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Applying Contemporary Interpersonal Theory to the Study of Trauma

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Abstract

Introduction: Symptom-focused theories of trauma and posttraumatic response have yielded many valuable clinical insights, ultimately leading a number of empirically supported approaches to diagnosing and treating trauma survivors. Limitations observed in these approaches have led some trauma-focused researchers and clinicians to examine the role not only of symptoms, but of interpersonal factors on trauma and posttraumatic response. The study of such interpersonal factors is the mainstay of contemporary interpersonal theory, although at present research and clinical intervention concerning trauma has been largely detached from the insights of contemporary interpersonal theory. **Objective/Method:** In this paper we review and integrate the disparate literatures on trauma and interpersonal theory. **Results/Conclusion:** We conclude that synthesizing these two literatures is not only feasible, but may also generate useful clinical insights and provide directions for future research relevant to trauma.

Keywords: assessment; interpersonal circumplex; interpersonal theory; PTSD; trauma theory

1. Introduction

Posttraumatic stress disorder (PTSD) and other trauma-related disorders have long been operationalized in terms of discrete behavioral symptoms (see American Psychiatric Association [APA], 2013). This approach has guided diagnosis and treatment, yielding improvements in both research on and clinical intervention with survivors of trauma. However, some have argued that a primarily symptom-based approach, while useful for diagnostic purposes, may not capture the phenomenology of trauma and posttraumatic psychological response.

Earlier approaches to understanding trauma and PTSD (e.g., Frankl, 1959) were based less on symptoms than on understanding trauma in terms of a fracturing of meaning in extreme situations, meaning that is essentially interpersonal in nature. Approaches to understanding trauma/PTSD emphasizing the role of making meaning of interpersonal situations overlap substantially with contemporary integrative approaches to interpersonal theory. Some researchers have made use of concepts from interpersonal theory to understand trauma (e.g., Nugent, Amstadter, & Koenen, 2011). However, there has yet to be work applying interpersonal theory to the treatment of PTSD or fully integrating it with trauma theory.

2. Diagnosis, Treatment, and Theory of Trauma

2.1. PTSD

2.1.1. Diagnosis. PTSD is a diagnosis initially developed from clinical observations of soldiers coming back from war, who exhibited a set of symptoms called variously “shell shock”, “battle fatigue”, and “war neurosis” among other things depending on the war in question (for historical reviews, see Hyams, Wignall, & Roswell, 1996; Monson, Friedman, & La Bash, 2014). These terms were meant not only to describe the kinds of problems war veterans experienced upon their return (e.g., fear, fatigue), but also allude to the possible etiology for

these problems. For example, underlying the term “shell shock” was the idea that the problems a soldier exhibited upon returning from war (in the case of this term, World War I) were attributable to the repeated shelling the soldier experienced while in the trenches.

As the general process of diagnosing psychiatric problems became more scientific and formalized, PTSD diagnosis became less focused on phenomenological/etiological description and more defined in terms of discrete criteria. This was perhaps first evident in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; APA, 1980) and is retained in the current fifth edition (DSM-5; APA, 2013). After its formalization as a symptom-based disorder (e.g., in the case of DSM-5, twenty symptoms preceded by at least one gateway [“Criterion A”] traumatic stressor), trauma-focused clinicians and researchers came to understand the phenomenology of PTSD in terms of unprocessed fear (and related emotions), and that as such the disorder was sustained by negatively reinforced emotional avoidance (Foa & Kozak, 1986). It is for this reason that until only recently PTSD was categorized as an anxiety disorder in the DSM (for critical review, see Zoellner, Rothbaum, & Feeny, 2011). PTSD was moved to a newly formed cluster of “trauma- and stressor-related disorders” in DSM-5 in order to underscore the etiological significance of exposure to one or more traumatic stressors, although the symptom-based nature of the diagnosis remained (APA, 2013). This change reflects movements in the study of traumatic stress advocating a formal trauma-related diagnosis that acknowledges the importance of developmental (van der Kolk, 2005) and other complex (Herman, 1992) traumatic stressors and posttraumatic stress reactions. While it is possible to capture non-traditional presentations of PTSD in DSM-5 using the Other Specific/Unspecific Trauma- and Stressor-Related Disorder diagnoses, the forthcoming edition of the *International*

Classification of Diseases (ICD-11) contains a formal Complex PTSD diagnosis (World Health Organization, 2018).

2.1.2. Treatment. Consistent with the operationalization of posttraumatic response in terms of a diagnosis of PTSD, contemporary trauma-focused treatment has been primarily diagnosis- (and thus symptom-) focused (Foa & Meadows, 1997). Several decades of research on PTSD treatment have yielded two primary front-line protocols for treating PTSD, Prolonged Exposure therapy (PE; Foa, Hembree, & Rothbaum, 2007) and Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2017). Based on the idea that PTSD is a disorder maintained by avoidance of aversive emotional experience, PE focuses on the affective symptoms of PTSD, especially fear and avoidance of objects, conversations, and other situations that the trauma survivor associates with fear. The assumption behind PE is that once the trauma survivor processes their fear, the cycle of emotional avoidance (and related thoughts and behaviors) that comprises PTSD will also diminish. In contrast, CPT is focused on cognitive symptoms of PTSD such as beliefs that oneself is irreparably damaged or that the world is dangerous, under the assumption that these thoughts maintain the avoidance and other problems that characterize PTSD. A third treatment for PTSD has also come to prominence, Eye Movement Desensitization and Reprocessing therapy (EMDR; Shapiro, 2017). EMDR includes some of the mechanisms of action of PE along with a focus on maladaptive cognitions found in CPT, and adds a novel element of physiological intervention (e.g., directed eye movements; see Shapiro & Solomon, 2017; Spates & Koch, 2004).

Research suggests that these treatments are effective in reducing PTSD symptoms (for review see Resick, Monson, Gutner, & Maslej, 2014). Despite success in symptom reduction, however, there have been several concerns voiced about them. Namely, critics have noted that

symptom reduction achieved by these treatments is often not sustained, treatment protocols have high rates of dropout, and samples on which the treatment studies are based often include patients with overly simple symptom presentations who often lack the diagnostic comorbidity common in trauma survivors (Spinazzola, Blaustein, & van der Kolk, 2005; Steenkamp, Litz, Hoge, & Marmar, 2015). Critics have further commented that the research base supporting these treatments is insufficient to rely on these treatments exclusively in military/veteran populations in which the need for trauma-focused treatments is arguably the highest (Steenkamp et al., 2015). For example, in their review of the research literature, Steenkamp and colleagues (2015) found that even after receiving the front-line treatments for PTSD, 60-72% of combat veterans continue to meet diagnostic criteria for PTSD, and their overall functioning remains similarly compromised. However, it should be noted that this latter review evaluated PE and CPT but did not include EMDR, which meta-analytic evidence suggests may be more effective at reducing symptoms and have lower patient attrition than PE and CPT (Chen, Zhang, HU, & Liang, 2015; Lee & Cuijpers, 2013; Maxfield & Hyer, 2002). This caveat notwithstanding, one reason for the noted shortcomings of these treatments may be that, consistent with symptom-focused diagnostic protocols more generally, they target and thus may only capture a small piece of the phenomenon of trauma and posttraumatic response. This has led some clinicians and researchers interested in trauma and trauma-focused treatment to examine the phenomenon of trauma from a different, more theoretically rooted perspective.

2.2. Trauma Theory

2.2.1. Shattering of meaning. In contrast to the observations that led to an understanding of posttraumatic response in terms of symptom-based diagnoses are approaches to understanding the joint phenomena of trauma and posttraumatic response based on trauma theory (e.g.,

Dalenberg et al., 2012; Herman, 1992). These latter approaches in general hold that the psychological problems experienced in the aftermath of trauma stem from an inability to integrate in a complete and/or healthy way the meaning of what happened before, during, and/or after the traumatic event(s). Approaches drawing on this idea understand trauma in terms of a shattering of meaning, an incompatibility of beliefs held before the trauma with subsequent interpretations of the traumatic experience(s) (Frankl, 1959; Freyd, 1996; Janoff-Bulman, 1992; McCann, Sakheim, & Abrahamson, 1988; Park, 2010).

The phenomenology of trauma as described in trauma theory is different in several subtle but important ways from the theories on which the contemporary diagnostically focused understanding of trauma rests. For example, in contrast to the fear-based understanding of trauma and posttraumatic response (Foa & Kozak, 1986) that is the basis for exposure-based treatments such as PE (Foa et al., 2007), fear is not the primary (or even necessarily the most important) emotion involved with trauma. For example, especially for trauma survivors whose index events involved perpetrating violence or aggression rather than being on the receiving end of it (e.g., in the case of killing in war), fear is much less prominent than emotions like disgust and shame (Grossman, 1995; see also Litz et al., 2009).

It is also important to point out that in trauma theory, the emotion itself may be less important than the trauma survivor's ability to put words to the emotion and to convey that emotion to one or more other people (Terr, 1990). Accordingly, and in contrast to approaches to PTSD treatment that focus on specific maladaptive thoughts that cause specific emotional symptoms (e.g., CPT; Resick et al., 2017), it is less trauma-related thoughts themselves than the inability to convey these thoughts to other people that matters in the phenomenology of posttraumatic response, as this inability prevents a person from making meaning of the traumatic

experience(s) (Charles, 2014). Indeed, some trauma theorists have proposed that the inability to understand and convey traumatic experiences and trauma-related thoughts and emotions to others is associated not only with PTSD but also other trauma-related problems (Freyd, 1996).

One trauma-related problem that has received much attention in the research literature is dissociation. Research suggests that traumatic experiences that are dissonant with core beliefs are especially likely to result in dissociative symptoms (for conceptual review see Freyd, 1996; Kaehler, Babcock, DePrince, & Freyd, 2013). Beyond acknowledging pathological forms of dissociation (e.g., flashbacks, exaggerated startle response) as symptoms of traumatic experience, however, recent work has also emphasized the role dissociation plays as a potential mechanism through which traumatic experience may disrupt psychological functioning. Such work incorporates an understanding of the self not as an inherently unified entity, but rather as a network of information processing systems (e.g., affective memory, declarative memory) that under optimal conditions works together as a unified whole (Steel, Fowler, & Holmes, 2005). However, traumatic experience can disrupt the synchrony of these systems, leading to affective, cognitive, and/or sensorimotor functioning that is out of synch (i.e., dissociated; Moskowitz, Read, Farrelly, Rudegeair, & Williams, 2009; Nijenhuis, 2017; Pace, 2012; Steel et al., 2005; van der Hart, Nijenhuis, & Steele, 2006). Examples of such dissociated experience include dissociative symptoms of PTSD (e.g., flashbacks), as well as other symptoms not only of PTSD (e.g., detachment from other people, sense of foreshortened future) but also of other conditions that are common among survivors of traumatic experiences (e.g., symptoms of anxiety, depression, psychosis, and personality pathology; Steel et al., 2005; van der Hart et al., 2006).

2.2.2. Meaning is interpersonal. One general theme that differentiates trauma theory from a more diagnosis-focused understanding of trauma is that in trauma theory, meaning is

intrinsically *interpersonal*. In other words, experiences are traumatic to the extent that the meaning people make of these experiences entails violation of expectations they hold about how people should treat, think about, and otherwise relate to each other (Boulanger, 2007; see also Freyd, 1996; Levendosky, Lannert, & Yalch, 2012; Shay, 1992). For example, an Army veteran who survives an ambush during a convoy in Iraq (but in which his friend and fellow squad member is killed) might develop beliefs about how he himself is and how other people are in order to make sense of his experience. Such beliefs might resemble the following: “people are dangerous” and “I am a weakling and a coward because I let my friend die.” Research suggests that traumas that are explicitly interpersonal (e.g., physical and sexual assault) have a stronger association with PTSD symptoms than non-interpersonal trauma (e.g., natural disasters; Forbes et al., 2012, 2014). However, the (trauma-relevant) meaning made for non-interpersonal trauma is often interpersonally relevant; for example, “what did I do to deserve this?” and “how could God have let this happen?” (Frankl, 1959; Janoff-Bulman, 1992).

It is not just the meaning of trauma that is interpersonal – so is the trauma survivor’s psychological response to the trauma. The symptoms of PTSD do not occur in a vacuum. The patterns of diagnostic emotions (e.g., fear), thoughts (e.g., about oneself being damaged), and behaviors (e.g., avoidance of trauma-related conversations) do not remain constant over time, but are rather cued by interactions (or the potential for interactions) with other people. More broadly, trauma theorists have long observed that the reactions trauma survivors typically demonstrate (especially in the case of repeated interpersonal trauma) take the form of disrupted interpersonal relationships (Courtois & Ford, 2013; Herman, 1992; Walker, 1979). For example, thoughts of other people as dangerous and oneself as weak expressed by the veteran in the previous brief vignette may lead him to become distant from and non-communicative with his romantic partner.

Although there is a strong thread in the study of trauma emphasizing the interpersonal relevance of trauma and posttraumatic response, there have been a number of limitations to the study and use of interpersonal factors within the context of trauma research and practice. For example, researchers and clinicians recognizing the relevance of interpersonal factors in trauma work (trauma theorists and otherwise) have often approached the study of these factors from different theoretical perspectives, ranging from cognitive theory (Resick et al., 2017) to attachment (Liotti, 2004; Levendosky et al., 2012) to poststructuralist psychodynamic thought (Charles, 2014). This has led to a lack of common language to discuss interpersonal factors and how they might affect trauma and posttraumatic response. In addition, trauma-focused researchers and clinicians have often worked without the benefit of the most up-to-date tools to conceptualize, measure, and apply interpersonally relevant constructs. However, these aspects (common language for discussing and other up-to-date means of studying interpersonal factors) are the bread and butter of contemporary interpersonal theory.

3. Interpersonal Theory

3.1. Introduction

3.1.1. Basic Concepts. The core principle of interpersonal theory is that the most important features of psychological life occur within and are the result of interactions between two or more people (Sullivan, 1953). These interactions are those between not only real, proximal people in the here and now, but also include interactions that occur in the head of one person about one or more other people (including alternative versions of oneself). For example, an interaction between person A and B in the here and now is no more or less meaningful from an interpersonal perspective than person A's thinking about a real or imagined she had with

person B. The people in an interpersonal interaction can be real or imagined, alive or dead, past, present or future.

According to interpersonal theory, people are not just the subject of interactions, but also meaningful in an individual's development (Benjamin, 2003; Blatt, 2008; Horowitz, 2004; Sullivan, 1953). From birth onward, a person achieves a sense of who she is first from her mother, then from other family members, peers, romantic partners, and eventually others in her broader relational life. Relationships with intimate others early in life not only form templates for future relationships, but also provide means of interpreting and contextualizing visceral experiences. Within the framework of interpersonal theory, those experiences an individual is unable to formulate using previous relationship templates remain unintegrated into (i.e., dissociated from) conscious awareness (Stern, 1999; Sullivan, 1953).

3.1.2. Agency, communion, and the Interpersonal Circumplex. Initial theorizing about the relevance and development of interpersonal factors laid the groundwork for a more systematic and integrative interpersonal theory, which synthesizes insights from attachment theory, developmental and cognitive psychology, and psychodynamic thought into a single coherent framework (Cain & Ansell, 2015; Hopwood, Zimmerman, Krueger, & Pincus, 2015; Pincus, 2005). Contemporary interpersonal theorists discuss interpersonal behaviors, beliefs, motivations, etc. in terms of two broad dimensions: agency and communion (Bakan, 1966; Wiggins, 1991). Agency can be roughly defined as the desire to achieve mastery and esteem relative to others, and communion as the desire to affiliate with and cultivate a sense of love for others. In contemporary interpersonal theory, agency and communion are independent from each other such that any human action can be understood as a combination of agency and/or communion (for example, a behavior can be communally agentic or selfishly agentic). Decades

of research have further suggested that agency and communion develop dialectically such that at first a human establishes the communal milestone of feeling connected and secure (see Bowlby, 1969) then the agentic milestone of independence through separation (see Mahler, Pine, & Bergman, 1975), then a communal milestone, and so on (Blatt, 2008).

In contemporary interpersonal theory, agency and communion form the primary axes of a conceptual and psychometric tool called the Interpersonal Circumplex (IPC) which interpersonal theorists use to understand, map, and predict human behavior. In the IPC, the meta-constructs agency and communion are often substituted with set of terms more descriptive of actual human behavior: dominance (a tendency to be more active) vs. submissiveness (a tendency to be more passive), and warmth (a tendency to be more engaged with others) vs. coldness (a tendency to be more detached from others) are terms commonly used on this map.

[insert Figure 1 here]

Extremity of the dominance/submissiveness and warmth/coldness of a behavior is indicated by how far the behavior is from the IPC's center. For example, a gentle smile might be just to the right of the center along the warmth axis, holding hands further right, kissing yet further, and consensual sex even further. Turning to the other side of the IPC and combining the two dimensions, an insult would be just to the left and up from the circle's center in the cold-dominant quadrant, a physical assault further up and left, and a murder even further.

3.1.3. Complementarity and reciprocal patterns. In addition to describing discrete behaviors, interpersonal theorists also use the IPC to describe and predict behavior between two or more people over the course of time using the principle of complementarity (Carson, 1969; Kielser, 1996). Complementarity operates in two ways. With respect to warmth, a behavior is complementary (i.e., conducive to a normal, comprehensible interaction between people) to

another behavior if it is as warm as the behavior preceding it. For example, if person A is nice to person B, person B is pulled to be nice back (and in approximately equal measure). In contrast, if person A is cold to person B, person A is more likely to respond comparably coolly.

Complementarity with respect to dominance entails contrast: when one person is dominant, the other is submissive (and to the same degree). For example, when person A talks, B listens, and vice-versa. Behaviors that combine warmth and dominance invite responses that complement each dimension respectively: when person A screams angrily (cold-dominance), person B cowers defensively (cold-submissiveness); when person A asks for help changing a tire (warm-submissiveness), person B shows him how (warm-dominance).

Complementarity influences people's behavior throughout their interactions in ways that can be measured moment-to-moment, which is a subject of recent interpersonally focused research (e.g., see Sadler, Ethier, Gunn, Duong, & Woody, 2009; Thomas, Hopwood, Woody, Ethier, & Sadler, 2014). Although momentary behaviors influence and are influenced by another's behavior, over the course of development habitual patterns of behavior emerge and solidify for each person as the product of his or her interpersonal experiences (Horowitz, 2004). People's idiosyncratic ways of interacting with other people (including the degree to which they are rigid in adherence to these ways) can be referred to as an interpersonal style or signature (Fournier, Moskowitz, & Zuroff, 2008, 2009). Interpersonal signatures become self-reinforcing by means of complementarity, and people train others to treat them in particular ways, thus producing reciprocal patterns of interpersonal behavior (Carson, 1979; Kielser, 1996; Leary, 1957; Sullivan, 1953; Wachtel, 2014). These reciprocal patterns put individuals at greater or lesser likelihood of having certain kinds of interpersonal transactions, including of developing certain psychiatric disorders and manifesting disorders in particular ways (Horowitz, 2004).

Indeed, reciprocal patterns of interpersonal behavior are especially salient when it comes to those behaviors that are disruptive to other people, as in the case of psychopathology (Carson, 1982; Kielser, 1996; Pincus, 2005).

3.2. Clinical Applications

3.2.1. Interpersonal theory of psychopathology. Interpersonal theory originally developed as a way to understand clinical phenomena and it has retained this emphasis over the course of its development. A key concept in interpersonal theory is that psychopathology is caused by distortions in how people interpret interpersonal transactions (real or imagined; Horowitz, 2004; Sullivan, 1953). Subsequent behaviors, which may take the form of observable behavior problems, are ultimately geared toward achieving normal goals of interpersonal transactions (e.g., to maintain esteem, to get close to another person, to protect oneself), but are maladaptive because they are based on distorted perceptions. For example, a person with prominent paranoia might view a commonplace and benign social interaction (e.g., the waiter at a restaurant asking a person to repeat their order) as aggressive (“he is trying to embarrass me”). These maladaptive patterns of behavior typically coalesce into coherent themes, which contemporary interpersonal theorists describe in terms of three distinct patterns (i.e., copy processes; see Benjamin, 1993, 2003) that develop in the context of interactions with significant figures in a person’s life. These copy processes include identification (treating others as one has been treated; e.g., abusing others in the way one was abused by an important other), recapitulation (maintaining a position complementary to an internalized other; e.g., acting as if a controlling other is still there and in control), and introjection (treating the self as one has been treated; e.g., being overly critical to oneself because an important other was overly critical). These copy processes influence people’s interactions with other people and, especially in the

case of serious psychopathology (e.g., personality disorders), provide a concise and clinically expedient explanation for why a given presenting problem is present.

In addition to influencing the presence of psychopathology, interpersonal style also influences how psychopathology might be expressed (Blatt & Shichman, 1983; Pincus, Lukowitsky, & Wright, 2010). This has been discussed in terms of pathoplasticity, the idea that interpersonal characteristics and other individual differences can influence symptom presentation, duration, and responsivity to treatment. Research on the pathoplastic effects of interpersonal style suggest that patients with submissive interpersonal profiles have greater chronicity of major depressive and substance use disorders than those with more dominant profiles (Boswell, Cain, Oswald, & McAleavey, 2017; Cain et al., 2012) and that patients with warm-submissive profiles have better outcomes in treatment for social phobia than those with cold-submissive profiles (Cain, Pincus, & Grosse Holtforth, 2010). Research further suggests that although interpersonal style influences symptom duration, it is less related to symptom severity within diagnostic groups (Cain et al., 2012; Hopwood, Clarke, & Perez, 2007; Przeworski et al., 2011). These studies suggest that interpersonal style figures prominently into symptom expression, which raises questions about the role interpersonal style plays in symptom etiology (e.g., vulnerability factors, preference for active vs. passive coping strategies).

Interpersonal style also has ramification for how patients can be treated clinically.

3.2.2. Clinical intervention. Principles of interpersonal theory can also be useful in clinical practice. Initial clinical applications of interpersonal theory came in the way of a method of clinical interviewing (Sullivan, 1954), with assessment of interpersonal style using the IPC coming a few years later (Leary, 1957). Contemporary interpersonally oriented clinicians use formal assessment of interpersonal style both for diagnostic purposes as well as to guide

therapists' behavior in session (Benjamin, 2003; Hopwood, Pincus, & Wright, in press; Kiesler, 1996). Specifically, by knowing what a patient's interpersonal style is, the clinician can use complementarity to match and/or contrast the patient's behavior. Indeed, a general approach of contemporary interpersonal therapy is for the therapist to complement a patient's behavior early in treatment and then act in a way that moves the patient to a more adaptive or flexible interpersonal stance later in treatment (Anchin & Pincus, 2010; Levenson, 2010). For example, a therapist might complement a dependent (warm-submissive) patient by guiding and reassuring him (warm-dominant) early in treatment, and be equally friendly but less directive (warm-submissive) later in treatment to allow for and pull the patient to be more assertive (warm-dominant). Examining the dynamics and functioning of complementarity in psychotherapy dyads in real time is a focus of ongoing research (Hopwood et al., 2016; Thomas et al., 2014).

Although use of complementarity as core clinical strategy is primarily the domain of explicitly interpersonally oriented treatment approaches, it is not confined to approaches directly influenced by interpersonal theory. For example, one study found that clinicians and patients displayed complementarity in cognitive, humanistic, and gestalt approaches to treatment in Shostrom's (1966) *Three Approaches to Psychotherapy* (Thomas et al., 2014). Research further suggests that complementarity is associated with improved treatment outcomes in cognitive-behavioral therapy (Tracey, Sherry, & Albright, 1999; for theoretical review see Safran & Segal, 1996). Outside the therapy room, recent research has also indicated the utility of conducting supervision within a contemporary interpersonal framework, that using and narrating interpersonal process (both in therapy sessions and how this transfers into supervision sessions) transparently can help supervisees mentalize and understand their clinical cases (Levendosky & Hopwood, 2017).

As we have suggested thus far in this brief review, contemporary interpersonal theory has applications to several different areas from basic research to clinical practice. As an integrative and inherently *human* theory, it has applications to virtually any domain of human interaction. However, just as trauma-focused researchers and clinicians have been slow to integrate contemporary interpersonal theory into their work, there has been little work to situate research on and treatment of trauma within the context of contemporary interpersonal theory.

4. Applying Interpersonal Theory to the Study of Trauma

4.1. Trauma, Posttraumatic Response, and the IPC

4.1.1. The interpersonal nature of trauma. Researchers and clinicians can use contemporary interpersonal theory to fill many of the theoretical and empirical gaps that currently exist in the study of trauma. This may be most immediately apparent in the conceptualization of trauma and posttraumatic response. For example, we can come to a dynamic understanding of trauma and posttraumatic response using the IPC as a stage across which trauma unfolds.

As previously noted, a key concept in trauma theory is that trauma represents a shattering of expectations (e.g., Janoff-Bulman, 1992). A key concept in interpersonal theory is that one of the earliest and most fundamental expectations is to feel connected and secure, to experience communion (e.g., Bowlby, 1969; Blatt, 2008). Combining these two concepts, we can define trauma as an experience that contrasts with this fundamental interpersonal expectation of communion. Using the IPC, we thus can plot trauma in general on the cold side of the IPC and normal expectations on the warm side.

[insert Figure 2 here]

Trauma can vary in terms of its level of agency. Trauma can be cold-dominant (e.g., in the case of physical or sexual assault) or cold-submissive (e.g., in the case of child neglect). Trauma can also vary according to its severity and duration. For example, the prototypical trauma (military combat) is thought about as being a single instance of severe trauma (e.g., a battle in which a soldier is wounded and his comrade-in-arms is killed, which we might plot far out in the cold-dominant area of the IPC). However, just as traumatic but less immediately life-threatening may be more chronic and repetitive, trauma (e.g., emotional abuse by an intimate partner, which would be less extreme in terms of cold-dominance than military combat, but occur for a longer period of time). It is also worth noting that some traumatic stressors (e.g., severe abuse from a parent or romantic partner, being held in captivity) may be both high in severity and long in duration (Herman, 1992), and that military combat is increasingly transitioning from occurring in terms of relatively infrequent, large-scale epic battles to constant, low-level conflicts (Nagl, 2002).

4.1.2. The interpersonal nature of posttraumatic response. Just as we can understand trauma in terms of the IPC, so we can understand the trauma survivor's response to trauma. To do this we can use the principle of complementarity. In general, and from an information processing perspective, we can understand the cold nature of traumatic experience as being mirrored by the detachment of the trauma survivor from themselves such that aspects of the survivor's self are dissociated from each other, giving rise to specific trauma-related symptoms. Complementarity can also be applied at the level of specific symptoms, as the symptoms of posttraumatic response are often complements to the trauma that produced them. For example, the fear response that is the hallmark of PTSD is a natural feeling for people thrust into extreme cold-submissive positions, as many are when they initially encounter a severe stressor in the

cold-dominant area of the IPC (e.g., a violent assault). From the perspective of trauma born of institutional betrayal, the neglect (cold-submissiveness) of the U.S. military issuing substandard military equipment to soldiers drafted and sent to the battlefield in Vietnam in many cases pulled for a resentful, belligerent response (cold-dominance) among these soldiers (for an extended discussion of institutional betrayal see Shay, 1992). In general, the interpersonal symptoms of PTSD (e.g., avoidance and mistrust of other people, believing that others are dangerous, thinking that one is damaged or that one's future will be shortened) are all cold, all involving distancing oneself from others (whether intentionally or not). These cold behaviors, in turn, feed into the affective symptoms of PTSD (e.g., fear at the thought of another trauma, anger at other people, sadness and disgust at oneself for what has happened) in a cycle of interpersonal-affective dynamics (for review see Hopwood et al., 2015; Yalch, Bernard, & Levendosky, 2015).

In the case of extreme traumatic experiences, particularly those that are chronic and repetitive, posttraumatic responses may result in maladaptively altered patterns of interacting with other people. It is useful to think about these in terms of copy processes. To take the trauma of military combat (cold-dominance), for example, the immediate interpersonal response may be defensive cold-submissiveness. If the combat veteran engaged in recapitulation (maintaining the complementary position) following the trauma, he would remain defensively cold-submissive throughout his everyday life, an interpersonal posture that is compatible with maintaining the initial fear response. If instead the veteran engaged in identification (treating others as one was treated), he might treat others in a hostile and assaultive (cold-dominant) way, feeling more angry than afraid. If the veteran introjected (treating the self the way one was treated), he would turn that aggression inward, attacking and berating himself, inviting a more depressive affective response. Of course, multiple copy processes may be active at different times and in different

situations. For example, the veteran in question might defensively avoid large crowds (recapitulation), act in a hostile way around people with whom he is close (identification), and silently beat himself up for being a worthless human being (introjection). Indeed, research suggests that such presentations are not uncommon in veterans with PTSD whose clinical presentations commonly include detached interpersonal relationships (recapitulation; e.g., Shura, Rutherford, Fugett, & Lindberg, 2017), aggression towards other people (identification; e.g., MacManus et al., 2015), and self-injurious behavior (introjection; e.g., Chu et al., 2018).

Whether manifesting as discrete symptoms or as copy processes that are longer lasting, because posttraumatic response consists of behaviors performed with other people (or in the case of avoidance, in service of other people), they elicit a complementary interpersonal response. For example, an angry, cold-dominant interpersonal stance will push other people away (i.e., will elicit a complementary cold-submissiveness), as indicated by the following vignette:

Other person: Good morning, Tom! (1)

Trauma survivor: What's good about it? (2)

OP: Nothing in particular I guess. Are you doing okay? (3)

TS: Why do I ask if I'm doing okay? Do you think something's wrong with me? (4)

OP: No, I just... (5)

TS: Stop looking at me like I'm crazy! (6)

OP: I'm sorry... (7)

[insert Figure 3 here]

In this case and others (e.g., one in which a cold-submissive trauma survivor pulls for hostile treatment), the treatment trauma survivors receive from others will reinforce the interpersonal posture they developed in the aftermath of the trauma. This model of trauma and posttraumatic

response has a number of implications to work with survivors of trauma, both from clinical and research perspectives.

4.2. Applications

4.2.1. Clinical practice. The above examples depicting trauma, posttraumatic response, and other people's responses to trauma survivors' behavior underscore the interpersonal nature of trauma. Clinical intervention with trauma survivors follows naturally from this. For example, contemporary interpersonal approaches to therapy (e.g., Anchin & Pincus, 2010) begin with a formal assessment of interpersonal style. Such an assessment would ideally evaluate multiple facets of interpersonal style, such as how the trauma survivor sees himself (interpersonal traits; e.g., measured using the *Revised International Adjectives Scale* [IAS-R; Wiggins & Trapnell, 1988]), how he wants to be with others (interpersonal values; e.g., measured using the *Circumplex Scales of Interpersonal Values* [CSIV; Locke, 2000]), difficulties he has interacting with other people (interpersonal problems; e.g., measured using the *Inventory of Interpersonal Problems* [IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988]), things other people do that bother him (interpersonal sensitivities; e.g., measured using *Interpersonal Sensitivities Circumplex* [ISC; Hopwood et al., 2011]), and interpersonal behaviors with which he has particular comfort and expertise (interpersonal efficacies; measures using the *Circumplex Scales of Interpersonal Efficacy* [CSIE; Locke & Sadler, 2007]). This multi-faceted assessment provides valuable insight into the nuances of the trauma survivor's interpersonal posture, which may generate hypotheses for both the clinician and the trauma survivor about the symptoms that comprise his posttraumatic response (e.g., thinking of himself as inept at interacting with others and thus being distant from others, which conflicts with his value of feeling connected and loved).

Having assessment data about a trauma survivor's interpersonal style can also inform the clinician about what interpersonal posture she might adopt throughout therapy. For example, for a trauma survivor for whom assessment data suggests characteristic cold-dominance, the clinician might adopt an initial stance of cool deference early in therapy, so as not to off-put him with what might appear to be excessive (and potentially threatening) warmth. Over time, as the survivor becomes more comfortable with clinician, she might behave more warmly, gradually pulling him to be warm in turn by via complementarity.

Knowledge of complementarity as a dyadic process can also be useful for understanding and modifying the clinician's interactions with the survivor on a moment-to-moment basis. This may be particularly important when the trauma survivor engages in specific trauma-related copy processes known to be damaging for the survivor's relationships and that the clinician thus does not want to reinforce. Below is a brief example of using complementarity to pull a survivor from being aggressive (cold-dominant) to a more connected stance of adaptive assertiveness (warm-dominant):

Trauma survivor: Talking about what happened in Iraq is pointless. And you're an idiot for asking me to do it (1)

Clinician: What I'm asking seems really unfair to you. I really appreciate you letting me know! (2)

TS: You have no idea how hard it is. (3)

C: I hear you loud and clear. I'm asking a lot from you right now. What ideas do you have about what you can do instead of talking about it with me? (4)

TS: Talk about it with the monkeys at the zoo... <snorts> (5)

C: Great idea! I actually think that's a perfect place to start! (6)

TS: Really? I was just joking, but I could actually do that... (7)

[insert Figure 4 here]

Although the above is an example of complementary behavior playing out overtly, this can also play out internally, in the form of transference and countertransference, as many relationally informed trauma-focused clinicians have noted (e.g., Boulanger, 2007; Charles, 2014). For example, if the clinician is feeling hostile and irritated (cold-dominant) with the survivor (e.g., because his persistent lack of homework completion), it could alert her to the cold-submissive posture of the survivor. The clinician can thus modify her overt behavior to something more amenable to the survivor's adaptive agency (e.g., "I can really see how hard you have been trying here in session and how you are beginning to see the benefits. What ideas do you have about how you can continue to improve, both inside and outside of session?" [warm-submissive, pulling for warm-dominance]). This matching of the clinician's interpersonal stance to that of the survivor combined with a verbal scaffolding of the survivor's in-the-moment experience can also help to formulate some of the here-and-now experience that the survivor might otherwise dissociate (Charles, 2014; see also Stern, 1999).

Importantly, although the assessment of interpersonal style and purposeful use of interpersonal dynamics in the consulting room form the backbone of contemporary interpersonally oriented therapy, it need not be limited to this. Interpersonal assessment and the use of assessment data to inform clinician-survivor interactions in the here-and-now are entirely compatible with structured approaches to trauma-focused treatments that are considered front-line today. For example, a rudimentary assessment (e.g., of interpersonal traits, problems, and values) prior to beginning CPT might provide the clinician some clues as to the salient themes to target with a trauma survivor (e.g., control, in the case of a trauma survivor with cold-dominance

problems) and what interpersonal stance might be most complementary early in therapy (for a conceptual overview of integrating interpersonal factors into the cognitive-behavior treatments, see Safran & Segal, 1996). Communicating the results of such an assessment in an empathic way could also help the trauma survivor by contextualizing the problems with which he or she has been struggling. This could result not only in putting a name to the problems and how they play out in the survivor's life, but also destigmatizing these problems by explaining them as an initially adaptive (if ultimately harmful) reaction to an impossible situation (see Finn, 2007).

In a similar vein, just as using interpersonal dynamics can be beneficial across different modalities of individual psychotherapy, so can it also be applied to group-based approaches (Leary, 1957). Group-based approaches are increasingly utilized in treating trauma survivors (for review see Ford, Fallot, & Harris, 2009), and psychotherapy groups composed of trauma survivors tend to have a group mentality characterized by cold-dominance (Hazell, 2017; Hopper, 2003). It is longstanding practice in group psychotherapy that clinicians interact with hostility at the level of the group as a group phenomenon rather than as a collection of hostile intentions of individual group members (Agazarian, 2006), and interpersonal dynamics (e.g., complementarity) as organized around the IPC provide a coherent means of putting this into practice. For example, noticing the hostile attitude pervading a psychotherapy group, an interpersonally savvy clinician might adopt a posture of warm-submissiveness to pull group members into a space that is more amenable to collaborative work (e.g., "There sure is a lot of anger in the room today! I'd really like to hear what's bothering you guys and what might be the best way to channel that anger").

Although thus far we have discussed the potential for interpersonal theory to be clinically useful with respect to the clinician's influence on the trauma survivor, it may also be useful for

purposes of understanding and dealing with the trauma survivor's influence on the clinician. One particularly relevant kind of influence for clinicians conducting trauma-focused treatment is vicarious traumatization, the development of psychiatric symptoms (e.g., of PTSD) on the part of the clinician in response to her repeated exposure to narratives of and similar interactions with trauma survivors (Pearlman & Caringi, 2009). Detection of specific symptoms of vicarious traumatization and of disrupted patterns of interpersonal behavior more generally (e.g., the clinician's slow drift toward a submissive detached style in and outside of session, rather than her pulling the trauma survivor towards assertive attachment) is an important task for the trauma-focused clinician. It is also a task that is particularly amenable for interpersonally focused approaches to clinical supervision (e.g., Levendosky & Hopwood, 2017) in which disrupted interpersonal patterns such as those associated with trauma (vicarious and otherwise) are of primary interest. In such supervision, vicarious traumatization can not only be understood and managed for the sake of the clinician's own mental health, but potentially also leveraged in the clinical care of the trauma survivor (see Boulanger, 2018; Pearlman & Caringi, 2009).

4.2.2. Research. In addition to research on the treatment of PTSD, interpersonal theory has also influenced more basic research on trauma. Much of this research has incorporated the assessment of interpersonal style using the IPC. For example, consistent with previous research on the pathoplastic effect of interpersonal style on psychopathology, one study suggests distinct interpersonal sub-types of PTSD (cold-dominant, cold-submissive, warm-dominant, warm-submissive), which are generally similar in terms of symptom severity, although the PTSD symptoms of trauma survivors in the cold-submissive sub-type are more chronic (Thomas et al., 2012). Research also indicates a buffering effect of interpersonal style, such that high trait dominance serves a protective function against the development of symptoms of PTSD (Bernard,

Yalch, Lannert, & Levendosky, in press), as well as symptoms of anxiety and depression (Yalch et al., 2013) and other forms of affective and physiological dysregulation (Yalch et al., 2015). These studies also suggest a main effect of warmth such that higher warmth is associated with fewer symptoms of psychopathology when the severity of trauma is taken into account.

There is an emerging body of subsequent research that has aimed at discerning possible mechanisms for these main, moderating, and pathoplastic effects. One recent study suggests that higher dominance and, to a lesser extent, higher warmth on the part of trauma survivors is associated with more adaptive (i.e., less alienated, angry, betrayed, self-blaming, fearful, and shameful) appraisals of themselves and other people in the aftermath of trauma (Yalch & Levendosky, 2015). Research also suggests that higher warmth is associated with a greater likelihood of trauma survivors seeking psychotherapy for psychological distress (Yalch, Schroder, & Dawood, 2017). However, the study of the potential mechanisms by which interpersonal style influences posttraumatic response is still in its infancy.

5. Discussion

In this paper we reviewed and integrated predominant approaches for the study and treatment of trauma/PTSD with contemporary interpersonal theory and research. We argued that an interpersonal approach to understanding trauma provides a complementary and clinically useful way of understanding trauma and posttraumatic symptomatology, and that such an approach might inform clinical practice as well as be useful in guiding future research.

5.1. Clinical Implications

We have described above an approach to assessing and treating posttraumatic response in terms of contemporary interpersonal theory. However, several trauma-focused treatment approaches currently exist that recognize the importance of interpersonal factors, either

implicitly or explicitly, even if these approaches do not take full advantage of advances provided by contemporary interpersonal theory. For example, there are a number of attachment-focused and otherwise interpersonally oriented approaches to treating PTSD and similar trauma-related conditions (e.g., Boulanger, 2007; Cloitre, Cohen, & Koenen, 2006; Courtois & Ford, 2013; van der Hart et al., 2006). Other approaches to treating trauma-related problems may lack an overall interpersonal framework but still address interpersonal issues explicitly (e.g., Linehan, 1993; Najavits, 2002). Approaches such as these are especially common in the treatment of complex forms of PTSD (i.e., high severity, multiple comorbidities) for which front-line treatments like PE and CPT may best be integrated within a phase-based model where greater interpersonal awareness and skill acquisition is required prior to successfully engaging in trauma-focused treatment (Landes, Garavoy, & Burkman, 2013). There is also some evidence that interpersonally oriented treatments not originally intended for PTSD (e.g., Interpersonal Therapy [IPT]; Weissman, Markowitz, & Klerman, 2000) may also be useful for reducing symptoms of PTSD (Markowitz et al., 2015).

Conversely, commonly used trauma-focused protocols can be understood within a contemporary interpersonal framework. For example, the themes that characterize trauma survivors' maladaptive thought patterns in CPT (safety, trust, power/control, esteem, intimacy; see Resick et al., 2017) can be mapped neatly onto the IPC, with safety and trust in the warm-submissive area, power/control and esteem in the dominant area, and intimacy in the warm area. Research also suggests that front-line trauma-focused treatments (e.g., PE) function to reduce maladaptive interpersonal beliefs, which in turn reduce PTSD symptoms and other symptoms of posttraumatic distress (e.g., McLean, Yeh, Rosenfeld, & Foa, 2015; Zalta et al., 2014). Thus, even without an explicit interpersonal focus, many implicit foci and mechanisms of front-line

treatments for PTSD are interpersonal in nature. Future research on clinical intervention with trauma survivors could examine the effectiveness of incorporating explicitly interpersonally focused assessment and treatment methods, either into existing trauma-focused treatments or as part of developing new treatments. Research applying interpersonal theory to the study of trauma more generally is another area of potential growth and may address some of the aforementioned gaps in the literature of treatment outcomes among trauma survivors.

5.2. Directions for Future Research

Although the body of research on interpersonal theory in general is vast, its application to trauma is somewhat limited. However, we can use previous research on interpersonal theory in general to map out future studies in the area of trauma. For example, extant research suggests that interpersonal style influences the presentation of posttraumatic symptomatology (e.g., Bernard et al., in press; Thomas et al., 2014; Yalch et al., 2013, 2015), but there is less research on how trauma and interpersonal style may mutually inform each other over time. This question may be especially salient given research suggesting that trauma may alter personality structure (e.g., Kaehler & Freyd, 2009, 2012; Yalch & Levendosky, 2014, in press; for theoretical review see Herman, 1992; van der Hart et al., 2006). Future studies could thus examine the longitudinal associations between traumatic experiences and interpersonal style.

Future research could also examine the dynamic model of trauma and interpersonal style proposed here. Such research could address questions about whether trauma survivors characteristically behave in cold ways (thus complementing the trauma they endured) and in what ways this may influence behavior towards and reactions from the people around them (e.g., do other people complement the cold behaviors of trauma survivors?). This research could optimally take advantage of recent advances in measuring interpersonal behavior (e.g., moment-

to-moment measurements of interpersonal behavior; for review see Lizdek, Sadler, Woody, Ethier, & Malet, 2012). To extend this to more applied domains, this vein of research on interpersonal dynamics among trauma survivors could also examine the degree to which interpersonal dynamics (e.g., complementarity) might influence the treatment of PTSD and other forms of posttraumatic response and whether this differs by treatment modality (e.g., PE vs. CPT vs. more relationally oriented trauma-focused treatments) or patient-clinician matching. Assessment using the IPC may also be useful in measuring outcomes of treatment that are less explicitly symptom-focused (e.g., number of aggressive, detached, and defensive interpersonal problems before and after treatment).

5.3. Limitations

In this paper we integrated the existing literature on the diagnosis and treatment of trauma and posttraumatic response with contemporary interpersonal theory. Although we argue that those treatments for PTSD that are currently considered front-line (e.g., PE and CPT) can be nested readily within interpersonal theory, there are some potential points of contention with this idea. Perhaps most notable is that whereas it can be argued that CPT is inherently compatible with interpersonal theory (e.g., because the themes by which it operates are all interpersonally oriented), PE (and to some extent EMDR) focuses primarily on affect, which is conceptually distinct from interpersonal dynamics and which some believe constitutes a separate (and comparably just as important) intrapsychic system (i.e., an affective system, also plotted on a circumplex; see Posner, Russell, & Peterson, 2005). Indeed, there is a small but growing literature on the role of affective traits as moderators of posttraumatic response (e.g., Yalch & Levendosky, 2017; Yalch, Levendosky, Bernard, & Bogat, 2017). Recent developments in interpersonal theory incorporate affective factors, conceptualizing the interpersonal system as the

lens through which the affective system receives input and the substantive cause for affective dysregulation (e.g., in the form of PTSD symptoms and other forms of posttraumatic distress; see Hopwood et al., 2015; Yalch et al., 2015). Future research can examine the plausibility of this idea.

A second limitation of this paper is that due to our focus on theory, we constrained our review of empirically supported trauma-focused treatments to those that adopt an explicit theory about trauma and posttraumatic response. We thus did not offer an in-depth review of those treatments that are more present-/skills-focused (e.g., Seeking Safety; Najavitz, 2002), including some treatment modalities that were developed for one disorder but have demonstrated some efficacy in “off-label” use for treating trauma survivors (e.g., Dialectical Behavior Therapy; Linehan, 1993). Future work might fruitfully integrate these and other approaches into contemporary interpersonal theory.

5.4. Conclusions

In this study we integrated the study of trauma and posttraumatic response with contemporary interpersonal theory. We conclude that these two ideas are not only compatible, but dovetail nicely with each other, and that the integration of these two strands of research and clinical thought may yield benefits for the researcher, the clinician, and, most importantly, the trauma survivor.

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Figure 1. *The interpersonal circumplex (IPC).*

Figure 2. *Conflict between trauma and previous expectations depicted on IPC.*

Figure 3. *Graphical depiction of other person complementing a trauma survivor's cold-dominance.*

Figure 4. *Graphical depiction of clinician pulling a trauma survivor to complement clinician's warmth.*