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Relationship between psychodynamic functioning, defensive mechanisms and trauma in patients with PTSD

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Relationship between psychodynamic functioning, defensive mechanisms and trauma in patients with PTSD

Psychodynamic functioning in patients with PTSD

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Abstract

Objective: Patients with Post-Traumatic Stress Disorder (PTSD) present a variety of symptoms, with different intensities, causing impairments in the individual, social and occupational functioning areas. The aim of this study was to understand the psychodynamic functioning of patients with PTSD, exploring the relationship between symptom severity, quality of life, subjective suffering, conflicts and psychic structure regarding sociodemographic characteristics, styles and defensive mechanisms.

Methods: This is a cross-sectional quantitative study with 60 participants. The following were used: sociodemographic questionnaire, the Operationalized Psychodynamic Diagnosis-2 (OPD-2) and the Defensive Style Questionnaire (DSQ-40).

Results: Participants had moderate to high symptom severity, with significant subjective suffering and isolation. The main conflict was Need for care x Self-sufficiency and the level of Total Structure was moderate/low. The use of immature, neurotic, and mature defensive styles was observed. More primitive personality structures, more rigid defenses and greater dependence were found in patients with history of past trauma. Other mental disorders were also associated.

Conclusion: OPD-2 was effective to assess the psychodynamic functioning characteristics of patients with PTSD. Therapeutic treatment should focus on the psychic structure and not only on symptom control. Prevention strategies should target vulnerability factors and strengthening of protective factors.

Keywords: violence, psychological trauma, posttraumatic stress disorder, psychoanalytic theory, defensive mechanisms.

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INTRODUCTION

Posttraumatic stress disorder (PTSD) generates emotional reactions of intense fear, anxiety or despair.[1] Its symptoms cause dysfunctions in the global functioning of patients, difficulties in interpersonal, social and work relationships, leading to low quality of life[2]. In addition, the important index of disorder chronicity[3] and the large number of associated physical and mental comorbidities lead to suicide.[1,2]

Studies have identified sociodemographic factors,[4] genetic and biological predispositions [5], history of past trauma, frequency and intensity of exposure, other associated mental disorders, in addition to low social support for the development of PTSD.[6] However, even in subjects diagnosed with the disorder, important differences are observed regarding the modulation of the response to emotional regulation,[7] the development of affective personality disorders,[8] persistence and severity of symptoms and social behavior difficulties .[9] Thus, different psychic functioning characteristics can play vulnerability or protective roles in relation to stress processing capacities and adaptive flexibility of the psychic apparatus in the face of trauma.[10,11]

In this way, it was identified that low level of structural personality functioning is related to the severity of posttraumatic symptoms,[11] that the accumulation of traumatic experiences is associated with the development of personality disorders[12] and that such disorders negatively impact the treatment of patients with PTSD.[13] Likewise, the use of different defensive styles belonging to mature, neurotic and immature factors are observed in order to protect themselves from the internal perception of painful affective states.[14] In war veterans[15] and Korean refugees,[16] the presence of defensive mechanisms (DM) belonging to the immature factor prevailed. In victims of emotional abuse, mature and neurotic factors prevail.[17] Patients with depressive disorders associated with PTSD are more likely of using immature factor defensive style compared to patients with anxiety disorders.[18] However, in many cases, the use of defense

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mechanisms is not effective, resulting in the persistence of symptoms, social withdrawal and, consequently, low quality of life.[14]

In this context, in a complex disorder like PTSD, a broad and deep evaluation about vulnerabilities and individual and interpersonal skills is recommended for treatment planning and intervention , seeking greater adherence, relief of symptoms and better condition of global well-being[19]. Thus, the Operationalized Psychodynamic Diagnosis (OPD-2) stands out as a multiaxial system that promotes, in addition to the nosological diagnosis, the understanding of the psychodynamic functioning of patients through a survey of their subjective suffering, resources and vulnerabilities, patterns of relational interaction, conflicts and personality structure.[10] The instrument is able to assess victims of Domestic Violence,[20] Generalized Anxiety Disorder,[21] Severe Mental Disorder,[22] Acute Stress,[23] among others.

Therefore, this study seeks to understand the psychodynamic functioning of patients with PTSD through the use of OPD-2. Furthermore, it will explore the relationship between symptom severity, quality of life, subjective suffering, conflicts and psychic structure in the face of sociodemographic characteristics and defensive styles and mechanisms used by such patients.

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METHOD

Participants

This is a cross-sectional quantitative study with 60 participants. Participants were selected among those who, after a traumatic event, sought care at a specialized center for studies and care for trauma victims in a public service in southern Brazil, those diagnosed with PTSD and over 18 years of age. The diagnosis was established by a psychiatrist according to Clinical Interview for the evaluation of PTSD-CAPS-5. Sample calculation was based on a validation study carried out by Krieger[24] in the presentation of the Brazilian version of the OPD-2,

reaching minimum of 53 participants. Data were collected between March 2019 and December 2020 by the researcher herself in a meeting lasting an average of one hour and 30 minutes. During this period, ten patients did not meet the diagnostic criteria. Another three invited patients declined to participate and one dropped out.

Instruments

Sociodemographic questionnaire:

Semi-structured questionnaire used to collect sociodemographic and clinical data.

Operationalized Psychodynamic Diagnosis (Operationalisierte Psychodynamische Diagnostik, OPD):[10]

Semi-structured Clinical Interview used for the formulation of a multiaxial psychodynamic diagnosis through five axes, as well as the therapeutic planning and focus. It is composed of "Axis I- Experience of the disease and prerequisites for treatment" in which the general functioning of the patient, quality of life and subjective suffering are evaluated; in "Axis II- Interpersonal Relationships"; integrate four interpersonal positions indicating patterns of interaction and response of objects a) how the patient experiences himself/herself - describes his/her relational experiences and behavior; b) how the patient experiences others - points out how he/she perceives and feels the behavior of others; c) how others (taking into account the interviewer) experience the patient, his/her offer of relationship and mode of behavior; d) how others experience themselves in relation to the patient, their reactions, impulses and feelings (Themes and Items are described in Supplementary Table I), in "Axis III - Conflict", identifies two most important conflicts in the diagnosis among the seven types: Individuation x dependency, Submission x control, Need for care x self-sufficiency, Self-worth conflict, Guilt conflict, Oedipal conflict and Identity conflict; in "Axis IV- Structure", which is composed of

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eight functions: Self-perception, Object perception, Self-regulation, Regulation of object relationship, Internal communication, Communication with the external world, Attachment to internal objects and Attachment to external objects, comparing the Total Personality structure. Coding occurs through criteria with the following scores: "0- absent, 1- mild/ not significant, 2- moderate, 3- high/significant, 4- very severe/very significant and 9- not evaluable". For axis II, among the 32 patterns of dysfunctional relationships, themes and resources, the three most prevalent items in each interpersonal position are scored. In Brazil/Portugal, agreement was 78% on axis IV, 66% on axis I, 57.7% on axis III and axis II had qualitative assessment based on the three items most scored by evaluators in each interpersonal position.[24,25]

Defensive Style Questionnaire (DSQ-40):[26]

questionnaire with 40 statements corresponding to 20 defense mechanisms: mature factor (sublimation, humor, anticipation, and suppression), neurotic factor (pseudo-altruism, idealization, reaction formation, and undoing) and immature factor (acting out, isolation, devaluation, autistic fantasy, denial, displacement, dissociation, splitting, rationalization, somatization, projection, and passive aggression). It presents a Likert scale from 1 to 9, with "1" indicating "strongly disagrees", "5", patient "neither agrees nor disagrees with the statement" and "9" suggesting that "strongly agrees". Defense and defensive styles scores are calculated by averaging statements and defenses, respectively. The higher the value, the greater the use of defense styles. The instrument was validated for Brazilian Portuguese and showed reliability rates assessed by the Cronbach's alpha coefficient of 0.77 for the Immature Factor, 0.68 for the Mature Factor, and 0.71 for the Neurotic Factor.

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Data analysis

OPD-2 clinical interviews were coded by two independent judges with specific training. The Kappa coefficient was independently calculated for each interview referring to axes I, III, IV and V. In this study, the agreement between judges was substantial; 73% on Axis I, 76% on Axis III, 84% on Axis IV and 100% on Axis V. For Axis II, they were selected and grouped into more punctuated relationship themes. Analyses were performed using SPSS software version 25.0. Categorical variables were represented by absolute and relative frequency. Quantitative variables were represented by mean ± standard deviation (mean ± SD) or by the median and minimum and maximum (median [min; max]) according to the distribution verified by the Shapiro-Wilk normality test. When one of the groups had size (n) smaller than 12 participants, quantitative variables were directly represented by median and minimum and maximum (median [min; max]) and compared by nonparametric Mann-Whitney or Kruskal-Wallis tests. To verify associations among qualitative variables, the chi-square test was used. $P<0.05$ was considered for statistical significance. When significant, local association was signaled by the standardized adjusted residual analysis (values greater than 1.96).[27]

Ethics statement

The study was approved by the ethics committee of the Federal University of Rio Grande do Sul (68271917.7.0000.5347) and obtained permission from the Specialized Center where data were collected. All patients signed the Free and Informed Consent Form. The instruments were answered to the researcher and interviews were audio recorded and transcribed.

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Results

Study Population

The sample consisted of 60 patients who sought or were referred for care and received PTSD diagnosis. Participants were mostly women, with mean age of 39.05 (SD=14.41) years. The majority indicated sexual violence (n=20; 33.3%) and the tragic death of an affectively close family member (n=20; 33.3%) as Index Traumatic Event (ITE) for seeking care, which occurred, in most cases, after two years of ITE. However, the experience of traumatic events prior to the one that motivated the demand for care was also mentioned, with average of 1.3 (SD=0.76) events. Table 1 shows the sociodemographic and clinical characteristics of patients.

Table 1 Sociodemographic and clinical characteristics of patients with PTSD

Category	Subcategory	n %
Sex	Female	52 (86.7%)
	Male	8 (13.3%)
Age	18 to 30 years old	20 (33.3%)
	31 to 40 years old	11 (18.3%)
	41 to 50 years old	12 (20%)
	51 to 60 years old	17 (28.3%)
Ethnicity	White	46 (76.7%)
	Not white	14 (23.3%)
Schooling	Illiterate	3 (5%)
	Elementary school	43 (71.7%)
	High school	13 (21.7%)
	Higher education	1 (1.7%)
Marital status	Single	28 (46.7%)
	Married/Stable relationship	30 (50%)
	Divorced	3 (3.3%)
Income[a]	No income	31 (51.7%)
	1 or 2 minimum wages	26 (43.3%)
	3 or more minimum wages	3 (5%)
Index traumatic event (ITE)	Physical violence	4 (6.7%)
	Sexual violence	20 (33.3%)
	Emotional violence	7 (11.1%)
	Urban violence	9 (15%)
	Tragic death of family member	20 (33.3%)
Time to seek health care	Up to 6 months	13 (24.5%)
	From 6 months to 2 years	11 (18.3%)
	From 2 to 5 years	9 (15%)
	From 5 to ten years	16 (26.7%)
Number of traumatic events during life	None	8 (13.3%)
	1 event	29 (48.3%)
	2 events	20 (33.3%)
	3 events	3 (5%)
Past psychiatric problems	Yes	48 (80%)
	No	12 (20%)

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Suicide attempts (SA) (after index traumatic event)	Yes	25 (41.7%)
	No	35 (58.3%)

The results were expressed as absolute frequencies (percentages).
a= A wage is a basic remuneration for the worker. A minimum wage is equivalent to $ 186.

Psychodynamic functioning according to OPD-2

In the multiaxial evaluation of OPD-2, it was identified how patients with PTSD organize their psychodynamic functioning. Axis I evaluates symptoms, their severity and the subjective suffering of patients with the disease, in Table 2, it was possible to observe the Global Assessment of Functioning (GAF) scale, which for the Task Force[10] is a continuum that extends from mental health to disease. The lower the value, on a scale from 1 to 100 points, the greater the disease severity. Patients with PTSD recorded level of mental, social and work functioning with score of 54.91 points, demonstrating significant symptoms or impairment.

Regarding Quality of Life (EQ-5D), which describes the patient's health status, on a scale from 1 to 15 points, with increasing severity value, the average value was 7.16, evidencing problems in carrying out their daily activities, pain or discomfort and anxiety or depressive symptoms. The subjective suffering experienced by patients was considered as moderate (48.3%), indicating, in addition to the severity of symptoms and their diagnosis, their attitude towards treatment and the way they perceive social contact.[10]

Table 2 Axis I - Mean and intensity of items assessed in the experience of the disease and prerequisites for treatment

		Intensity			
	Mean (SD)	**1**	**2**	**3**	**4**
Objective assessment of the disease / problem					
GAF (last 7 days)	54.91 (8.31)	-	-	-	-
EQ-5D	7.16 (1.27)	-	-	-	-
Experience and form of presentation of the disease					
Subjective suffering	2.49 (0.72)	3 (5%)	29 (48.3%)	23 (38.3%)	0

GAF=Global Severity Index; EQ-5D= quality of life.
Results are expressed as absolute frequencies (percentages).
The higher the score, the higher the severity. Score 0 was not recorded in the table.

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In Axis II, the most representative Dysfunctional Themes were: 1) they experience themselves as isolated and distant in relationships (n=31; 51.66%), but alert, protecting themselves from attacks (14; 23.33%) due to difficulties in establishing limits for the performance of the other (n=13; 21.66%); 2) perceive others as negligent and feel abandoned (n=23; 38.33%), or imposing themselves in a rude way (n=22; 36.66%), attacking and harming them (n=14; 23.33) %); 3) others experience patients as distant and isolated (n=28; 46.66%), insufficiently protecting themselves (n=16; 26.66%) and allowing much space for their performance (n=14; 23.33%); 4) others experience themselves in the relationship with patients in an ambivalent, distant and isolated way (n=28; 46.66) or excessively caring and protecting themselves (n=22; 36.66%), avoiding aggressiveness (n=14; 23.33%).

In Axis III (Figure 1) the main Psychic Conflict, which represents a continuum defined from their personal histories, tensions, individual patterns of experience and behavior,[10] was the "Need for care versus Self-sufficiency" (n=22; 41.5%). In this model, patients are dependent, needing constant proof of the attention and care of the other. Their fears relate to being too close or to the fear of losing the other. All conflicts are described in Figure 1.

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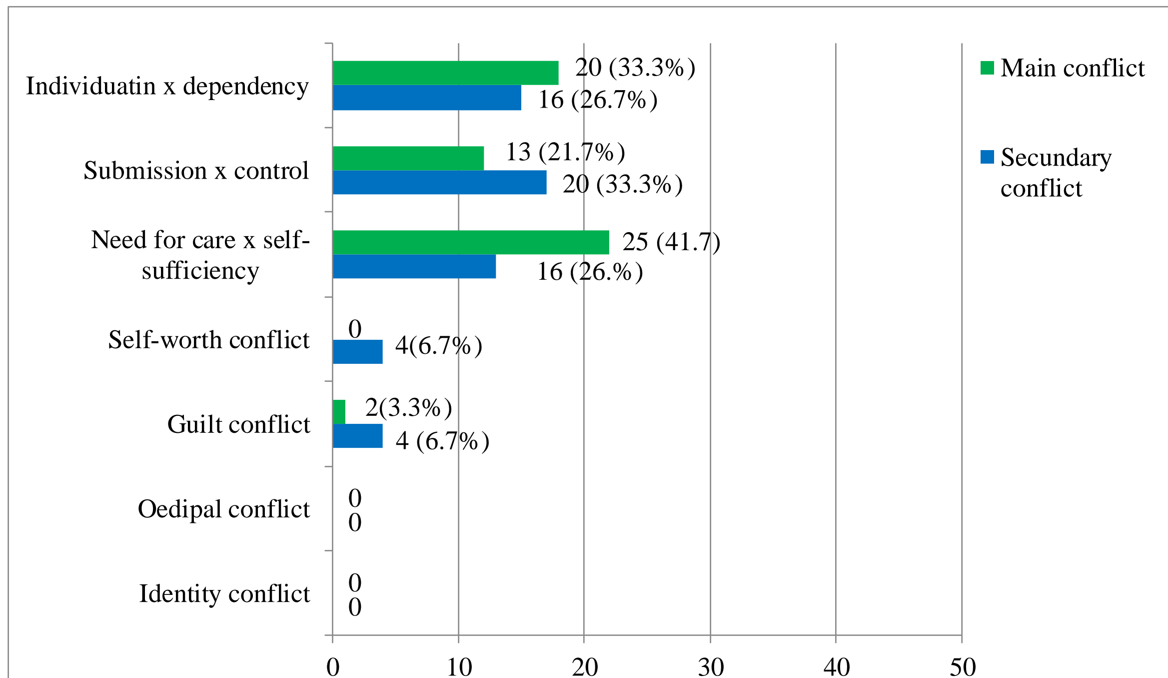
Figure 1 Axis III. Frequency of presentation of conflicts



Results are expressed as absolute frequencies (percentages).

The way in which the conflict is processed is identified in the guide affection mobilized in the patient's contact with his/her family, friendship, professional life, social environment, money, body/sexuality and manifestation of diseases, in addition to the behavior observed from these interactions. This processing mode can vary among passive/submissive, mixed but passive, mixed but active, and predominantly active modes.[10] In these patients, all modes of presentation of conflicts were scored, observing the mixed but active mode as the main mode (n=20; 33.4%). Thus, patients seek to prove their self-sufficiency in relationships; however, latent depressive feelings emerge as a defense against the feeling of emptiness. Other patients manifested the mixed but passive mode (n=17; 28.3%) as they appear attached, dependent or demanding. In the predominantly active mode (n=14; 23.3%), the need for security is totally denied, and in the predominantly passive mode (n=9; 15%), the separation from the other proves to be impossible, with impulses to approach and control.

In Axis IV, Total Self Structure was evaluated, which represents the vulnerability and/or availability of the personality's mental functions, ability to process internal and external stresses and to regulate the Self and its relationships.[10] Moderate/medium level was found (Table 3; M=2.15±0.30), the main anxiety refers to the loss or separation from the object, in addition to the fear of one's own internal impulses. All dimensions of the structural assessment show, in the vast majority of patients, moderate to low intensity level with difficulties in cognitive, emotional and attachment abilities.

Table 3 Axis IV- Mean and level of integration of structural personality functions

		Intensity				
	Mean(SD)	**1 elevated**	**1,5**	**2 moderate**	**2,5**	**3 Low**
Cognitive abilities						
Self-perception	2.16 (0.30)	0	3 (5%)	35 (58.3%)	21 (35%)	1 (1.7%)
Object perception	2.18 (0.29)	0	2 (3.3%)	35 (58.3%)	22 (36.7%)	1 (1.7%)
Regulation						
Self-regulation	2.22 (0.28)	0	1 (1.7%)	32 (53.3%)	26 (43.3%)	1 (1.7%)
Regulation of object relationship	2.24 (0.32)	0	2 (3.3%)	30 (50%)	25 (41.7%)	3 (5%)
Emotional communication						
Internal communication	2.24 (0.35)	1 (1.7%)	3 (5%)	23 (38.3%)	32 (53.3%)	1 (1.7%)
Communication with the external world	2.19 (0.33)	1 (1.9%)	2 (3.8%)	31 (51.7%)	25(41.7)	1 (1.7%)
Attachment						
Attachment to internal objects	2.19 (0.29)	0	2 (3.3%)	34 (56.7%)	23 (38.3%)	1 (1.7%)
Attachment to external objects	2.15 (0.34)	1 (1.7%)	2 (3.3%)	38 (63.3%)	16 (26.7%)	3 (5%)
Total structure	2.15 (0.30)	1 (1.7%)	2 (3.3%)	35 (58.3%)	22 (36.7)	0

Results are expressed as absolute frequencies (percentages).
The closer to 1, the greater the structural integration and closer to 4, greater disintegration. Scores 3.5 and 4 did not score.

In axis V, according to DSM-5, 41 (68.33%) patients had some mental disorder associated with PTSD. Diagnoses were performed according to DSM-5[1], after Clinical Interview. It was observed that 29 (70.7%) patients had another mental disorder, among them Major Depressive Disorder (MDD; n=18; 43.9%), Borderline Disorder (BD; n=3; 7.3%) and Generalized Anxiety

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Disorder (GAD; n=8; 19.5%). On the other hand, 12 patients (29.3%) had two other associated diagnoses, MDD and GAD (n=8; 19.5%) and BD and GAD (n=4; 9.7%).

Defensive styles according to DSQ-40

Patients with PTSD denoted the use of all defensive factors, with the Neurotic Factor being the most prevalent (4.45±0.73). From this perspective, undesirable contents come to consciousness in a disguised or distorted way in order to ward off threatening desires, anxieties and emotions.[28] The most used DM was somatization (5.26±1.07) belonging to the Immature Factor (5.56±0.98), with trend to react to stress through somatic manifestations such as pain, bodily and not psychic sensations. Complete results are found in Figure 2.

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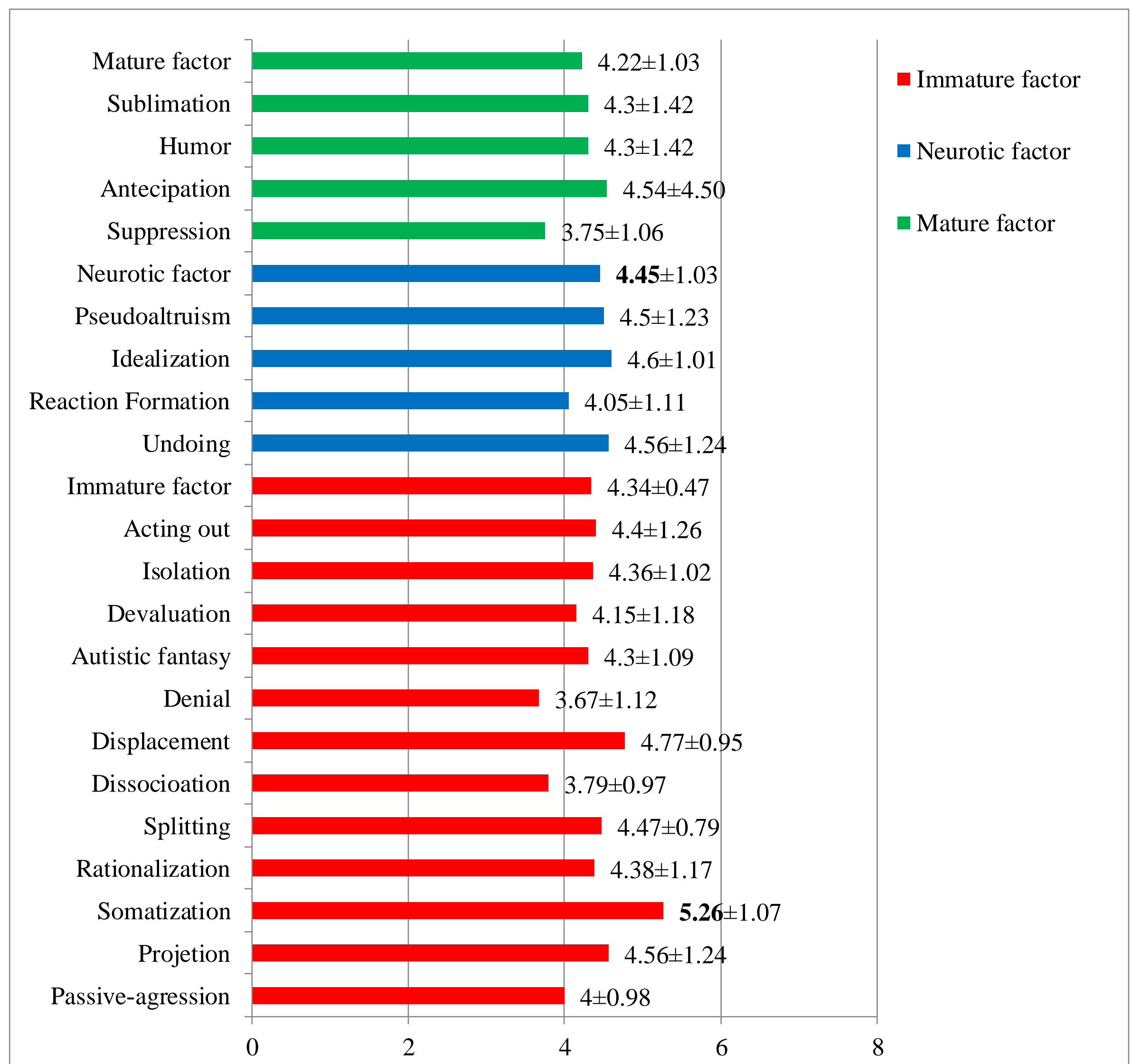
Figure 2 Description of the use of Defense Mechanisms and Defensive Styles.



M±SD= The results were expressed as Mean and Standard Deviation as the test correction guides.
The higher the score, the greater the use of DM. In bold are the most used defensive mechanisms.

Bivariate analysis

Considering OPD-2, DSQ-40 variables and sociodemographic data, it was possible to observe important issues for the understanding of patients with PTSD. Axis I: Women had better Global Assessment of Functioning (GAF= median_{woman}=55[35-75]; p=0.015) despite showing symptoms and moderate difficulties in mental, social and occupational areas. Men, on the other hand, had more significant impairments (GAF_{man}=50[40-55]).

Furthermore, better GAF was identified in patients who did not experience any traumatic event prior to the ITE (ITE_{none}=60[50-70]; p=0.037), had no previous psychiatric problems (Previous $psychiatric\ problems_{none}$=60[45-70]; p=0.037) and had not attempted suicide (SA_{no}=55[45-70]; p=0.008). Likewise, better quality of life was observed in subjects without psychiatric problems before ITE (Previous $psychiatric\ problems_{none}$=6[5-9]; p=0.021) and who had not attempted suicide (SA_{no}=7[5-10]; p=0.032).

Assessing Axis I of the OPD-2 and DSQ-40, those who rarely presented Subjective Suffering made greater use of the Mature defensive style (Subjective $Suffering_{none/rarely}$=5.88[5.13-5.88]; p=0.040) and Anticipation DM (Subjective $Suffering_{none/rarely}$=5.50[5.50-6.50]; p=0.032) and Neurotic defensive style (Subjective $Suffering_{none/rarely}$=5.50[5.13-6.00]; p=0.046). However, the Dissociation DM (Previous psychiatric $problems_{none}$=4.25; min-max=[3-5.50]; p=0.005) and Rationalization defensive mechanisms (Previous psychiatric $problems_{none}$=5[4- 6]; p=0.042) were evident in patients who had no psychiatric problems prior to ITE.

On Axis II, the way in which others report experiencing themselves in relation to the patient, isolated, distant and withdrawing from relationships, was significant in relation to patients who showed low structural level related to attachment to external objects (n= 3 (100%); p=0.040). In addition, when investigating the patterns of dysfunctional relationships regarding DM, it was found that patients who reported experiencing themselves as trying not to isolate from relationships used, more often, the Immature defensive style (4.5[2.7-5.7]; p=0.025) and Autistic Fantasy MD (5[2.5-6.0]; p=0.041). Likewise, the others, in an attempt to stay closer to the patient, presented the Immature Factor (4.5[2.7-5.7]; p=0.016) and Autistic Fantasy DM (5[2.5-6.0]; p=0.01) and Rationalization as prevalent (5[2.5-7.0]; p=0.003) and also the Neurotic Factor (4.6[3.0-6.1]; p=0.022). On the other hand, those who experienced themselves in relation to the patient seeking more contact exhibited greater use of the Immature defensive style (4.5[2.7-5.7]; p<0.001), Denial DM (4.0[1.5-6.0]; p=0.002), Cleavage (5[1.5-6.0];

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p=0.025), Neurotic style (4.6[3-6.3]; p=0.014), Annulment DM (5.0[2.5-6.5]; p=0.032) and Idealization DM (4.5[3.0-7.5]; p=0.047).

In relation to Psychic Conflicts, in Axis III, the "Individuation versus Dependence" conflict was identified in patients who had no income (No $income_{absent/not\ significant}$=3(9.7%); $n_{significant/very\ significant}$=28(90.3%); p=0.042) or with income of 1 or 2 minimum wages (= $n_{absent/not\ significant}$=9(34.6%); $n_{significant/very\ significant}$=17(65.4%); p=0.042). This conflict was also identified in patients who experienced trauma during their development (1 event=$n_{absent/not\ significant}$=3(10.3%); $n_{significant/very\ significant}$=26(89.7%); p=0.042). Also, when "Individuation versus Dependence" and "Submission versus Control" conflicts were more significant, the greater was the use of the Devaluation DM (Individuation versus $Dependence_{absent/not\ significant}$=3[2-6]; Individuation versus $Dependence_{significant/very\ significant}$=4.50[2- 8]; p=0.022; Submission versus $Control_{absent/not\ significant}$=3.5[2-5]; Submission versus $Control_{significant/very\ significant}$=4.5[2-8]; p=0.019). On the other hand, the Self-esteem Conflict was more significant in relation to those who used the Autistic fantasy DM ($Self\text{-}esteem_{absent/not\ significant}$=4.5[1.5-6]; $Self\text{-}esteem_{significant/very\ significant}$=5.5[4-6]; p=0.041).

The Mode of Functioning of the main conflict was significant in relation to the number of traumas during patients' lifetime: those who had trauma before ITE presented predominantly Passive Mode (n=8 (27.6%); p=0.021); and patients who had two traumas exhibited mixed but Active Mode (n=11(55%); p=0.021). This Mode of Functioning was also observed in those who had attempted suicide (SA=$_{yes}$=8(32%); p=0.005). On the other hand, patients who did not attempt suicide showed mixed but passive mode of functioning (SA_{no}=14 (40%). In addition, there was a predominantly active mode of functioning of the main conflict against the Devaluation DM (4.5[2-6]; p=0.030), Autistic Fantasy (4.5[3-5.5]; p=0.034) and Dissociation (4[2.5-6.5]; p=0.043).

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When considering the level of Structural Integration of Personality, Axis IV, low attachment to internal objects (+3 minimum wages= n=1(33.3%); p=00.29) and low capacity in object perception (+3 minimum wages = n=1(33.3%); p=00.29) were found in with income of more than three minimum wages. It is noteworthy that high level of attachment to Internal Objects was presented by patients who reported not having experienced trauma during their development (No trauma= n=2(25%); p=0.032). Likewise, high level in relation to Object Regulation was identified in patients with greater use of the Displacement mechanism (4.25[4-4.5]; p=0.028).

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Discussion

This study evaluated the psychodynamic functioning of patients with PTSD relating them to defensive styles, defensive mechanisms and sociodemographic characteristics. The main findings were: 1) sexual violence was the most common; however, patients had already suffered other traumas during their lives; 2) In the bivariate analyses, the following was observed: a) Patients who had not suffered traumas during their lives dismantled their more organized personality structure (Axis IV), with ability to control impulses and regulate affections, had better GAF and EQ-5D (Axis I), did not attempt suicide and used the displacement mechanism; b) More flexible defensive styles such as Neurotic and Mature (Anticipation) were used by patients who rarely presented Subjective Suffering (Axis I); c) The relationship theme “allowing contact” (Axis II) was significant in the face of the use of defenses of the Immature style (Autistic Fantasy, Rationalization, Denial, Cleavage) and Neurotic style (Annulment and Idealization), both in relation to the experiential perspective of the patient and the others; d) More primitive Conflicts (Axis III) were associated with subjects with lower income, who had experienced trauma before ITE, were more dependent, devalued (Axis II) and used Immature defenses (Devaluation and Autistic Fantasy); e) the Mode of Functioning of the Conflict (Axis

III) had variation in relation to the number of traumas during life, SA and DM of the Immature style (Devaluation, Autistic Fantasy and Dissociation).

When evaluating the psychodynamic functioning of patients with PTSD, it was possible to observe, in addition to the current problem, ITE and symptoms, but how the stress caused by the trauma is related to the psychic constitution of subjects. In general, it is known that trauma, felt as a threat to physical or psychological integrity, produces accumulation of excitations, often intolerable to the psychic apparatus.[29] When producing imbalance, the traumatic experience is relived in order to dominate excitatory stimuli.[30] Thus, the failure to be able to speak, reflect and understand the traumatic event leads to a discharge in the body itself, converting affection into a symptom and seeking to repress the anguish aroused by the trauma, as well as its infantile, conscious or unconscious representations.[31] The search for tension relief through the repetition of the painful experience and the formation of symptoms aims to reduce all the tension of the psychic apparatus, causing it to return to an inanimate state. Through these observations, Freud developed his idea about the death instinct.[32] In the evaluated patients, individual characteristics- sex, no trauma prior to ITE, personality structure, conflictual schemes and the use of defensive mechanisms- and social factors- interpersonal relationships- influenced the modulation of the stress response and the ability to withstand and reorganize themselves in the face of stressful situations.

Consistent with literature, the majority of patients who developed PTSD were female[1] with low schooling and low socioeconomic status.[1,29] In addition, there was wide variation in terms of age among patients, which may be related to the long period of time between the occurrence of ITE and the search for specialized care, usually over two years.

Although no significant associations were found between ITE and the other variables under study, high prevalence of sexual violence was observed as a traumatic event that triggered the symptoms. This type of aggression is one of the main causes for the development of PTSD[34] in

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both sexes,[35] causing feelings of hopelessness, abandonment and isolation in relation to relationships, increasing the risk for SA.[36] Such symptoms were presented on Axes I, II and III of the OPD-2 in this study.

In the same proportion, the tragic death of a family member with affective proximity was also revealed as a significant trauma. The unexpected death of family members due to violence or traffic accidents, as well as the expected death due to a terminal illness, was associated with the occurrence of PTSD in women with lower schooling.[37] Also, parents who lost children victims of violent death presented PTSD between 4 and 60 months after the event,[38] which points to the relevance of a specialized look at this type of trauma.

In addition to ITE, patients revealed that they had experienced trauma prior to the event that caused PTSD, which supports different studies.[2,19,39] Trauma can become devastating, especially in childhood, as object representations become unstable, making it difficult to organize a sense of identity and the ability to reflect/mentalize.[40] The absence or fragility of the object's response to accept, interpret and satisfactorily respond to traumatic experiences, combined with the individual's responses to the experienced situation can lead to feelings of helplessness and abandonment, reactivated in other stressful situations.[30] Thus, exposure to a new trauma or multiple traumas throughout life, and the development of PTSD symptoms together with other psychiatric disorders, was shown to be associated with worse global functioning (Axis I), with loss of income, relationship difficulties, feelings of abandonment and isolation (Axis II), causing high SA index.

Jun et al.[16] indicated that the less adapted to reality, the more immature the defenses and the lower the trauma management capacity. Baie et al.[11] confirmed the relationship between lower level of personality functioning and greater severity of PTSD symptoms. This research expands these results by showing that protection in the face of traumatic experiences enabled the formation of a more organized personality structure (Axis IV), constituted by the internalization

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of secure representations, with stable Self structuring. This can be observed in the significant association between patients who reported not having experienced trauma during their development and the high level of attachment to internal objects.

In addition, greater ability to distance oneself, control impulses, regulate affections and relationships with others, lead to skills of self-perception and perception of others separately, facilitating exchanges with the external world. In this way, it is possible to trigger defensive mechanisms capable of minimizing their anguish by shifting them (displacement DM) to less threatening objects. Such characteristics served as a protective factor when experiencing ITE, allowing these patients to maintain their social, relational and work functioning, without suicide attempts, even with the development of PTSD, unlike patients with more disorganized Psychic Structure, that is, a moderate, moderate to low and low structural level.

The structural conditions of personality, from the organized functioning to severe limitation, have direct interaction with the manifestation of psychic conflicts and, consequently, the established interpersonal relationships. It was observed that dysfunctional conflicts presented a repetitive pattern in interpersonal and intrapsychic dynamics and aroused affects. The Main Conflict (Axis III; Figure 2) identified was the "Need for care versus Self-sufficiency", which refers to the desire for security and care in close relationships in the face of dependence and inner emptiness. Those with trauma prior to ITE and lower income, felt even greater helplessness, devaluation and dependence on the other. Such characteristics corroborate the findings referring to failures in the differentiation between the other and the Self and, consequently, in the organization of a personality structure with less integration in these patients. In the Secondary Conflict, "Submission versus Control"[10] was evaluated, where they seek to dominate or submit to others.

The Mode of Functioning of the main and secondary conflicts, mixed but active modes, points to an excessive attachment and demand to people with whom they relate. The loss of power

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was felt as a threat, a negligence, with the occurrence of withdrawal. Such characteristics confirm and strengthen what was identified by Both et al.[41] and Favaretto et al.[19] in studies on trauma patients.

It is interesting to observe that the greater the number of traumatic events experienced in the course of their lives, the more primitive and active the conflict (Axis III). Thus, impulse regulation occurred through inflexible defenses, fantasies or dissociation between trauma and emotion, characteristic of greater structural personality disintegration (Axis IV), not being effective. With the intensification of the fear of fusion with the other, they isolate themselves even more, increasing the anguish and the need for their release, with the passage to the act, the suicide attempt.[10]

Furthermore, the use of DM of different factors, Immature, Neurotic and Mature, was investigated, aiming at protecting the Ego in face of a traumatic experience, corroborating other studies on the subject.[14,43] The most used DM was Somatization (Figure 2), where the conversion of psychic derivatives into bodily symptoms occurs, changing the focus of pain. It was also the use of rational explanations for their actions and symptoms, trying to separate the current trauma from consciousness. However, other patients with more flexible defensive style, such as mature and neurotic, were able to anticipate emotions, tolerating anxiety and experiencing the current trauma with less subjective suffering (Axis I).

Isolation DM was evaluated by Jun et al.,[16] being positively correlated with the severity of PTSD symptoms. In this study, its use stands out in relation to the established dysfunctional patterns of relationships (Axis II), since when patients feel abandoned, perceiving others as negligent or imposing, isolate themselves. Even those who seek to maintain their relationships end up by using immature and neurotic defensive styles, with rational explanations, where the reduction of stress occurs in an imaginative way, without the real approximation of the other.

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It is interesting to note that when evaluating how others place themselves in the relationship with patients (Axis II), their defenses are also at a more rigid level, idealizing qualities of themselves and others, denying aspects of reality, trying to repair their actions or even to separate the good and the bad in order to preserve their conscience. This characteristic concerns projective identification, being a defense or part of interpersonal communication between patients with PTSD and their relational contacts. It could be then inferred that patients place a subtle pressure for others to acquire aspects of their Self or a painful internal object in order to dominate and control the other, or even, in order to seize their emotional capacities, controlling their anguish. When the projected material somehow resonates with aspects of the object that pre-existed the projection, the object starts to think, feel and behave according to what was projected.[44]

Thus, this research provides important evidence for the investigated topic. As limitations, its cross-sectional design and the reduced number of patients stand out. The variables analyzed were unable to explain the worse global functioning in patients and the relationship between greater personality disruption and higher income. Patients had high symptom intensity and significant difficulties in global functioning. In this way, structural variables presented frequency concentrated in one category, and it was not possible to perform analysis through regressions since there was no convergence of results, opting for the bivariate analysis, and increasing the sample is necessary. In addition, patients who developed the disease and those who did not manifest it after a traumatic event should also be analyzed. A longitudinal survey could point to the persistence of symptoms and post-traumatic growth related to the findings of this research.

In could be concluded that OPD-2 was able to assess the psychodynamic functioning characteristics of patients who suffered trauma and developed PTSD, establishing possible protective and vulnerability factors for the lower severity of symptoms and limitations,

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transgenerational violence, flaws in the psychic constitution, making the reflexive and defensive process difficult. It was also able to relate to the DSQ-40, complementing the understanding of these patients and their defenses.

The possibility of a multiaxial assessment, complementary to the nosological diagnosis, helps health professionals to direct the psychological/psychiatric treatment, leading the patient to actively face the disease. The characteristics raised point to the need for work aimed not only at the current moment and the symptoms presented, but at limitations of the Self, building or presenting new elements of secure attachment, offering new connections, providing the opportunity to differentiate from the other and thus, establishing greater stability and structural integration. This reconfiguration becomes possible through the therapist's listening, welcoming, containing, naming and behavior[10] in addition to the use of psychotropic drugs, when necessary. There is also a need to expand specialized health services for early assessment and intervention with a view to preventing the disorder from becoming chronic. In general, public health policies must direct actions to break the cycle of transgenerational violence and the trivialization of child violence, factors of vulnerability in the face of trauma.

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Disclosure

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Supplementary Table 1 Relational Themes and Items

Patient experiences himself (through others and with others) often as...	Relational themes	Patient experiences others often as...
Others-including the interviewer-experience the patient often as...		Others-including the interviewer-experience themselves in relation to the patient often as...
1. Allowing plenty of space, letting others act autonomously	Allowing space	1. Allowing plenty of space, letting others act autonomously
2. Guiding little, avoiding influence	Guiding others	2. Guiding little, avoiding influence
3. Admiring, idealizing	Recognizing others	3. Admiring, idealizing
4. Apologizing, avoiding censorship	Assigning responsibility	4. Apologizing, avoiding censorship
5. Being overly affectionate	Expressing affection	5. Being overly affectionate
6. Harmonizing, avoiding aggressiveness	Manifest aggressiveness	6. Harmonizing, avoiding aggressiveness
7. Caring much, worrying	Caring	7. Caring much, worrying
8. Imposing yourself rudely	Make contact	8. Imposing yourself rudely
9. Restricting space, intervening	Allowing space	9. Restricting space, intervening
10. Controlling, making claims and demands	Guiding little	10. Controlling, making claims and demands
11. Belittling, devaluing and shaming others	Recognizing others	11. Belittling, devaluing and shaming others
12. Accusing and censoring	Assigning responsibility	12. Accusing and censoring
13. Withdrawing affection	Express affection	13. Withdrawing affection
14. Attacking and harming	Manifest aggressiveness	14. Attacking and harming
15. Neglecting and abandoning	Caring	15. Neglecting and abandoning
16. Pretending, Ignoring	Make contact	16. Pretending, Ignoring
17. Claiming space and independence 18. Challenging and Giving up	Adapting	17. Claiming space and independence 18. Challenging and Giving up
19. Showing off, making yourself the center of attention	Being assertive	19. Showing off, making yourself the center of attention
20. Denying guilt	Admitting guilt	20. Denying guilt
21. Not reacting when others show affection	Accepting affection	21. Not reacting when others show affection
22. Insufficiently protecting yourself, allowing dangerous developments	Protecting yourself	22. Insufficiently protecting yourself, allowing dangerous developments
	Depending on others	

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23. Depending heavily on others, clinging	Allowing contact	23. Depending heavily on others, clinging
24. Having few boundaries, being overly involved		24. Having few boundaries, being overly involved
25. Avoiding autonomy, seeking guidance	Claiming space	25. Avoiding autonomy, seeking guidance
26. Complaining, abstaining, resigning	Adapting	26. Complaining, abstaining, resigning
27. Belittling yourself, devaluing yourself	Depending on others	27. Belittling yourself, devaluing yourself
28. Blaming yourself	Allowing contact	28. Blaming yourself
29. Closing yourself, running away from other people's affections	Accepting affection	29. Closing yourself, running away from other people's affections
30. Protecting yourself, especially from attacks, being on the alert	Protecting yourself	30. Protecting yourself, especially from attacks, being on the alert
31. Not depending on others, being self-confident	Depending on others	31. Not depending on others, being self-confident
32. Isolating, separating, withdrawing	Allowing contact	32. Isolating, separating, withdrawing

(OPD Task Force, 2016, p 175).

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