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Making Sense of Repetition Phenomena by Integrating Psychotraumatology and Psychodynamic Psychotherapy

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Psychotherapy and psychotraumatology share a preoccupation with repetition phenomena, manifested as transference, compulsions to repeat, or intrusive reexperiencing. Terminological diversity obscures compelling similarities between these repetition phenomena and discourages speculation about processes involved in their genesis. This paper remedies these oversights by integrating recent empirical evidence pertaining to memory with European intellectual traditions embraced by its pioneering dynamic psychotherapists. Using dreams as a prototype repetition, the phenomenological diversity of repetition phenomena is shown to be reconcilable with current evidence about memory encoding, storage, and retrieval. Differences in persistence, intensity, pervasiveness, and treatment resilience of repetition phenomena are explained using concepts derived from psychological and biological sciences. Implications for psychotherapeutic theory, practice, and evaluation are considered.

KEY WORDS: intrusive reexperiencing; repetition phenomena; memory; psychotherapy; compulsion to repeat.

This paper begins by highlighting the confusion and uncertainty that surrounds the genesis, psychological significance, and treatment of different kinds of intrusive phenomena associated with traumatic experiences. Two basic principles are identified by the authors from the outset. First, repetition phenomena are pervasive; they are not exclusively related to trauma or, indeed, to any particular psychopathology. Second, while there are similarities among different kinds of repetition phenomena, there are also important differences; differences that have been ignored or played down by theoreticians and clinicians.

The authors then describe the historical development of the pivotal role played by repetition phenomena in dynamic psychotherapy and psychotraumatology. In particular, they emphasize how there has been a failure to develop an empirical approach to treatment and how clin-

icians have been guilty of assuming that these phenomena were essentially homogeneous.

Particularly with regard to dreams, the authors develop their view that to advance our understanding and treatment of trauma-related repetition phenomena, we need to call upon advances made in the biological domain. These advances relate particularly to how and where memories are laid down. This approach would afford us the opportunity to design and apply treatments on a more empirical basis, reflecting the role of underlying mediating processes. Also, such an approach could help us to understand better why some phenomena become chronic and treatment-resistant.

Conceptual Background

Efforts to describe and define the unique factors that differentiate human reactions to traumatic stress from other related experiences continue to engender controversy (Summerfield, 2000). At the root of this controversy lie phenomenological uncertainties as well as conceptual confusions which, if resolved, will promote insights that

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inform both theoretical and applied aspects of psychotraumatology and dynamic psychotherapy. This is particularly so for the cardinally significant reactions of persistent intrusive reexperiencing of the traumatic event (American Psychiatric Association [APA], 1994; World Health Organization [WHO], 1992). Scant advances have been made in promoting our understanding of these particular sequelae of trauma, and much conjecture has been granted the status of scientific fact (Chemtob et al., 1988; Dunmore, Clark, & Ehlers, 1999; Foa & Kozak, 1986). In the absence of coherent rationales for the treatment of these repetitions many clinicians remain mystified by patients' reports of persistent intrusive reexperiences (Lindy, 1988) as well as by the processes that account not only for their resolution in some patients (van Etten & Taylor, 1998) but also their treatment resilience in others (Ørner & de Loos, 1998).

In stark contrast, sophisticated phenomenological descriptions and evidence-based conceptualizations furnish scientific foundations for understanding posttraumatic arousal, and numbing or avoidance. These reactions have been extensively researched, and their treatment is informed by sound theoretical rationales because the reactions in question form part of other relatively common clinical syndromes such as anxiety and panic disorders, obsessive-compulsive disorder, and depression (APA, 1994).

This paper will suggest a pathway for rectifying the theoretical and conceptual disparities between these symptom clusters in order that each is equally well-understood. Such advances require integration of the philosophical insights brought to the world by Europe's long and distinct legacy of philosophical discourse (especially as incorporated within theories and practices of dynamic psychotherapy) with recent scientific discoveries regarding brain centres mediating memory encoding, storage, and retrieval. A unique historical convergence of knowledge is revealed by this approach and both psychotraumatology and psychotherapy stand to be enriched by recognizing two simple insights. The first is that repetition phenomena (all of which involve some element of reexperiencing) are pervasive in the human condition and are not an exclusive consequence of trauma. Second, that, in spite of seemingly compelling phenomenological similarities (which have tended to sustain single concept explanations for their occurrence), closer examination of repetition phenomena reveal their strikingly different characteristics. To account for such variation it is necessary to formulate a range of different explanations, each of which has practical implications for the practice of dynamic psychotherapy.

For the purposes of this paper, repetition phenomena are defined as contemporaneously observed or reported

reactions, manifested as behaviors, feelings, cognitions, memories, or physical sensations, expressed on their own or in combination, that involve some degree of reexperiencing of significant past events (e.g., intrusive reexperiencing of trauma, recreation of trauma, transference, recurrent dreams, and acting out).

The Compulsion to Repeat in Dynamic Psychotherapy

European pioneers in the field of dynamic psychotherapy were impressed, when taking patients' life histories, by reports of some developmentally significant life events being relived and reexperienced through disruptive behavioral repetitions and recurrent cycles of affect and in dreams. This was found to be particularly true in the case of trauma and neglect endured during early life stages (Freud, 1920) and also of later life exposure to extremely horrifying events such as were reported by World War I and II battlefield survivors (Fairbairn, 1952; Rivers, 1918, 1920). Speculations about repetitions and reexperiencing phenomena gave rise to one of the great wisdoms of psychodynamic theory and practice, namely the notion of a compulsion to repeat (Freud, 1915, 1920).

The compulsion exerts its influence in all our lives. It is construed as compulsive because of the observed persistence, persuasiveness, and predictability of repetition phenomena. They share with other compulsions the characteristic of appearing to be precipitated by influences external to the person at the moment of each repetition. Furthermore, rational declarations of intent to avoid cyclical repetitions are no guarantee against their recurrence. The term is usually applied to complex sequences of behaviors, thoughts, and feelings that culminate in predictable outcomes such as are evidenced by cycles of abuse or violence (Herman, 1992). Much less widely acknowledged is the fact that the compulsion to repeat is the general process that underpins much more subtle repetitions identified and labelled variably as "transference," "acting out," "recreation," and "reenactment" (Rycroft, 1968).

Freud's conceptualization of repetition phenomena as a strong human propensity to revert to one of life's earlier prototypical conditions was one of the inspired ideas elaborated in "*The Psychopathology of Everyday Life*" (Freud, 1904). However, when trying to explain this puzzling phenomenon, Freud retreated into an esoteric biological reductionist formulation premised by the axioms of orthodox psychoanalytic drive theory. In "*Beyond The Pleasure Principle*" Freud (1920) invoked the existence of a death instinct; a drive to revert, to repeat, and to reestablish a biological state of the inanimate from whence the origin of all animate states will ultimately be traced. Discontent with biological reductionism, combined with

systematic evidence that relationships, attachment patterns, and life events could have demonstrably direct, predictable, and profound influences on personal adjustment led eventually to the formation of the British tradition of object relations theory (Fairbairn, 1952; Klein, 1964; Winnicott, 1958). Its explanations for the compulsion to repeat are no less convincing. Laplanche (1988) explained its occurrence as a product of acting out internalised sadomasochistic object relations whereas Rycroft (1985) viewed it as a resistance to change and development.

For all the theoretical and applied importance of the compulsion to repeat, its genesis has never been adequately explained (Malan, 1979). Such conceptualizations as have been offered fail to dispel the impression of a conceptual inadequacy at the heart of the dynamic psychotherapies. Description has taken precedence over explanation, and psychotherapeutic enterprise is founded on an article of faith, namely, that it is therapeutic to make explicit the hitherto implicit links between current experience (construed as repetitions) and their origins in earlier developmentally disruptive events. According to this conceptualization, the acquisition of conscious insights linking the present to the past is a precondition for developing mastery over the compulsion to repeat and for eliminating its disruptive influence.

Some support exists for the therapeutic value of forging such links and of examining the implications of insights gained. For instance, Malan, Heath, Bacal, and Balfour (1975) present evidence suggesting therapeutic outcome to be, to a significant extent, a product of the number of interpretations offered to link observed repetitions to formative experiences and of the patients' acceptance of their veracity. Malan (1979) later advocated using reduced frequencies of disruptive repetitions as an outcome measure for psychotherapy along with a demonstrated capacity for adopting more flexible repertoires of behaviors, cognitions, and feelings.

The Compulsion to Repeat in Psychotraumatology

Despite the significance of cyclical repetition phenomena to the field of psychotraumatology, its nomenclature has marginalized the notion of a compulsion to repeat. This is in spite of traumatologists having done sterling service to promote public, professional, and political awareness of many cyclically repetitive phenomena operative at social, familial, and personal levels. A seminal European influence in this regard is the conceptualization and documentation of generational cycles of disadvantage offered by Rutter and Madge (1976). This notion has subsequently been elaborated by psychotraumatology to highlight a propensity of some trauma to beget further

trauma, which was the unifying theme of the 5th European Conference on Traumatic Stress held in the Netherlands in 1997 (Schuffel & de Loos, 1997). The conference gave particular prominence to initiatives aiming to break cyclical oscillations of abuse and neglect (Courtois, 1988) and cycles of violence (Herman, 1992).

Notable examples of constructive uses of the evidence base of psychotraumatology include Bloom and Reichert's descriptions of the interconnectedness of many forms of violence (Bloom & Reichert, 1998) as well as Schwartz, Galperin, Lori, and Master's account of the ways in which compulsively recurrent sexual behaviour disorders repeat affects, thoughts, sensations, and behaviors originally experienced by patients during formative experiences of sexualized abuse and neglect (Schwartz, Galperin, Lori, & Masters, 1995). However, it should not pass unnoticed that these descriptive refinements have been achieved without parallel progress in developing theoretical rationales that adequately explain such repetition phenomena.

Other Manifestations of the Compulsion to Repeat

Psychodynamic theory links contemporaneous reactions to formative influences, the origins of which may lie in the distant past and of which a person may have no conscious recall. Reactions observed in therapy, or reported by patients, may repeat in substantial detail the behaviors, cognitions, and affects associated with particular events. Some repetition phenomena are referred to as acting out, recreation, or reenactment. They may be manifest as simple momentary responses or highly elaborate sequences of reactions that recreate and reenact complex traumatic and developmentally disruptive experiences.

Psychodynamic theory and practice originally held such repetitions to be impediments to therapy because their present-centered focus compromised the development of memories and narratives of the original formative experiences. Subsequently a competing view suggests that by noting the content of what is acted out, recreated, and reenacted, therapists are provided with material that is helpful for the formulation of hypotheses about the nature and personal significance of past events, even in the absence of conscious recall. In therapy hypothesis testing can proceed by offering interpretations that seek to link aspects of recent repetitions to past events (Malan, 1979). This is broadly consistent with what is observed for patients with posttraumatic stress disorder (PTSD) except that the link to the precipitating event is generally known from the start. There is however no reason to assume that conscious recall of a formative event is a precondition for repetitions to occur.

These particular repetitions are recognised by *DSM-IV* (APA, 1994) and *ICD-10* (WHO, 1992) symptom lists for PTSD but without reference to notions of acting out, recreation, and reenactment. For instance, a person may "... act or feel as if some aspect of the trauma were recurring ..." (*DSM-IV*, B3), and may experience "... intense psychological distress at exposure to internal or external cues ..." (*DSM-IV*, B4). These are valuable operational definitions for acting out, reexperiencing, and recreation under conditions where the precipitating trauma is known.

Psychotraumatology has become less sanguine about the amenability of all repetition phenomena to change. In a detailed case study involving a British World War II veteran, Ørner and de Loos (1998) demonstrate some repetition phenomena to be amenable to psychotherapeutic interventions as advocated by Malan (1979). Others respond to psychopharmacological treatment but some repetitions become chronically recurrent.

Transference as a Repetition Phenomenon

In psychodynamic theory and practice, transference is defined as "... the process by which a patient displaces on to the therapist (and significant others) feelings, ideas etc that derive from previous figures or relationships in his or her life" (Rycroft, 1968, pp. 168–169). This phenomenon is clearly another manifestation of the compulsion to repeat observed at an interpersonal level. As was the case for other repetitions, transference was initially regarded as an obstacle to therapeutic recovery because of the distortions it imposes on patient–therapist relationships. Freud and many of his contemporaries later revised this formulation and elevated transference and its interpretation to its pivotal status in dynamic psychotherapy. The patient's propensity to repeat through transference is therefore a potentially useful focus for therapeutic work in so far as it reveals qualitative aspects of formative relationships and experiences even in the absence of conscious recall.

Despite their distinctive and different philosophical lineages both dynamic psychotherapy and psychotraumatology recognize that past experiences are repeated in the present in a multitude of ways. A synthesis of approaches may therefore have some merit but, because each is at best only part complete, the emergent model will fail to offer a fully comprehensive account. A case therefore exists for seeking additional evidence that will advance our theoretical and conceptual understanding of repetition phenomena beyond that which has been possible so far. This is provided by recent advances in dream research.

Dreaming as a Repetition Phenomenon

In the wake of trauma it is common to have at least some recurring dreams about what happened. Some of these repetitions fade over time but survivors of overwhelmingly threatening trauma often report dreams that are recurrent and involve highly evocative reenactments (Ørner & de Loos, 1998). Because dreaming is experienced by those with and without a differential diagnosis of PTSD a prevalent assumption has been that all dreaming comprises a conceptually identical phenomenon.

Freud (1904, 1932) argued for the normality, indeed the universality, of dreaming. In his view this reexperiencing phenomenon has its roots in repressed, unfulfilled biological needs and drives, which will recur until they are gratified. He also postulated that dreams are persistent because, at least in part, they offer some gratification of the underlying drives. According to this formulation interpretation of dreams is indicated in every instance (Freud, 1932). Freud made an interesting concession after reflecting on the phenomenology of dreams reported by World War I veterans. He alluded to the possibility that the biological, need-driven conceptualization of dreaming may not account for persistently intrusive dream images following severe trauma. However, he did not elaborate on this important suggestion, possibly because to have done so would have highlighted a major conceptual limitation in his single bioreductionist model of mind (Gedo & Goldberg, 1973). This important historical detail has been largely overlooked by psychodynamic theorists and practitioners who continue to advocate the interpretation of all traumatic dream material (Strunz, 1989).

Object relations perspectives have promoted the recognition that traumatic events and formative relationships can themselves cause profound and lasting functional changes that will be manifested as repetitions. Dreams make explicit the nature of and thematic issues raised by the failure of events and relationships to meet basic human needs. Psychodynamic therapies informed by object relations perspectives seek to remedy the repetition phenomena by exploring alternative modes of interpersonal functioning. Inspired by this theoretical perspective, the British psychotherapist Rycroft (1985) proposed that dream material reveals how we think about formative experiences and relationships whilst in a less guarded state of "part consciousness." He points to the high levels of imagination revealed by dream imagery, and he suggests that the purpose of dream interpretation should be to explore nuances of personal meaning rather than seek to reveal a network of causal influences.

Rycroft's link between dream content and daytime mental activity is supported by recent dream research,

(Rycroft, 1985). A review by Greenberg, Catz, Schwartz, and Pearlman (1992) reports a substantial body of evidence confirming the adaptive potential of dreams. They propose that dreams help to integrate critical impressions with long established cognitive schemas in order to promote adaptations to problems and challenges faced in everyday life. Even at a clinical level dream material has been shown to contain elements that can help patients to overcome affective disorders (Beauchemin & Hayes, 1996). Reiser (2001) provides a comprehensive review of theories of dreaming and highlights the value of various perspectives and the need to integrate associated hypotheses generated from them.

However, Schreuder (1996) and Schreuder, van Egmond, Kleijn, and Visser (1998) caution against assuming that all repetitive dreams can improve understanding and adjustment. They advocate more clearly differentiated perspectives on repetition phenomena and, specifically, they express reservations about using interpretative techniques in therapeutic work with chronically traumatized patients.

In support of more individually tailored perspectives these authors refer to research indicating that the repetition of trauma in dreams takes at least three different and distinct forms: anxiety dreams with trauma-related content, traumatic nightmares, and traumatic reenactment. Each of these forms of dreaming is known to be mediated by different neurophysiological and psychophysiological processes (Mellman, Kulick-Bell, Ashlock, & Nolan, 1995; Shalev, Orr, & Pitman, 1993). Nonetheless, a blinkered preoccupation with the shared phenomenological characteristics of dreams has fostered and sustained an ill-advised presumption that all dreams are conceptually identical phenomena. Until recently, few have highlighted and elaborated the implications of the very marked and striking phenomenological dissimilarities among dreams (Schreuder, 1996). To maintain, as has psychodynamic theory, that a single psychological formulation of dreaming can account for all its manifestations is no longer reconcilable with available evidence.

These insights have significant theoretical and practical implications for other repetition phenomena. For instance, a similar range of different conceptual frameworks has to be invoked to explain trauma-related repetitions as well as those that have traditionally preoccupied dynamic psychotherapists. Psychotherapeutic interventions for repetition phenomena premised by orthodox psychological models of the mind may only be indicated when the primary mediating processes occur at the level of the cerebral cortex. Where mediation can be traced to subcortical brain centres that are largely impervious to modification by higher cerebral activity, it is unlikely

that interpretative techniques will effect therapeutic change.

At a conceptual and practical level the implications are as follows. Patients with acute stress disorder or PTSD (APA, 1994) precipitated by a single recent traumatic event of moderate severity are likely to experience dreams containing images that repeat aspects of what happened. The phenomenology of these dreams is unlikely to differ significantly from anxiety dreams reported by individuals who do not have PTSD. Characteristically, such dreams do not waken up the dreamer; they occur during REM sleep phases; and dream episodes are recalled at the end of a major sleep period. Although dream images can be distressing, manifest dream content is amenable to interpretation, review, and discussion that promote insight and therapeutic progress as well as lead to a reduced frequency of repetitions over time.

Traumatic nightmares, on the other hand, share some of the phenomenological features of anxiety dreams but, in other respects, are quite different. These are terrifying repetitive dreams of reexposure to traumatic events. They are known to occur during both REM and non-REM sleep, and, in chronic PTSD, they are often persistent, intrusive, and treatment-resistant. Nonetheless, Schreuder (1996) argues that traumatic nightmares can contain symbolic representations of anxieties rooted in pretrauma and posttrauma phases of a person's life. Typically, such anxieties concern existential issues, especially those involving threat to life, threat of abandonment and death, or, at a higher psychological level, narcissistic wounding and loss of identity. Themes can be explored through interpretation and discussion referenced not only to trauma but also to other significant formative experiences. Although they may promote improved personal adjustment such psychotherapeutic interventions will not necessarily confer lasting relief from recurrent traumatic nightmares or other related repetition phenomena. The presenting condition may become resistant to treatment and run a chronic course.

Posttraumatic reenactment during sleep defines an extreme end point of the continuum of dream repetitions. It is characterized by a subjective impression of reliving traumatic experiences. Schreuder (1996) describes these repetitions as exact and explicit recreations of traumatic incidents. Unlike other types of dreams, they constantly recur in a form that is largely unaltered and unelaborated, and they appear to be impervious to the effect of time. Anxieties and sensory perceptions experienced during posttraumatic reenactment repeat the most evocative reactions originally provoked by initial traumatic experiences. Triggers for posttraumatic reenactment are typically unrelated to anxieties associated with earlier developmental

life phases, existential threats, or current reality-based conflicts or worries. The initial trauma that is reexperienced remains an isolated experience that has not been processed, and the reexperiencing has no symbolic or other relationship with anxieties and conflicts in later life (Schreuder, 1996).

The prospects of resolving or eliminating posttraumatic reenactment using psychotherapeutic techniques are poor. As a form of catharsis, reenactment does not necessarily effect change either. Nor does it reduce the frequency of other trauma-related repetitions experienced by patients with severe and chronic PTSD (Ørner & de Loos, 1998). It is of significant clinical and theoretical interest that systematic desensitization techniques have been reported to reduce the frequency of posttraumatic reenactment in conjunction with a multidimensional approach to the treatment of severe, chronic PTSD (Shalev, Bonne, & Eth, 1996).

Nadel and Jacobs (1999) have reviewed recent advances in our understanding of the central nervous system processes that mediate traumatic experiences. Their conclusions are consistent with calls for more subtle and differentiated conceptualizations of repetition phenomena (Schreuder, 1996; Schreuder et al., 1998). The evidence also suggests that improved understanding of the mediating processes (for what are different types of memories) could furnish evidence-based rationales for therapeutic interventions that may be indicated or contraindicated in the wake of trauma.

Implications for the Treatment of Trauma-Related Reactions

As indicated above, the field of dynamic psychotherapy has a long and distinguished tradition of recognizing, both in theory and in clinical practice, the subtle, compelling, diverse, and compulsive nature of repetition phenomena. Psychotraumatology has, from a perspective of positivistic science, confirmed that significant past life experiences do evoke reactions that repeat some aspects of formative experiences. It is also clear that conscious recall of precipitating events is not a precondition for repetitions, but some representation of the experience in memory is.

This conceptualization is consistent with the observation that repetition phenomena are ubiquitous in the human condition rather than something occurring only exceptionally. Our past experiences do transfer to the present to exert significant influence on our lives; this is how we can tell learning has occurred. Repetitions are by no means a cipher for psychopathology, and repetitions are not ex-

clusive to PTSD because they are also manifest in the symptoms of depressive and obsessive-compulsive disorders (Brewin, 1998).

In concert these insights and this evidence generated by dynamic psychotherapy and psychotraumatology suggest that we should seriously question the view that all repetition phenomena can be explained in psychological terms and treated accordingly. Only in some of their varied manifestations are repetition phenomena primarily a product of psychological processes. Explanations of the most chronic and persistently intrusive repetitions must draw upon the emergent evidence base about neurophysiological and biochemical processes that are differentially involved in memory encoding, storage, and retrieval.

It must be accepted that repetitions manifest as a compulsion to acting out, recreation, transference, reenactment, and dreaming share some phenomenological features but, on closer examination, they are revealed to be much more diverse than generally realized. Any therapist treating patients with PTSD, or its related disorders, has to be clear about the conceptual implications of the differentiating phenomenological features of reported repetitions, and to plan treatment accordingly. Similarly, researchers will do well to recognize that all repetitions are not the same and should not be studied as if they were.

For dynamic psychotherapy, this integrative perspective offers a new way of explaining why some patients respond very positively to interpretations of repetition phenomena whereas others seem impervious to this treatment technique. In the former case, mediating memory processes may be stored in brain centres amenable to influence by high level intellectual activity. In the latter case, trauma encoding probably occurs at a subcortical level and is not readily accessed by or amenable to change by the high level cognitive processes engendered by interpretations. The conduct of evidence-based psychotherapeutic assessment therefore calls for a differentiation of repetition phenomena according to their likely sources of mediation, such that clinicians can use these improved theoretical and conceptual formulations as evidence-based rationales for planning and providing multimodal therapeutic interventions. Our awareness of the different ways in which each treatment intervention exerts its influence should make it more possible for us to define realistic outcomes for PTSD and to offer evidence-based prognoses for the short, intermediate, and long term.

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