies also seem to have a particular niche in treatment-resistant cases. The Austen Riggs psychoanalytic hospital has written extensively on this approach with patients who have not responded to traditional community interventions [31]. The present chapter focuses on psychoanalytic approaches in the situation of treatment resistance in combat PTSD. If symptoms can significantly mitigate by 12 sessions/6–12 weeks, with/without a medication trial of 6 months, then there is little reason to engage in more rigorous time- and resource-intensive therapy. As noted above, many patients do not respond to initial attempts of treatment or have complex comorbidities, and it is for this population that psychoanalytic approaches can be considered for the treatment of PTSD.

There is limited writing on psychoanalysis as an approach to PTSD from modern military operations. There is only one published psychoanalytic case, which was an approximately 3-year analysis of a Vietnam veteran, during which developmental trauma was linked with combat trauma [32]. Within the post-9-11 Global War on Terror (GWOT), Carr has published a few cases using psychoanalytic psychotherapy, especially highlighting the relational and intersubjective aspects [33–35].

The following account will (1) present a case, (2) describe the course of treatment, including outcome measures of complex treatment-resistant PTSD, (3) give two transcripts of actual sessions of psychoanalysis for combat PTSD, and (4) present a psychodynamic formulation with unique considerations for military patients. The conclusion summarizes the case and identifies areas for future research to further clarify the contribution of psychodynamic psychotherapies to treatment of PTSD.

8.1 Case Presentation/History

This case describes a 30-year-old male lower enlisted soldier in the combat arms with one GWOT deployment (material is used with his consent and identifying details/dates are disguised). The patient had no premorbid (pre-combat) treatment or identified BH conditions. He did have a comorbid gastrointestinal condition, which was diagnosed early in his military career, and this condition is often considered psychosomatic or at least significantly influenced by emotional stress. The patient, a married man, in his early 30s, is a self-described "country person" from a long line of "poor country people." He grew up in the rural South. He joined the army in his mid-twenties because he always wanted to be in the army and be a policeman, and the army afforded him the opportunity to do both. He said he would have joined the army earlier, but he had to take care of his family first. In so doing, owning a home at age 21, prior to enlisting, was one of the accomplishments for which he was most proud, and something that no one else in his family was able to do.

He was raised by his biological parents, who were married. His father was often unemployed due to the unpredictability of construction work. His mother worked as a secretary and provided stable income and "held the family together." He had a close family member of approximately the same age who had "some sort of emotional problems." The patient described frequent angry outbursts from this relative and emotional lability/affective instability, with which the parents were apparently frequently engaged.

After graduating from high school, he went to work at a warehouse. Soon after graduating from high school, his mother was diagnosed with colon cancer and died after battling the cancer with surgery and radiation/chemotherapy. He described how, growing up, he learned to tell the truth, keep his word, work hard, take care of the family, and respect others.

He had been in the army for 5 years when I saw him. His first duty station was outside of the continental US, where he worked in the military corrections facility for a year. He was then stationed for 2 years at a large army base in the Midwest. He reenlisted to be stationed at a post in the southern USA so that he could be closer to his roots. It was from there that he was deployed to the Middle East for a year.

Consistent with most complex treatment-resistant patients in the military, his course had several stages, including initial treatment from primary care manager (PCM), then walk-in BH, then being followed by a psychiatric nurse practitioner, a series of consults from a neurologist, my initial assessment, my initial psychotherapy, then psychoanalysis. The patient presented in early September 2012 to primary care with complaints of pervasive anxiety, hypervigilance in crowds, nightmares, sleep problems, and an upper arm tremor. Consistent with military programs to emphasize primary care screening and management of BH conditions (Respect.mil), his PCM consulted (via electronic communication) with the Respect.mil psychiatrist. The consultation was essential to start SSRIs and refer for specialist care. After 2 days of his PCM appointment and with his PCM's guidance, the patient walked in to "sick call." The "sick call" psychiatrist continued him on paroxetine (a medi-

cation FDA approved for the treatment of PTSD), and propranolol was added. Additionally, the provider referred the patient to neurology for his tremor, a definitive management in the BH clinic, and told the patient to continue follow-up in "sick call" while this was being arranged.

Due to demand for BH services and neurology, the patient was not able to be scheduled for another 2 months. My colleague, the walk-in psychiatrist, had three visits in the "sick call" clinic, during which supportive psychotherapy and attempts at adding adjunctive buspirone, prazosin, and buproprion were attempted.

By December 2012, 3 months after presentation, the patient had his first appointment with his assigned provider, a psychiatric nurse practitioner, who switched him to venlafaxine and continued supportive psychotherapy. These visits continued for the next few months. It was during the December-through-March time period that I learned of the case since I had the responsibility of reviewing the cases managed by the nurse practitioner. I worked with the neurologist to ensure completion of the brain magnetic resonance imaging (MRI), electroencephalogram (EEG), neurological exams, all of which were normal and showed no neurologic cause for the tremor. In an attempt at symptomatic treatment, propranolol was continued and primidone was added but were discontinued after a few months due to lack of effect on the tremor.

It was in early April that I, on behalf of the entire treatment team, contacted the unit commander since there had been some questions about duty limitations. He was essentially given a non-deployable profile, and his other duty limitations were formalized (the unit had—months ago—limited his work to administrative duties due to his "shakes"). At the patient's request, I also met him with his wife for a session, and she confirmed the various anxiety and PTSD symptoms and confirmed the time line of the symptoms, as being a change from baseline and starting during deployment.

8.2 Treatment/Management

Since I was already significantly involved, the psychiatric nurse practitioner and I agreed that he would terminate and that I would manage the patient, whose symptoms had remained basically unchanged since presentation. It was in early May 2013 that the patient and I had our first formal appointment (this was approximately 8 months after he had initially presented to our clinic). Since he had already experienced initial evidence-based psychopharmacology (SSRI) and supportive psychotherapy, I consider this as the point that he transitioned to a treatment-resistant category. Moreover, the neurologist had also shared the normal MRI, EEG, and exam findings with the patient and was ending care with a "non-physiologic" diagnosis. When I met with the patient in early May, I shared my discussion with the neurologist and that "anxiety might be contributing or causing this." The patient seemed to take this without much reaction. He was tacitly agreeable and accepting, but my impression was that the patient still held out that there may be a physical etiology

for his tremor. The patient and I also noted that coming in seemed to be helpful for him as well as the venlafaxine, by now, 225 mg/d. So, I recommended that we embark on a more formal course of psychotherapy, and I would continue to monitor his prescription. I suggested that we meet twice a week for the next 6 weeks in a 12-session brief treatment and then make some decisions about the longer term at the end. Our scheduled 12 sessions ran throughout May and June.

Regarding the content of our twice weekly psychotherapy, it presaged the themes of the psychoanalysis. Psychotherapy themes included: coming from a family where not expressing emotions was valued; beliefs that angry emotions were necessarily linked with destructive actions; anger was adjudged as a "bad" emotion; significant resistance to combat discussion with anxious tearful affect and worsening tremor when discussing combat; he did connect his "stress" with his psychiatric and tremor symptoms; beliefs that he needed to comply with authority and sorting through interpersonal experiences to figure out what was wanted by authority, especially military authorities; controlling emotions was very important to him, and when he was not in complete control he feared becoming overwhelmed. The details of traumatic events from deployment were probed directly, but the patient was unable to elaborate much since the process of telling his story in detail generated overwhelming levels of anxiety (the transcribed sessions below do include some narration of traumatic events which occurred while he was deployed). Consistent with many combat veterans, the trauma often involves several demarcated events, but it also seems to be a cumulative experience of the deployment being traumatic in total. At the very least, this veteran had been on several patrols during which he perceived his life to be in imminent danger.

At the end of our scheduled sessions, with no remission, I felt like I could offer a proper military retention decision. I opined that he needed a medical discharge since he remained symptomatic despite full evaluation and treatment trials and due to the possibility of decompensation if he would to deploy again. With regard to the initial psychotherapy, manualized treatments, such as CPT or PE or EMDR, were not tried. Consistent with the treatment guidelines, our work did involve cognitive restructuring and elements of exposure in addition to narration, relaxation skills, and psychoeducation.

Since he got benefit from the psychotherapy (though clearly not curative), I recommended that we continue to meet starting the next month in psychoanalysis. This next phase is what I want to specifically highlight in a treatment approach for a treatment-resistant PTSD patient. I told him we would continue in ways similar to our recent meetings but that he would come in four times per week, lie on the couch, and speak aloud what was coming to mind. I also told him that I would be sitting behind him and probably ask less than he was used to in the therapy sessions. Regarding the technique, I saw it as my role, as an analyst, to set the psychological frame to allow the possibility of having his mental experiences symbolized with words, in the context of appropriate containment and psychological holding.

In order to demonstrate the process, examples of two back-to-back complete early psychoanalytic sessions are given below:

Session #35.
SEP2012.
P [patient]: Yesterday after I left here, I went and just stayed at home.
It helped not being around anybody.
I did a few things at the motor pool.
It's been quieting down.
But, I have my GI appointment. [Note his symptoms and their relationship to his psychiatric condition.]
And, I was so angry yesterday.
T [therapist]: What led to that?
P: Not sure.
I know that I did want the appointment, but I want to be by myself.
I want to be by myself, but I Skyped my wife and kids. [They lived about an hour away, and the patient would commute there on weekends.]
That's all I did yesterday.
I didn't want to do anything yesterday. It was a mood swing toward the bad.
T: Maybe there's a connection between what was going on and your mood. What do you think?
P: I don't know. What would it be?
T: Maybe one of the ways that you deal with the bad feelings is to isolate and withdrawal.
P: I want to be relaxed and not worried.
T: How is that connected?
P: It's the same thing.
Because I'm not worried, I'm more relaxed. More comfortable
T: Would you be more specific about the worries?
P: It's when I'm not alone. People around me.
I am watching their hands. I keep on guard.
It's about that they may be there to hurt me or my family.
It's just that being in a group; I'm worried.
I'm worried about myself.
Am I going to hurt somebody, when I don't need to?
T: Would you describe more about the worries about hurting somebody?
P: I might have another flashback.
I'm going to freak out.
I'm going to smash them.
Things I was trained to do downrange or as a police officer.
I'm uneasy.
When I'm by myself, I'm in control.
Otherwise in crowds, it's chaos.
T: You mentioned throwing people down, what do you mean?
P: Well, in the villages, while deployed, they would keep getting closer.
Sometimes you had to force them off, to the ground.
I don't want that to happen again, especially stateside.
I want to forget that part of my life.

I now have issues with trust due to the patrols.
T: Would you be more specific?
P: It was a lot of different things.
A couple of times we needed space.
[Local police] would be pushing them back. They would throw things, even without being attacked.
They couldn't do that.
It was so crowded in the villages: narrow passages, mud bricks, people lined in the alleys.
You would look up and there would be guys with guns on the roof—right above your head.
On the vehicle patrols, they would throw stuff at us.
We would sometimes give bags of chips and that sort of thing, but they would still be angry.
One time, some in the platoon left on foot patrol. There were just four of us left behind to guard the vehicles—hundreds of villagers.
And, we had another incident in the mountains.
Our lead truck slammed into something.
We needed parts.
But, all we saw was a cloud of smoke.
I didn't know if it was an IED [improved explosive device] or what. One guy got banged up and broke some ribs. The gunner was thrown around in the turret.
We had to wait on the QRF. [Quick Reaction Force]
I was in an open truck.
Then, they started to throw rocks.
I wanted to just start shooting. I didn't know if they would start escalating.
And, I can't keep track. And, they're gathering.
I don't like talking more about this, and people and the crowds.
[silence]
T: What feelings are being stirred?
P: Then, I had to stay calm.
I just tried to forget, and I would tell myself to stay strong.
Before you mentioned tears, but if I cry, then I would be giving up.
I'm not going to lose control.
I just want to forget.
It's in the past.
T: What do you mean by lose control?
P: I'm trying to keep control of myself.
I told myself that I would be strong during deployment.
If I had a problems, I told myself that I could make it through it without breaking down.
T: Yes, but, you're not on deployment now.
P: Yes, but I won't lose control.
T: I wonder about how showing emotion would necessarily mean losing control.
P: It means that to me.

T: How so?
P: Because I told myself that I wouldn't break down and crying is breaking down and breaking down is losing control.
T: Where, then, do all the emotions go?
P: I just want peace and quiet
T: Yes, we've been learning that the ways you deal is to be in a quiet place. But, I wonder if there are other ways?
P: For me, it's just quietness.
T: We have just a few more minutes in the session. Any other thoughts or questions?
P: No
T: Ok, see you tomorrow.

This session highlighted the themes of anger and his fears of getting overwhelmed by his anger. It also demonstrated his fears of his other emotional impulses. Both of these were dealt with, psychologically, by isolation, both in affect and interpersonally. The analyst's technique was significant for basically assisting the patient elaborate verbally on his thoughts and feelings. Technically, it did seem notable that there was a lack of transferential work in this session, other than the general containing and holding transferences of a patient sharing his emotional experience in the presence of the therapist. The lack of transference, in the traditional sense, where a patient relates to the analyst as a way similar to early relationships, and the internal conflict which gets lived out in this relationship with the analyst (transference neurosis) were never significantly clearly present in this case. Despite lack of transference interpretation, there is emerging evidence that non-transference interpretation may be just as helpful as transference interpretation [36]. Another notable technical point is how the patient's telling of his combat exposure resembled imaginal exposure (recounting combat memories in a controlled way) consistent with behavioral exposure therapies.

The next session:

Session 36.
SEP2012.
P: I have the scope scheduled.
He says it's straightforward [diagnosis of his GI condition].
He said mental things affect this.
And, that's probably the reason for my having more issues.
He suggested more fiber and to stay on the Bentyl.
It was a quick appointment—30 min.
T: What do you make of the statement about mental disorders affecting the body and your GI track?
P: My stomach is more screwed up, the more upset I get.
He also said to drink 8 glasses of water.
T: What do you mean by the more upset you get the more it affects your stomach?
P: It applies. I get stressed and worked up.
Regular people don't get upset like this. It's the stuff from deployment.

T: Yes, coping with deployment has affected your body.
P: The more upset I get the more pains in my stomach.
But it stays. It won't go away.
I go to the bathroom; nothing happens. No relief.
Sometimes I can't stop or it's diarrhea.
I don't know how it's going to happen.
It hurts.
The more stress, the worse it comes on.
I could even be at home, and I'm still in pain. But, it doesn't hurt as bad there.
T: It does seem that the more intense the upset feelings are, the more it affects your gut.
[pause]
How is it to talk about this?
P: I'm alright.
I've been dealing with it.
I watched my mom go through stomach issues.
I'm not afraid to talk about it. It's different from talking about deployment.
T: Yes, you've had some experience something similar in your family, with your mother.
[silence]
T: With the recent GI appointment, how did you make the decision to get the colonoscopy?
P: It's been since 2010. I need one every two years until I'm 40.
I'm uncomfortable about the colonoscopy but I have to do it.
My mom had a colostomy bag.
I go through it to avoid that. I had to go ahead and schedule one.
T: They're screening for the condition you mom had?
P: Yes, familial polyps.
And I take the Bentyl and fiber pills, that are over-the-counter.
I want it to be clean.
T: Do you have any hesitance with the colonoscopy and all of this?
P: Nobody looks forward to it, but it's got to get done.
I don't know of anybody who wants a camera up their butt.
I hope the results come back clean.
T: You have mentioned that before: "clean"?
[silence]
T: Have you finished the bowel prep?
P: I haven't eaten.
If it's not in the bottom, then it's not familial. They told me that it would be carpeted. [Referring to familial polyposis.]
The results should be in be Friday.
[pause]
T: Is your wife involved?
P: Not this time, but she normally is.
I took the laxative to clean it out.

I've been going.
It doesn't take much to get me going: black tea; apple juice.
I just need the enemas.
They're not giving me anesthesia.
T: No anesthesia?
P: Yes, I'm not happy.
I would rather not remember it.
With anesthesia, someone would need to take me home. And, I don't trust anyone, in my unit.
I've been made fun of. I don't want to be the butt of jokes.
I'll go in afterwards.
T: You won't get quarters?
P: Don't know.
T: Have you thought about asking the doctor?
P: I'm not that kind of person.
T: What do you mean?
P: I know I have a job to do.
And, they make you bring in the slip.
You still have to go in anyway.
T: Is it possible to call them and say that you bring the slip in tomorrow?
P: I don't want to tell them [his unit/chain-of-command].
They would make fun of me.
I'm not going there. They talk about me and my shakes and my PTSD.
T: Could you just tell them you had a doctor's appointment and that the doctor told you to be off?
P: I understand the chain-of-command. I can't tell my supervisor what to do. I don't want to be disrespectful. They will take it out on me.
I try to be polite, to step around it.
It seems to help out.
I'm not going to be disrespectful.
I'm polite, respectful; not a dick.
T: Maybe there's a middle ground.
[pause]
T: We have just a few minutes left in today's session. Any other thoughts or questions?
P: No.
T: Ok.

The themes of the content of this session were centered on how he could appreciate the psyche affecting his soma. Once again, the somatic seemed uncontrolled for him, and he significantly feared the lack of control. The presence of his military unit is noted in this material, but as a shaming and not supportive entity. His reporting lack of support from the unit was contrasted with his own beliefs in how he was striving to do the right things for the military. The idea of a bowel problem is especially noted in the context of this patient, with a primary relative who had died

of gastrointestinal (GI) cancer. Additionally, the closeness and potential intimacy of the internal probes seem to be not considered but taken instead, by the patient, as simply a sterile medical procedure, which, to this author, seems related to the way he often approached the analysis. The lack of transference work, in a specific sense, was highlighted by the inability to address the question of how it might be to speak of these issues in the relationship with the analyst.

8.2.1 Outcomes/Resolution

The following chart indicates the PTSD Checklist—Military Version (PCL-M) scores during the course of the psychoanalysis (scores were obtained naturalistically, every few weeks, throughout the course of treatment; Fig. 8.1).

The following chart indicates the course of the Outcome Questionnaire 45 (OQ45) scores during the course of the psychoanalysis (scores were obtained naturalistically, every few weeks, throughout the course of treatment; Fig. 8.2).

In both cases of measurements, after 88 sessions of classical couch 4×/week psychoanalysis (not including pre-analytic psychotherapy and assessment), there was a general trend toward improvement. With a 20-point start-to-finish change, there was "reliable change" on the OQ45 [37]; with a 10-point change on PCL-M, there was "meaningful change" on PCL-M [38]. The one outlier higher score, on both measures, toward the end of the course of analysis was obtained directly after he had a meeting with his command, and this likely represented the anxiety related to his conflicts concerning authority figures. Given the conversion comorbidity and since this was a treatment-resistant case, in that he remained symptomatic despite initial psychotherapy and several medication trials, it was notable that there was

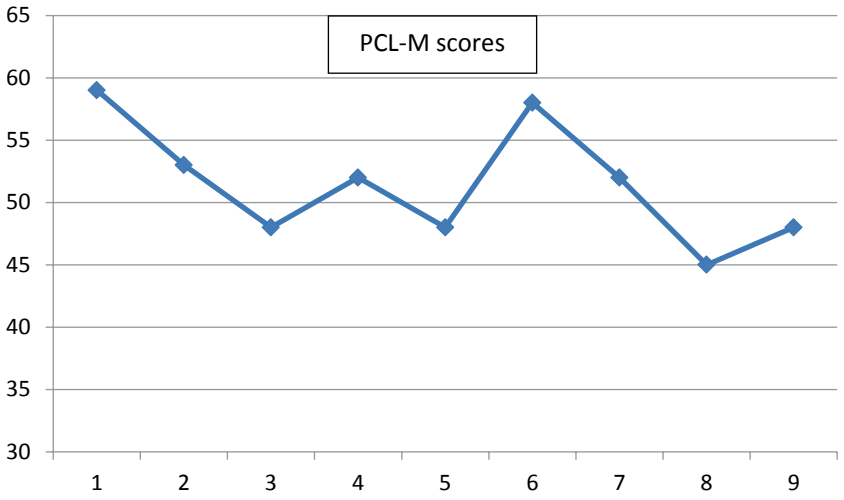

Fig. 8.1 Posttraumatic Checklist Military version (PCL-M) scores. (The x axis is the iteration of the scale administration, approximately every 3-4 weeks. The y axis is the PCL-M score value.)

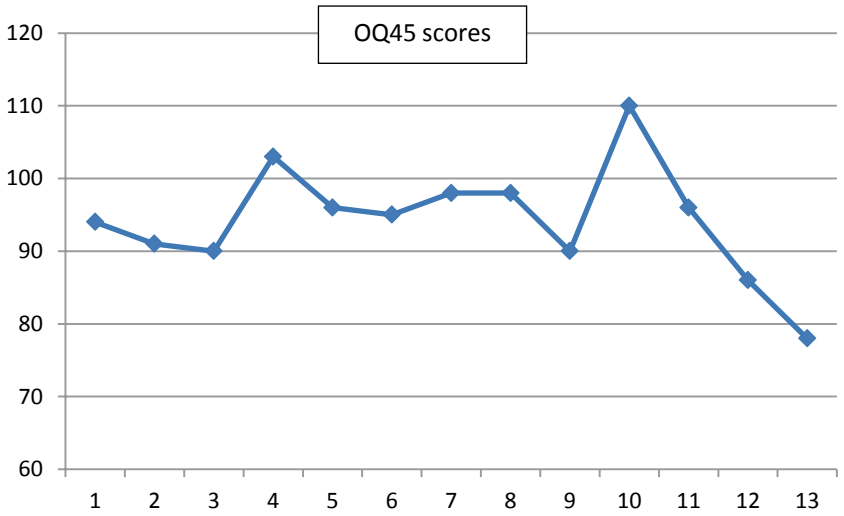

Fig. 8.2 Outcomes Questionnaire (OQ45) scores. (The x axis is the iteration of the scale administration, approximately every 2-3 weeks. The y axis is the OQ45 score value.)

any improvement whatsoever. The improvement seemed to have persisted, since at 1-year follow-up after treatment termination and leaving the military, he did report that his tremor "shakes" had diminished to basically not noticeable and that he was looking for a job but had not found one yet. He also remained married and had a new child. Additionally, after termination, he went for approximately 6 months with no treatment at all. So, in addition to the measures reported, the traditional psychoanalytic measure of health as the capacity to love and work demonstrated improvement or, perhaps, just turning the Freudian "hysterical misery into ordinary unhappiness" [39].

With regard to traditional psychoanalytic formulation, it might be suggested that the conversion symptom would be a compromise between his impulse to strike out and the reality of the dangers of doing so, which would make sense from the history and the material, though speculative for this short analysis. Specifically, he was extremely angry (out of his awareness/unconscious) with what he perceived was a self-interested company-level leadership, rather than believing his command showed genuine concern for his welfare during combat. In this case, he was unable to appropriately express his anger, for several reasons, including the reality of the hierarchy in military organization and his own parts of identity (mostly out of his awareness/unconscious) which valued compliance with authority. With regard to psychoanalytic technique, the patient worked in line with the "fundamental rule of psychoanalysis" [40]. Specifically, he came on time to four or five 45-min appointments per week, lay on the couch, and said what came to mind (or usually answered my questions, punctuated by silences). More importantly, I offered a safe place offering psychological "holding" [41] and containment for his experiences [42]. Some unique aspects of the analytic situation, due to the military environment, were that he always called me by my military rank. Additionally, my neutral-

ity and abstinence, in a classical sense, could be significantly questioned, since I was a military uniformed provider seeing a military uniformed active duty patient. Moreover, I had seen the patient in an initial course of psychotherapy (time limited) with new goals negotiated at the completion of each stage. I was also performing general psychiatric functions, such as managing medication. My position, as a military psychiatrist, in addition to being his psychoanalyst, was most apparent early in his treatment when the severity of his symptoms and lack of improvement with first-line interventions required me to act by recommending a medical discharge (which the patient consciously favored). The analysis was likely affecting by these aspects, especially compliance, which is inherent in military hierarchy and culture and was a major part of his conflict. Moreover, in retrospect, I think starting a little more gradually would have been perhaps a better option to let him more naturally build up to more intensive work, rather than moving from monthly visits to twice weekly, then psychoanalysis.

8.3 Conclusions

This is the "talking cure," as first voiced by Anna O., the famous analytic patient of Freud's original collaborator, the internist Dr. Breuer [39], which is to say the treatment gave meaning in the midst of unmetabolized impulse, affect, and reaction to trauma. As I think about the case, it was somewhat a guided exploration of his unrepresented affects and bringing that material to verbal symbolization. Though this was an analysis, with the patient invited to "say what comes to mind" in free association, I found myself trying to gently guide the patient encouraging him to verbalize by asking questions, or having him elaborate, seeking clarification, or gently confronting, or occasionally making links. However, what makes psychoanalysis unique is the "remembering" in the form a transference and the ability to understand that and change in the present [43], which seemed minimal in this case.

For psychoanalytic treatment of PTSD, some of the healing is likely a very slow titration, in a mitigated form, with microlevels of anxiety from exposure, like behavioral treatment. In the PE protocol, the imaginal exposure is the retelling, and this is similar to analysis. Additionally, the in vivo element comes alive in the treatment frame in that the patient is coming to the office daily and the behavioral experiments become coming in and sitting in the waiting room. It seems to me that psychoanalysis is holistic and noninterventionist in a medical sense. It opens up the possibility of the patient using the psychological holding and containment of the treatment to heal naturally.

Beyond general efficacy, the cost-effectiveness of treatment-resistant PTSD is another area for future study. Economically, the cost of treatment is astounding as many treatment-resistant PTSD cases go to partial hospital or specialized inpatient treatment centers. The inpatient may cost up to US$1000 per day, with partial approximately US$500 per day (personal communication, 2014). The typical 30-day inpatient program for complex, comorbid, resistant PTSD can run upwards of US$30,000. My treatment is estimated to cost less than one third of that, with the

added benefit of more naturalistic environment, such as staying in the milieu of the primary supports and no concerns for decompensation upon discharge from the hospital environment. In conclusion, it seems psychoanalysis is a valuable approach (combined with other interventions, such as SSRIs) in treatment-resistant combat PTSD cases.

8.4 Clinical Pearls

Although not rigorously researched as an independent treatment modality, psychoanalysis in the treatment of combat PTSD may include evidence-based elements such as narration, cognitive restructuring, exposure, and education.

Despite the patient being classified as being treatment-resistant, psychoanalysis can provide measureable relief to the patient.

Psychoanalysis can allow the possibility of the patient using the psychological holding and containment of the treatment to heal naturally.

The psychoanalytic approach can be cost-effective in comparison with inpatient programs for complex, comorbid, resistant PTSD.

References

1. Adams C. Millions went to war in Iraq, Afghanistan, leaving many with lifelong scars. McClatchy Newspapers. http://www.mcclatchydc.com/2013/03/14/185880/millions-went-to-war-in-iraq-afghanistan.html. Accessed 12 Jan 2015.
2. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. N Engl J Med. 2004;351(1):13–22.
3. Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA. 2006;295(9):1023–32.
4. Milliken CS, Auchterlonie JL, Hoge CW. Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War. JAMA. 2007;298(18):2141–48.
5. Hoge CW, Grossman SH, Auchterlonie JL, Riviere LA, Milliken CS, Wilk JE. PTSD treatment for soldiers after combat deployment: low utilization of mental health care and reasons for dropout. Psychiatr Serv. 2014;65(8):997–1004.
6. Gay P. Freud: a life for our time. New York: Norton; 2006.
7. Freud S. Beyond the pleasure principle. In: Strachey J (Ed. and Trans.), editor. The standard edition of the complete psychological works of Sigmund Freud. Vol. 18. London: Hogarth Press; 1955. p. 1–64. (Original work published 1920).
8. Freud S. Inhibition, symptoms, and anxiety. In: Strachey J (Ed. and Trans.), editor. The standard edition of the complete psychological works of Sigmund Freud. Vol. 20. London: Hogarth Press; 1959. p. 77–176. (Original work published 1926).
9. Freud S. Introduction to psychoanalyis and the War neuroses. In: Strachey J (Ed. and Trans.), editor. The standard edition of the complete psychological works of Sigmund Freud. Vol. 17. London: Hogarth Press; 1955. p. 205–16. (Original work published 1919).
10. Ferenczi S, Abraham K, Simmel E, Jones E. Psychoanalysis and the War neuroses. Int Psycho-Anal Lib. 1921;2:1–59. (London: The International Psycho-Analytic Press).

11. Plant RJ. William menninger and American psychoanalysis, 1946–48. Hist Psychiatry. 2005;16(2):181–202.
12. Harrison T. Bion, Rickman, Foulkes and the Northfield experiments: advancing on a different front. London: Jessica Kingsley Pub; 2000.
13. Fairbairn WRB. Psychoanalytic studies of the personality. London: Tavistock/Routledge; 1952.
14. VA/DoD Clinical Practice Guideline. Management of Posttraumatic Stress. October 2010.
15. American Psychiatric Association (APA). Ursano R, Chair. Practice Guideline For The Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder. 2004.
16. Foa EB, Hembree EA, Rothbaum BO. Prolonged exposure therapy for PTSD: emotional processing of traumatic experience. Oxford: Oxford University Press; 2007.
17. Resick PA, Monson CM, Chard KM. Cognitive Processing Therapy, Veteran/Military Version (manual). Boston: National Center for PTSD; 2006.
18. Shapiro F. Eye movement desensitization and reprocessing (EMDR). 2nd ed. New York: 2001. Guilford.
19. Hoge CW. Interventions for war-related posttraumatic stress disorder: meeting veterans where they are. JAMA. 2011;306(5):549–51.
20. Wilk JE, West JC, Duffy FF, Herrell RK, Rae DS, Hoge CW. Use of evidence-based treatment for posttraumatic stress disorder in army behavioral healthcare. Psychiatry. 2013;76(4):336–48.
21. Milrod B, Leon AC, Busch F, Rudden M, Schwalberg M, Clarkin J, et al. A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. Am J Psychiatry. 2007;164(2):265–72.
22. Bateman A, Fonagy P. Effectiveness of partial hospitalization in the treatment of borderline personality disorder—a randomized controlled trial. Am J Psychiatry. 1999;156:1563–9.
23. Bateman A, Fonagy P. Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. Am J Psychiatry. 2001;158:36–42.
24. Bateman AW, Fonagy P. 8-year follow-up of patients treatment for borderline personality disorder: mentalization-based treatment versus treatment as usual. Am J Psychiatry. 2008;165(5):631–8.
25. Bateman AW, Fonagy P. Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry. 2009;166(12):1355–64.
26. Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry. 2007;164(6):922–8.
27. Gunderson J. Handbook of good psychiatric management for borderline personality disorder. APPI; 2014.
28. Leichsenring F, Rabung S. Effectiveness of long-term psychodynamic psychotherapy: a meta-analysis. JAMA. 2008;300(13):1551–65.
29. Gerber AJ, Kocsis JH, Milrod BL, Roose SP, Barber JP, Thase ME, et al. A quality-based review of randomized controlled trails of psychodynamic psychotherapy. Am J Psychiatry. 2011;168(1):19–28.
30. Shedler J. The efficacy of psychodynamic psychotherapy. Am Psychol. 2010;65(2):98–109.
31. Plakun E, editor. The Austen Riggs reader: treatment resistance and patient authority. New York: Norton; 2011.
32. Phillips SH. Trauma and War—a fragment of an analysis with a Vietnam veteran. Psychoanal Study Child. 1991;46:147–80.
33. Carr RB. Combat and human existence: toward an intersubjective approach toward combat-related PTSD. Psychoanal Psychol. 2011;28:471–96.
34. Carr RB. Two war-torn soldiers: combat-related trauma through an intersubjective lens. Am J Psychother. 2013;67(2):109–33.
35. Carr R. Authentic solitude: what the madness of combat can teach us about authentically being-with our patient. Int J Psychoanal Self Psychol. 2014;9:115–30.
36. Hoglend P, Amlo S, Marble A, Kjell-Petter B, Oystein S, Sjaastad MC, et al. Analysis of the patient-therapist relationship in dynamic psychotherapy: an experimental study of transference interpretations. Am J Psychiatry. 2006;163:1739–46.

37. Lambert MJ, Kahler M, Harmon C, Burlingame GM, Shimokawa K. Administration & scoring manual for the Outcome Questionnaire-45.2. Salt Lake City: OQMeasures; 2011.
38. VA. National Center for PTSD. Using the PTSD Checklist for DSM-IV (PCL). http://www.va.ptsd.gov. Accessed 14 Jan 2015.
39. Breuer J, Freud S. Studies in Hysteria. In: Strachey J (Ed. and Trans.), editor. The standard edition of the complete psychological works of Sigmund Freud. Vol. 2. London: Hogarth Press; 1955. p. 1–323. (Original work published 1895).
40. Freud S. On beginning treatment. In: Strachey J (Ed. and Trans.), editor. The standard edition of the complete psychological works of Sigmund Freud. Vol. 12. London: Hogarth Press; 1958. p. 121–44. (Original work published 1913).
41. Winnicott DW. The maturational processes and the facilitating environment. Int Psycho-Anal Lib. 1965;64:1–276. (London: The Hogarth Press and the Institute of Psycho-Analysis; 1965).
42. Bion WR. Learning from experience. London: Tavistock; 1962.
43. Freud S. Repeating, remembering, and working through. In: Strachey J (Ed. and Trans.), editor. The standard edition of the complete psychological works of Sigmund Freud. Vol. 12. London: Hogarth Press; 1958. pp. 145–56. (Original work published 1914).