Mardi J. Horowitz

Short-Term Dynamic Therapy of Stress Response Syndromes

Handbook of Short-Term Dynamic Psychotherapy

Short-Term Dynamic Therapy of Stress Response Syndromes

Mardi J. Horowitz

from
Handbook of Short-Term Dynamic Psychotherapy

e-Book 2015 International Psychotherapy Institute

From *Handbook of Short-Term Dynamic Psychotherapy* edited by Paul Crits-Christoph & Jacques P. Barber

Contents

Short-Term Dynamic Therapy of Stress Response Syndromes

The ideas in this chapter were developed for understanding the processes of symptom formation and change in the stress response syndromes. Stress response syndromes were selected because their anchoring in known and meaningful external events facilitated the study of change. Many of the suggested techniques are applicable to other disorders, since in any approach one should take into account the personality configuration of the patient and how he or she can master stress of external or internal origin.[1]

ORIGINS AND DEVELOPMENT

Early in the 1970s, my colleagues and I conducted clinical investigations of persons who were struggling to master recent stressful events. At the time, there was no diagnosis of posttraumatic stress disorder (PTSD) in the official nomenclature, *DSM II*. Yet in our clinical observations we found that intrusive and repetitive thought, especially unbidden images, was a distinctive symptomatic response to stress, and often occurred in conjunction with its apparent opposite, phases of ideational denial and emotional numbing related to the potentially traumatic experiences.

In a series of experimental studies we found that most people's subjective experience of intrusive thought increased after they experienced

stress-inducing perceptions. Those experiments consisted of showing different types of subjects different types of films in laboratory settings with varied demand characteristics. In field studies, my colleagues and I also focused on a variety of persons who had recently undergone major life events. This led to the development of questionnaires that were specific to the subjective experiences that may increase after stress, such as found in the intrusion and avoidance measures on the Impact of Event Scale and in clinicians' equivalent rating scales, such as the Stress Response Rating Scale (Horowitz, Wilner & Alvarez, 1979; Weiss, Horowitz & Wilner, 1984).

Bolstered by the positive findings of our experimental and field investigations, we thought it wise to pursue the clinical investigations in more detail. Increased understanding of the mental processes involved in the integration of memories of traumatic events and of changes in personality structure that came with mastery of an experience such as mourning led us to formulate techniques specific to a kind of dynamic therapy for stress response syndromes. The outcomes of such therapies were found to be effective, as summarized elsewhere (Horowitz, 1986; Horowitz, Marmar, Weiss, DeWitt & Rosenbaum, 1984; Horowitz, Marmar, Weiss, Kaltreider & Wilner, 1986).

One advantage of selecting a stress response syndrome such as posttraumatic stress disorder for study is that part of the etiology is known.

That is, the syndrome is, in part, a consequence of the experience of a major life event, usually an injury or loss, or a major threat. Because the event is known, one has a good tracer; memories of the stressful event do or do not gain conscious representation, with or without subjective volition. The goal is also fairly clear: to help the patient at least regain his or her preevent level of personality functioning. Larger goals are also possible—for example, to rework the predisposing conflicts that might have combined with the stressful event to lead to symptom formation.

SELECTION OF PATIENTS AND GOALS OF TREATMENT

Brief, time-limited psychotherapy has a distinct advantage for clinical psychotherapy research. The time between pretherapy evaluation and posttherapy follow-up evaluation is compressed. Knowledge of outcome can be gained in less than a year. This permits the researcher to change his or her mind, within a short time, about how to conduct the next step in a research effort. A time-unlimited psychotherapy could go on for some years before the outcome might be fruitfully assessed.

Time-limited psychotherapy is a useful technique if the traumatic event is fairly recent and if the person does not have an excessively conflictual or deficient personality structure. In the approach developed with my colleagues, we excluded persons with psychotic and borderline personality

disorders, persons involved in litigation, and persons who had experienced a complex and long series of linked traumatic events. We focused instead on accepting for study persons who developed a neurotic level of illness.

THEORY OF CHANGE

The theory guiding the delineation of our brief therapy for PTSD, pathological grief, and other disorders precipitated by recent traumas involves three components: state theory, person schemas theory, and control process theory. These theories are discussed in my book *Introduction to Psychodynamics: A New Synthesis* (1988) and applied to a set of transcripts from a case of a pathological grief reaction in *States of Mind: Configurational Analysis of Individual Psychology* (Horowitz, 1987). A very condensed view will be given here.

States of Mind Theory

State theory describes how, after a serious life event, a person may begin to manifest different states, different state durations, and different state transition patterns than were present before the stressful event. During a stress response syndrome there is an increase in either undermodulated or overmodulated states, as in periods of intrusive experience or times of omission, denial, and numbing. The time that is given up to these under- or

overcontrolled states is derived from well-modulated states, sometimes called working states. In the immediate clinical situation, the therapist observes increased phenomena of intrusions, as in undermodulated states, and takes from these topics for which gaining mastery in psychotherapy is important. The therapist also observes, and helps the patient approach, observable omissions of topics that would deal with the serious implications of a stressful event.

The patient's current state of mind makes a difference in therapy techniques; the therapist selects techniques to aid self-regulation for patients in undermodulated states, to reduce excessive controls such as topic inhibition in overmodulated states, and to confront contradictions and conflicts in well-modulated states.

Person Schemas Theory

Person schemas theory has to do with enduring but slowly changing views of self and of other, and with scripts for transactions between self and other. Each individual may have a repertoire of multiple self schemas. When a traumatic event occurs, there may not be appropriate schemas available for showing how to adapt to the event. Integrating the event into memory is a complex process that has to do in part with modifying schemas such as role relationship models so that the person's inner expectations of self as related

to another will accord with new realities. An example of this is manifest in a mourning process, when a person must get used to the fact that he or she is no longer in a continuous real and living relationship with the deceased.

Achieving schematic change may require many repetitions in the effort to recognize new realities and practice new ways of thinking and acting. Change requires conscious and/or unconscious conceptual processing. After a traumatic event, the person must bring forth different themes related to a central focus, which is how the traumatic event relates to the self. A brief therapy may help the patient *start* schematic change; months later the change may have occurred. In psychotherapy, memories of the stressful event and personal reactions to it are reviewed. By the effects of the therapist's focusing attention, correcting distortions, making linkages, and counteracting defensive avoidances, a new working model of what happened and its implications to the self is developed. The repetition of a working model, gradually changed by more attention to the actual properties of the situations, gradually leads to schematic change. That schematic change is both epigenetic and characterized by the formation of schemas of schemas. Epigenetic development (Erikson, 1963) consists of new acquisitions that are grafted onto previous schemas. Thus the previous schema may gain new elements and more correctly approximate the characteristics of reality.

The schemas of schemas that may be formed are overarching or

supraordinate forms. They integrate previous schemas. By integration, some of the properties of previous schemas can be softened. For example, a schema in which the other person is seen as critical can be softened by incorporating it into a higher symbolic form in which the other person is seen as sometimes helpful and sometimes critical. In other words, schemas change by evolution; they are not erased. The earlier forms remain available, but the more mature overarching forms have relative priority, and so may control the emergence of the less mature schemas. This construction is not the same as the corrective emotional experience; it has been termed a corrective relationship experience or a new learning experience (Horowitz et al., 1984).

Control Process Theory

Control process theory suggests that people use different types of controls to facilitate or inhibit conscious recognition or communication of conflicts between preexisting schemas and the new traumatic situation. A mismatch between old schemas and new situations leads to intense emotional responses. People use avoidance or inhibition to avoid entering distraught states of mind. They may improve work on the traumatic topic when they recover a sense of being in control and can stabilize a well-modulated state even while experiencing negative emotions and the pain of cognitive recognition of loss.

The therapist's choice of technique depends on what type of controls the patient is using, is capable of, or is capable of learning. As already mentioned, if the patient is exerting excessive control, one may want to use a variety of procedures to help him or her reduce the level of avoidance. The procedures include interpretation of what is warded off, why it is warded off, and how the patient might proceed in contemplating such a painful topic. This may help the patient accept the theme of emotional response to the stressful event in a dose-by-dose manner. If, however, the patient is unable to exercise control, then the aim of the therapy may be to help him or her do so; by careful deflection from the emotional heart of a topic, the therapist aims first at helping the patient to enter a working state in which he or she can deal with, rather than be overwhelmed by, memories or fantasies related to the traumatic event and preexisting schemas.

One also must consider fantasies and preexisting schemas because any traumatic event triggers various latent topics into activity. Responses are an array of different associations and concepts that incorporate magical belief systems as well as realistic knowledge schemas. The differentiation of reality and fantasy is an important technique, which elsewhere has been shown to be related to the outcome of brief therapies of stress response syndromes (Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984).

The therapist must pay attention to setting different goals and to using

different levels of interpretation with different types of patients. This issue of levels of interpretation is dealt with elsewhere (Horowitz, 1989), as is the technical variation of general principles with different types of personality styles (Horowitz, 1986; Horowitz et al., 1984). Here the general principles of a treatment approach are outlined by reprinting text from Horowitz (1986, pp. 122-146).

TECHNIQUES OF MODERN PHASE-ORIENTED TREATMENT

Although the various treatment techniques suggested in the past have had their efficacy, they have also had their hazards. Too often the techniques were applied by therapists in a stereotyped rather than a patient-specific manner. During World War II, psychoanalytically oriented psychiatrists tended to use abreactive hypnosis, and “directive organic" types of psychiatrists, as they were then called, tended to use rest and sedation. We now understand the importance of orientation to treatment not by schools but by the immediate situation as well as the phase of response and the character of the patient.

Phases are often determined by the current degree of control over a tendency toward repetition. In general, the rest and support types of treatment try to supplement relatively weak controls. The treatment staff takes over some aspects of control operations, and they reduce the likelihood

of emotional and ideational triggers to repeated representations. In contrast, the abreactive-cathartic treatment reduces controls through suggestion, social pressure, hypnosis, or hypnotic drugs. The long-range goal of the abreactive-cathartic treatment is not to reduce controls, however, but to reduce the need for controls by helping the patient complete the cycle of ideational and emotional responses to a stress event.

Unfortunately, the repertoire of available techniques and theories has never been well classified, though a rudimentary attempt at phase-specific technique classification is presented in table 1, the goal being to convey a general idea, not to recommend particular treatment forms.

TABLE 1

Treatments for Stress Response Syndromes

States	
Denial-Numbing Phase	Intrusive-Repetitive Phase
Reduce controls Interpret defenses and attitudes that make controls necessary Suggest recollection	Supply structure externally Structure time and events for patient when essential Organize information Reduce external demands and stimulus levels Recommend rest Provide identification models, group

	membership, good leadership, orienting values Permit temporary idealization, dependency
Encourage abreaction	Work through and reorganize by clarifying and educative interpretive work
Encourage description Association Speech Use of images rather than just words in recollection and fantasy Conceptual enactments, possibly also role playing and art therapy	Differentiate Reality from fantasy Past from current schemata Self attributes from object attributes Remove environmental reminders and triggers, interpret their meaning and effect
Reconstructions to prime memory and associations	Teach "dosing," e.g., attention on and away from stress-related information
Encourage catharsis	Provide support
Explore emotional aspects of relationships and experiences of self during event	Evoke other emotions, e.g., benevolent environment
Supply support and encourage emotional relationships to counteract numbness	Teach desensitization procedures and relaxation

Source: M. J. Horowitz, *Stress Response Syndromes,* 2nd ed. (Northvale, NJ: Jason Aronson, 1986).

Completing integration of an event's meanings and developing adaptational responses are the goals of treating a stress response syndrome.

One knows that this achievement is near when the person is freely able to think about or to not think about the event. These goals can be broken down according to immediate aims that depend on the patient's current state. When the stress event is ongoing, aims may center on fairly direct support. When the event's external aspects are over, but the person swings between paralyzing denial and intolerable attacks of ideas and feelings, then the immediate aim is to reduce the amplitude of these swings. Similarly, if the patient is frozen in a state of inhibited cognitive-emotional processing, then the therapist must both induce further thought and help package these responses into tolerable doses (see table 2).

TABLE 2

Priorities of Treatment

Patient's Current State	Treatment Goal
Under continuing impact of external stress event	Terminate external event or remove patient from contiguity with it Provide temporary relationship Help with decisions, plans, or working-through
Swings to intolerable levels: Ideational-emotional attacks Paralyzing denial and numbness	Reduce amplitude of oscillations to swings of tolerable intensity of ideation and emotion Continue emotional and ideational support Selection of techniques cited for states of intrusion in Table 1

Frozen in overcontrol state of denial and numbness with or without intrusive repetitions	Help patient "dose" reexperience of event and implications that help remember for a time, put out of mind for a time, remember for a time, and so on. Selection of denial techniques from Table 1 During periods of recollection, help patient organize and express experience. Increase sense of safety in therapeutic relationship so patient can resume processing the event
Able to experience and tolerate episodes of ideation and waves of emotion	Help patient work through associations: the conceptual, emotional, object relations, and self-image implications of the stress event Help patient relate this stress event to earlier threats, relationship models, self-concepts, and future plans
Able to work through ideas and emotions on one's own	Work through loss of therapeutic relationship Terminate treatment

Source: M. J. Horowitz, *Stress Response Syndromes,* 2nd ed. (Northvale, NJ: Jason Aronson, 1986).

Treating Acute Patients in an Intrusive Phase of Response

Most patients seek help for stress response syndromes when they are overwhelmed with intrusive ideas and emotions. The reality of the traumatic events usually contributes, with the patient's sense of urgent need, to the therapist's wish to react rapidly and to provide help. For many physicians and psychiatrists, this urgency may translate into prescribing antianxiety or sedative agents. Although this is sometimes indicated, the availability of the

care provider and the establishment of a treatment program are often sufficient. The act of talking about the events and personal reactions during an extended session often markedly reduces the sense of being overwhelmed. When insomnia is producing fatigue and lowering coping capacity, sedation with one of the antianxiety agents may be used on a night-by-night basis. Smaller doses of the same agent may be prescribed during the day, again on a dose-by-dose basis, if the patient's severely distraught, anxious states of mind challenge adaptive functioning.

The patient and persons close to the patient should be cautioned against using multiple mood control agents, especially against combining alcohol with prescribed medications. Alcohol in small doses may be a sufficient soporific and calming agent without additional medication, but for some patients it may lead to excessive self-dosages. Antidepressive agents should not be prescribed to relieve immediate sadness and despondent responses to loss, but they may be used for prolonged pathological reactions that meet the necessary diagnostic criteria for the major depressive disorders, if psychotherapy alone is not leading to clear, rapid, and progressive improvement.

In addition, in the acute phase of responding to a traumatic event, the patient may be advised, for a time, to avoid driving, operating machinery, or engaging in tasks in which alertness is essential to safety. Persons already

under stress are more likely to have accidents because they have lapses of attention, concentration, and sequential planning or because they have startle reactions that disrupt motor control.

During the intrusive phase, relatives and colleagues may also offer support. Advice that has been useful in the past to the patient can be extended directly or through such social support networks. The following paragraphs, which restate some of the principles already discussed, may be helpful.

1. Remember that the victim remains vulnerable to entering a distraught state of mind, even in states of safety and even weeks after the event. Such distraught states as pangs of searing grief, remorse, terror, or diffuse rage are attenuated or are less likely to occur if the victim is surrounded by supportive companions. The companions should be aware that being there is doing a lot and that helping may not require doing the impossible. Persons who have sustained the same type of trauma are sometimes especially helpful companions, and that is why self-help groups include persons who are at different phases of dealing with similar situations.

2. The more the person has been traumatized, the longer the phases of response will be. After a major loss, considerable revision is necessary in both daily life and inner views of life. This revision may mean that the person is not even relatively back to normal, in terms of usual mood patterns, for a year or two. This contrasts with the expectation in many work

environments that the traumatized person should be back to usual functional levels within a week or two. The work place may provide sustaining interests and social supports so that the victim is not left isolated or encapsulated; yet some modulation of what is expected should extend for longer periods than has become the case in a society driven by work productivity and advancement.

3. Sleep disruption is a common part of posttraumatic stress disorders. The victim comes to associate efforts to relax and sleep with episodes of panic or vivid unpleasant imagery associated with the trauma, especially if it has occurred at times when the victim's guard has been lowered or concentration on daytime activities is reduced. It may be helpful to change habit patterns in whatever way strengthens the sense of safety that permits restful sleep. This may include leaving the room lights on or sleeping with a pet or with another person. In extreme cases, rest can be encouraged by telling the victim that a companion will stay awake and watch over him or her during sleep.

4. The person who has been traumatized may have cognitive impairments of which he or she is not aware. The victim may feel more effective, alert, and reflexively responsive than is actually the case and may be more at risk of accidents while driving or operating machinery. Any kind of drug, such as a single drink of alcohol, may have a more impairing effect on such persons than would usually be the case. For these reasons, advising the victim not to drive or engage in hazardous work tasks is advisable even when the victim

insists this is not necessary. Such limitations must be tactfully imposed so as to avoid anything that might encourage a transition to incompetent self-concepts.

5. Right after a traumatic event, the victim's relatives and friends rightfully cluster around and want to know all about what happened. The victim, often alone at the time of the event, now recounts the story again and again. There is here a paradox, because later on the victim will want to retell the story repeatedly but now, early, is when it is demanded. These many early repetitions may lead to an exhausting reliving of the still vivid experience with all its violent emotional responses. Later the relatives and friends may behave as if they were tired of hearing about it and may counter with their own similar tales of mishap and woe. The victim may then feel pent up with the need to repeat the traumatic experience and to communicate his or her conceptual and emotional responses to it. It is at these later stages that empathic listening, without trying to short-circuit the conversation, may be very useful. Then gradually the victim's attention can be brought first to the present and then to the future.

6. The victim expects to be upset after a trauma, and so when responses come later, after a period of restored good functioning, they come as a surprise and may lead to a fear of losing mental control and unnecessary doubts about recovery. Knowledge about the normal phases, including a return of intrusive ideas and emotions after a period of denial, can be very useful for the victim at this point.

> Sometimes, however, the victim will have a correct intuitive sense of being blocked in working through a trauma. This subjective sense may be usefully echoed by a relative or friend who also recognizes that the reaction is too intense, prolonged, complicated, or impacted. That social communication, in the context of a calm and straightforward discussion, may enable the victim to seek professional help when it is indicated.

In evaluating a patient in an acute, probably intrusive phase of response to a traumatic life event, the clinician should specifically inquire about intrusive experiences, as the patient may find them difficult to describe on his or her own. The clinician then may label symptoms as a normal response to stress in order to reassure the patient that he or she is not losing control of his or her mind. When the patient describes what is intruding into his or her experience, the clinician should encourage him or her to expand on the topic in order to develop further the meaning of the event. Usually nonspecific statements are helpful in encouraging this elaboration; for example, the therapist may ask, "Can you tell me more about that?" "Is there anything else?" "What was it like for you?" and so forth.

While listening to the patient expand on the topic, the clinician should be alert to blocks in thinking or feeling in the next step in a sequence that might lead to some kind of acceptance or closure of the event. For example, thinking about the event's implications may lead to ideas of what caused it.

The patient may think that he or she did something that caused the event, which would lead to feelings of intense guilt, and so he or she may immediately block off this train of thought to avoid experiencing the guilt.

When the clinician discovers a block to working through reactions to a stressful event, he or she may help the patient by looking at the differences between realistic appraisal and fantasy appraisal. For example, if a patient feels that he has brought on a heart attack by harboring angry thoughts toward his boss, it may be important to indicate to him that this was not the cause of the coronary occlusion and that he does not have to blame himself for it. This is not meant to complete the therapy in a single visit but to move toward a hopeful focus for the treatment.

The clinician does not have to be a figure who restores what has been lost. But it is important to the patient that the clinician represent a person who is not overwhelmed by thinking about the implications of some illness, injury, or loss. The very presence of the clinician as a person who is able to contemplate these events and to think about them logically is often extremely reassuring to the patient during an intrusive phase. The denial phase is also an especially important one to consider in relation to treatment interventions. Denial may serve adaptive purposes, allowing the person to restabilize, but it may also interfere with important decisions that may have to be made at once. Health care choices are one example, as with a patient

who has developed gangrene following an accidental electrical burn and must decide immediately how much amputation he will permit.

Time Pressure during a Denial Phase

Intellectualization may be openly advised for the patient as a way to make immediate decisions. For example, the patient may be told that although there will be many emotional reactions to the situation, for the time being it might be best to consider only those problems requiring an immediate choice and to talk them over in terms of advantageous and disadvantageous outcomes. The processes involved in denial may also be labeled so that the patient can understand why it is difficult to concentrate on making a decision. Sometimes it is necessary to accept the patient's inability to make a fully rational decision at the moment because of the specific stress disorder and to explain both the denial phase and the information pertinent to decision making to another person who is accepted by the patient as serving his or her best interests. When this is the case, the therapist should realize that this is a transient assignment, not one that should continue for a long time. Later the patient should be told how and why these decisions were reached.

No Time Pressure during a Denial Phase

Patients may be told that they are pushing away recognition of the event's implications and that this is a normal adaptive reaction. This should be done uncritically, indicating the acceptability of such defensive avoidances. If patients are not, on their own, progressing through a period of denial and numbness, it may be helpful to remind them of the need to make the next adaptive move. The patients may be encouraged to allow a conscious review of memories, and to experience ideas and feelings related to what has passed.

Patients may be urged to take a one-dose-at-a-time approach, contemplating the most immediate consequences of what has happened and perhaps putting off the next considerations for a while. This kind of reassurance indicates to the patients that they can tolerate some aspects of what has seemed intolerable but that they do not have to confront everything all at once. Patients may also be given realistic reassurance that they will eventually be able to tolerate what now seems overwhelming. The example of mourning may be given; it seems intolerable to accept a loss that has just occurred, but people come to accept it over a year or two. It is often helpful in this regard for the clinician to indicate that he or she will remain available to the patient as a support until the patient works through and accepts his or her experience.

TECHNIQUES SPECIFIC TO SHORT-TERM DYNAMIC THERAPY OF RESPONSE SYNDROMES

At the Center of the Study of Neuroses, University of California, San Francisco, my colleagues and I developed a brief psychotherapy for stress response syndromes (Horowitz, 1973, 1976; Horowitz & Kaltreider, 1979; Horowitz et al., 1984). This procedure uses a time limit of twelve sessions which can be varied as required by individual circumstances, characteristics, and responses. A sample of what tends to happen in such therapies is given in table 3.

TABLE 3

Sample Twelve-Session Dynamic Therapy for Stress Disorders

Session	Relationship Issues	Patient Activity	Therapist Activity
1	Initial positive feeling for helper	Patient tells story of event	Preliminary focus is discussed
2	Lull as sense of pressure is reduced	Event is related to previous life	Takes psychiatric history. Gives patient realistic appraisal of syndrome
3	Patient testing therapist for various relationship possibilities	Patient adds associations to indicate expanded meaning of event	Focus is realigned; resistances to contemplating stress-related themes are interpreted
4	Therapeutic alliance deepened	Implications of event in the present are contemplated	Defenses and warded off contents are interpreted, linking of

			latter to stress event and responses
5		Themes that have been avoided are worked on	Active confrontation with feared topics and reengagement in feared activities are encouraged
6		The future is contemplated	Time of termination is discussed
7-11	Transference reactions interpreted and linked to other configurations; acknowledgment of pending separation	The working through of central conflicts and issues of termination, as related to the life event and reactions to it, is continued	Central conflicts, termination, unfinished issues, and recommendations all are clarified and interpreted
12	Saying goodbye	Work to be continued on own and plans for the future are discussed	Real gains and summary of future work for patient to do on own are acknowledged

Source M. J. Horowitz, *Stress Response Syndromes,* 2nd ed. (Northvale, NJ: Jason Aronson, 1986).

When a person seeks help, the therapist establishes a working alliance through which he or she assists the patient in working through his or her reactions. In addition, efforts may be directed at modifying preexisting conflicts, developmental difficulties, and defensive styles that made the person unusually vulnerable to traumatization by this particular experience.

Therapy begins by establishing a safe and communicative relationship. This, together with specific interventions such as an analysis of defensive avoidances and an identification of warded off contents, alters the status of the patient's controls. The patient can then proceed to reappraise the serious life event and the meanings associated with it and make the necessary revisions of his or her inner models of the self and the world. As this reappraisal and revision take place, the person moves into a position to make new decisions and to engage in adaptive actions. The patient can follow any altered behavior patterns until they become automatic. As he or she is able to achieve new levels of awareness, this process is repeated and deepened. That is, as the patient can relate more closely, he or she can modify controls further and assimilate more warded off thoughts about the current stress. There is then the necessity of working through the reactions to the approaching loss of the therapist and the therapy.

Within the time limits of a brief psychotherapy, the therapist works to establish conditions that will help process the painful event. There is an early concern by the patient for both the safety of the relationship and the therapist's ability to help him or her cope with the symptoms. These symptoms can seem less overwhelming when the therapist offers support, suggests some immediate structuring of time and events, and prescribes medication if anxiety or insomnia are too disruptive.

Introducing plans for terminating the therapy several sessions before the final one leads to a reexperience of the loss, often with a return of the symptoms. But this time the loss can be faced gradually, actively rather than passively, and within a communicative and helping relationship. Specific interpretations of the link of the termination experience to the stress event are made, and the final hours center on this theme. At termination, the patient will usually still have symptoms, both because of the time needed to process a major loss and because of anxiety about the loss of the relationship with the therapist.

Patients sometimes become aware during these brief therapies of a particular style they have for *not* thinking about events, and they are able deliberately to alter that avoidance. It may be possible for them, by continued work on their own after therapy, to live out changes that may gradually modify their habitual defenses and attitudes. In this manner, the brief therapy of stress response syndromes follows the techniques of focal dynamic therapy, as described by Malan (1979), Basch (1980), Strupp & Binder (1984), and Luborsky (1984), and may also use special imagery techniques, as described by Singer & Pope (1978) and Horowitz (1983).

When people experience the impact of a serious life event, such as a loss or injury, their most advanced, adaptive role relationships can be threatened. They may regress to earlier role relationships, or the meaning of the life event

itself may create some new role relationship, perhaps with unattractive, dangerous, or undesirable characteristics. Such persons may then enter a series of painful, strongly affective states based on altered self-concepts and role relationship models. As a consequence of the therapeutic facilitation of normal processes, these disturbing role relationships or self-concepts can once again be subordinated to more adaptive, more mature self-concepts and role relationships. Intensive work using this type of brief therapy model may change the symptomatic response to a stressful life event and may facilitate further progress along developmental lines.

Realignment of Focus

Patients will usually have presented painful symptomatology or problematic states as the chief complaint or motivation for seeking help. The first focus or agreement between patient and therapist will be to help attenuate these symptoms or states or to avoid reentry into them. Problematic states will be seen in relation to other states of experience and behavior. A broader analysis of the situation with the patients will include examining the reasons for entering the problem states and other, even more threatening states that are warded off. As painful symptoms are ameliorated, the emphasis may shift to exploring when and why the patient enters these painful states. This revised focus often pertains to particular self-concepts and inner models of relationships. If this shift in focus is not made at the right

time, the patient may move toward termination or avoidance of treatment when he or she achieves enough control to enter a relatively stable denial phase. Separation from treatment at this time may be an error because the patient has not worked through some of the most difficult parts of his or her stress response and may not do so on his or her own.

Example: From a Bereavement Case

The patient was a young woman in her mid-twenties. She sought help because of feelings of confusion, intense sadness, and loss of initiative six weeks after the sudden, unexpected death of her father. Her first aim was to regain a sense of self-control. This was accomplished within a few sessions, because she had found a substitute for the idealized, positive relationship with her father in the relationship with the therapist and realistically hoped that she could understand and master her changed life circumstances.

As she regained control and could feel pangs of sadness without entering flooded, overwhelmed, or dazed states, she began to wonder what she might further accomplish in the therapy and whether the therapy was worthwhile. The focus gradually shifted from recounting the story of her father's death and her responses, to understanding her past and current inner relationship with her father. The focus of therapy became her vulnerability to entering states governed by defective, weak, and evil self-concepts. These

self-concepts related to feelings that her father had scorned her in recent years because she had not lived up to his ideals. He died before she could accomplish her goal of reestablishing a mutual relationship of admiration and respect through her plan to convince him that her own modified career line and life style would lead to many worthwhile accomplishments.

This image of herself as bad and defective was matched by a complementary image of her father as scornful of her. She felt ashamed of herself and angry with him for not confirming her as worthwhile. In this role relationship model, she held him to be strong, even omnipotent, and in a magical way she saw his death as a deliberate desertion of her. These ideas had been warded off because of the intense humiliation and rage that would occur when they were clearly represented. But contemplation of such ideas in therapy allowed her to review and reappraise them, revising her view of herself and of him.

Every person has many self-images and role relationship models. In this patient, an additional important self-image was of herself as a person too weak to tolerate the loss of a strong father. As is common, no life event occurs in isolation from other life changes but is almost invariably part of a cluster of events and effects. After this woman returned from her father's funeral, she turned to her lover for consolation and sympathy. She had selected a lover who, like her father, was superior, cool, and remote. But when she needed

compassionate attention, he was unable to provide it, and they separated. Establishing a therapeutic alliance thus provided much needed support, but its termination threatened her once again with the loss of a sustaining figure. In the midphase of therapy, it therefore was necessary for her to focus on those weak self-images in order to test them against her real capability for independence.

To recapitulate, early in therapy this patient rapidly established a therapeutic alliance around a working focus to relieve her of the acute distress of the intrusive phase of a stress response syndrome, in this case an adjustment disorder. This alliance led to a rapid attenuation of the problematic states of mind. With this symptom reduction, the focus shifted to the aim of working through various aspects of her relationship with her father. In addition to the primary meanings of her grief, that is, the loss of a continued relationship with her father and the hope of changing it, she had to work through several additional themes: herself as scorned by her father, herself as too weak to survive without her father, and herself as evil and partly responsible for his death.

These important self-concepts, present before the death, were worked on during the midphase of therapy. They were related to role relationship models that pertained not only to her father but also to other past figures (mother and jiMings), current social relationships, and transference themes.

As she contemplated and worked with these themes, her focus expanded from past and current versions of these constellations to include additional issues. Were she to maintain these self-concepts and views of role relationships, she might either reject men altogether or continue with a neurotic repetition of efforts to regain her father and convert him to the ideal figure she remembered from early adolescence. This prospective work also included examining her reaction to separation from the therapist and how she would in the future interpret that relationship.

Interpreting Defenses and Transference for a Particular Event

All patients will have a combination of reactions to stress events and their prestress problems. Therapists therefore should attend to the manifestations of characteristic defensive styles and the emergence of transference even during the comparatively brief treatment of a stress response syndrome. What do therapists do with this information? Do they interpret defenses, interpret and try to work through transference? Or do they work around defense and transference to bring the stress-event reactions to a point of completion? Each patient-therapist pair can arrive at a satisfactory end point by means of different routes. Nonetheless, using the gestalt of the stress event can be one of the guiding principles. This means that defensive modifications and self-object dyad interpretations can be made and that they can be centered on the specific contents of the stress-event

memories.

Example of Connection-Forming Interventions.

A young woman had attacks of incapacitating anxiety for months after she was raped. She had flirted with the man and encouraged his advances, but when she wished to go no further in the sexual encounter, he forced her, with threats of violence, to have intercourse. She decided not to report the matter to the police or to a physician. She came for help later because of increased anxiety.

The first work involved her telling the story of how she was traumatized by this man's vicious behavior. This, plus the establishment of a therapeutic relationship, helped reduce her anxiety, but an unclear sense of her own participation remained and required further therapeutic attention.

During psychotherapy she was generally vague in her verbal communication. Nonverbally, there were bodily gestures to which the therapist did not respond but that he found somewhat erotically stimulating. When the therapist failed to show interest in her physical attributes and movements, the patient seemed to feel hurt; she looked dejected, withdrew, and talked in a self-depreciating manner. Despite this reactivity, the patient did not appear to be conceptually aware of her bodily gambits, the therapist's lack of attention to them, or her hurt responses.

Through many such observations of process, the therapist made two inferences. One was that the patient had a repressive/denying and dissociative style. The other concerned a pattern for interpersonal relationships in which she offered an erotic surrender to a domineering other person and expected attention and care in return.

These inferences were not interpreted directly or in terms of the transference manifestations. Instead, they were used as information to help reconstruct the rape and preceding events. The rape was seen as a pattern contributed to by the real but unrecognized assaultive nature of the man involved, her general pattern of relating to men, and her method of avoiding appraisal of this particular man.

In this way, some aspects of the fear, anger, guilt, and shame evoking ideas about the event were worked through. In addition, the therapeutic process allowed some progressive change in the patient's self- and object concepts. For example, one unconscious attitude present before the stress event was that an erotic approach was the only way to get attention because she herself was so undeserving. She must give her body in order to get attention. In work on the meaning of the rape, she became aware of this defective self-concept and related rescue fantasies. She was able to revise her attitudes, including her automatic and unrealistic expectations that dominant others would feel guilty about exploiting her and then be motivated by guilt

to be concerned and tender.

The relatively clear contents of the stress-event memories provided a concrete context for this work. The focus of discussion was outside the therapeutic relationship, although there was a tendency toward a compulsive repetition of the "rapist-raped" relationship in the transference situation. The therapeutic alliance was maintained but might have been disrupted by the anxiety that would have occurred if interpretation of the same self-object transactions had been directed to the transference situation.

At some point, if advisable, it may be possible to extend recognition of the same patterns to the transference, to childhood relationships, and to current interpersonal relationships. That is, this focus on the stress events does not mean that the interpretation of transference is omitted from a stress-focused treatment. But there is no intent to allow a transference neurosis to evolve, and transference interpretations will usually focus on negative responses that are likely to impede therapy.

Example of a Blend of Transference Recognition Focusing on a Recent Stressful Event.

A young woman patient broke her leg in a fall from a ladder while helping her father paint his house. A partial paralysis complicated matters and disrupted her plans to accept a teaching position on graduation from

college. She came to therapy because of a reactive depression. One of the dormant psychological complexes activated by her injury was hostility toward her father for not taking good enough care of her. The relevant theme of the stress event was anger that her father had given her a rickety, second-class ladder while he used a good one. She had, in the past, been unable to recognize her own ambivalence toward her father, even when he gave her good cause to be hostile. Awareness of her anger was warded off at the time treatment began.

During one treatment hour, the emotion closest to the surface was anger at the therapist because he would not prescribe sleeping pills for her insomnia. Though the therapist was able to infer this emotion, it was not recognized or expressed clearly by the patient.

We shall now artificially dichotomize the immediate problem of whether the therapist should interpret the anger in terms of the transference or in terms of the stress event. A therapeutic rule of thumb is to focus on negative transference reactions, such as surfacing anger at the therapist; negative reactions interfere with other therapy processes, and the patient might even quit or withdraw. The problem is not only how to deal with negative transference feelings, so that they are reduced enough for the therapy to progress, but also how to use the information gained to work through the stress event. One way to decide whether to focus on the emergent

anger is the therapist's diagnostic impression of the patient's strength. If the patient is capable of tolerating it, the therapist can interpret what is going on. But if the patient is in danger of fragmentation, as in severe narcissistic and borderline characters, the therapist may not interpret the anger directly, but instead may deal with it in a counteractive way or give it a peripheral interpretation in relation to characters outside the treatment situation.

If the therapist decides to interpret the anger in a fairly direct manner, he or she still must decide which line of interpretation will be the most therapeutic. For example, the therapist can choose among four lines of approach:

1. You are angry with me because you feel that I am not taking care of you, just as your father did not take care of you (interpretation of the transference link to father).

2. You are angry with me and are afraid to express it or even know it (interpretation of the fear of being angry).

3. You are angry with me, and so you withdraw (interpretation of the defensive maneuver).

4. You get angry when your dependency needs are not met (interpretation of underlying wishes).

These are, of course, not the wordings of the interpretations but a shorthand illustration of the various possible directions. In a full segment of work, each

aspect of the interpretation may be made.

Whichever type of interpretation is made first, it may be possible to link the exploration of the anger to the recent stress event, even though the focus remains on working through the immediate negative sentiments toward the therapist. For example, the interpretation may be worded as follows, except that it would be given in short phrases rather than all at once:

> Therapist: You are angry with me right now because I am not meeting your need for a sleeping pill, just as you are still angry with your father because you feel he took poor care of you by giving you a lousy stepladder.

The principal advantage of this type of wording, which links current transference to the model of the stressful event, is that it maintains a conceptual clarity regarding the treatment's goals and priorities. If the focus is on only the transference meanings of a patient-therapist transaction, the transference will be accentuated as a topic of interest to the therapist. Doing some transference work creates more transference work because the therapist's interest in the transference aspects of treatment has an intrinsic transference-evoking effect, a paradoxical cycle. The tendency is toward a character analysis (Oremland, 1972) rather than working through the life event and then terminating or establishing some other therapeutic contract.

Example of Depression after the Death of a Loved One.

During the first three interviews the work focused on a young male patient's feeling that his mother had left him alone by dying. As a result of this work, his feelings of intense loneliness decreased. The pain and threat of his loss had been reduced to a level at which his available defensive and coping strategies could inhibit further emotional responsivity. During the ensuing interviews, his feelings of sadness and ideas of being left were absent.

Despite the symptomatic relief, the therapist inferred that the stressful event had not been completely worked through but, rather, had only been worked on to the point that denial and numbness had become possible. At this point in treatment, as is common, the patient searched for topics to discuss because he did not want to lose the therapist through treatment termination. That is why in one hour he brought up a current problem, an argument the night before with his girlfriend.

There was no doubt that the emotion nearest the surface was anxiety about the argument, and the therapist gave his attention to this situation. But in his interventions he chose not to explore in detail the relationship between the patient and his girlfriend because he felt it would deflect the therapeutic path to interpersonal relationships in general and from there into a long-term therapy. Instead, he linked the patient's fears of losing his girlfriend to the recent loss of his mother by saying, "Another loss might be very hard for you to contemplate right now."

This remark was enough to link the young man's current emotional state to the incompletely processed stress event. Through such maneuvers, it was possible to avoid diffusion of the therapy to many topics. With this patient, a decision to attempt a general characterological revision might be made after more work on the loss.

These case examples do not mean that the work of relating the meaning of subsequent occurrences to the stress event can be forced. In some patients, especially adolescents or young adults, loss of a parent or sibling may be worked on only to a point that denial can set in. Then the implications of the loss are vigorously inhibited, and attempts at connection, such as illustrated here, will not succeed. In such instances, the therapeutic goal must be reconsidered, the defenses accepted, and the patient either seen over a considerable period of time with a therapeutic strategy or terminated until later work is indicated.

EMPIRICAL SUPPORT

My colleagues and I have developed a series of measures useful for assessing the outcome of such treatments, the disposition of patients, the process of therapy, and the interaction of these variables. These include the Impact of Event Scale, which offers specific stress measures for self-report (Horowitz, Wilner & Alvarez, 1979; Zilberg, Weiss & Horowitz, 1983); the

Stress Response Rating Scale, which measures the clinician's assessment of current stress levels (Weiss, Horowitz & Wilner, 1984); and the Patterns of Individualized Change Scales (PICS), which assess social and work functions as well as self-esteem and specific stress symptoms (Kaltreider, DeWitt, Weiss & Horowitz, 1981; DeWitt, Kaltreider, Weiss & Horowitz, 1983; Weiss, DeWitt, Kaltreider, & Horowitz, 1985).

The therapeutic process measures pertinent to this approach to psychotherapy include assessments of the therapeutic alliance (Marziali, Marmar & Krupnick, 1981; Marmar, Marziali, Horowitz & Weiss, 1986) and the assessment of specific therapist interventions on a therapist actions scale or checklist (Hoyt, 1980; Hoyt, Marmar, Horowitz & Alvarez, 1981). These process scales, the assessment of patients' motivations for dynamic psychotherapy (Rosenbaum & Horowitz, 1983), and the developmental level of the self-concept (Horowitz, 1979; Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984) rely on independent opinions of judges reviewing videotapes, audiotapes, or transcripts and have been found to be reliable at satisfactory levels.

Using all such measures in the study of fifty-two cases of pathological grief reactions after the death of a family member, we examined the results of a twelve-session, time-limited brief dynamic psychotherapy of the kind just described (as reported in detail in Horowitz et al., 1981). Before treatment,

this sample had levels of symptoms comparable with those of other outpatient samples in treatment research. The SCL-90 is perhaps the most widely used measure of symptomatic distress and thus provides a valuable benchmark. The mean total pathology score at intake on the SCL-90 for the sample was 1.19 (SD = 0.59). This level is almost identical with the figure of 1.25 (SD = 0.39) reported by Derogatis, Rickels, & Rock (1976) for a sample of 209 symptomatic outpatients analyzed in a validation study of this measure. The mean depression subscale score in our sample at intake was 1.81, and in the Derogatis et al. study it was 1.87. The scores for anxiety were also comparable: 1.39 in our sample and 1.49 in the sample of Derogatis et al.

A significant improvement was seen in all symptomatic outcome variables when pretherapy scores were compared with follow-up levels. These findings are given in table 4. The results are also expressed in terms of the standardized mean difference effect-size coefficient recommended by Cohen (1979) for before-and-after data. He defined a large effect as 0.80 or greater. Our large effect sizes were in the domain of symptoms and ranged from 1.21 to 0.71. Changes in work and interpersonal functioning (PICS relationship composite) and the PICS capacity for intimacy were more moderate.

The approach to brief dynamic therapy described here was also successfully adapted to the treatment of depression by Thompson, Gallagher,

and Breckenridge (1987). In their study, brief dynamic therapy reduced depressive symptoms in elderly adults significantly and was equal in effectiveness to both cognitive and behavioral treatment conditions.

Table 4

Outcome Variable Means at Time of Pretherapy and Posttherapy Follow-up Assessments

Primary Distress Measures	Pretherapy Score, Mean	(SD)	Posttherapy Score, Mean	(SD)	No.	t	p	Effect Size (SD Units)
Self-report								
Stress specific Intrusion(IES)	22.1	(7.6)	12.9	(8.0)	48	8.53	<.001	1.2
Avoidance (IES)	19.1	(9.8)	8.7	(8.5)	49	5.15	<.001	0.9
General Anxiety (SCL)	1.4	(0.8)	0.7	(0.6)	48	6.40	<.001	0.9
Depression (SCL)	1.8	(1.0)	1.0	(0.8)	48	6.41	<.001	1.0
Total Pathology (SCL)	1.2	(1.6)	0.7	(0.5)	48	6.90	<.001	0.9

Evaulating Clinician Report								
Stress specific Intrusion (SRRS)	17.6	(9.9)	9.7	(8.1)	49	5.15	<.001	0.7
General Total neurotic pathology (BPRS)	15.6	(5.4)	11.0	(6.2)	49	5.03	<.001	0.7
PICS, Independent Clinician Judgments								
Stress symptoms composite	3.6	(0.6)	4.7	(1.1)	43	–6.56	<.001	1.0
Relationship composite	4.2	(1.1)	4.6	(1.0)	44	–2.29	.027	0.4
Intimacy capacity	3.4	(1.6)	4.1	(1.6)	42	–3.65	.001	0.6

Note: IES indicates Impact of Event Scale; SCL, 90-item Hopkins Symptom Checklist; SRRS, Stress Response Rating Scale; BPRS, Brief Psychiatric Rating Scale; and PICS, Patterns of Individual Change Scales.

Source: M. J. Horowitz, Stress *Response Syndromes*, 2nd ed. (Northvale, NJ: Jason Aronson, 1986).

Time-Unlimited Psychotherapy

Complex, delayed, or chronic stress response syndromes are probably best treated within a time-unlimited format. The same applies to persons with posttraumatic stress disorders in the context of a personality disorder, especially those personality disorders characterized by vulnerability to the coherence and stability of self organization. Even in such extended psychotherapies, however, a focus on working through the traumatic events and the reactions to them may be usefully preserved. This brings into question the level of interpretation to be used during such therapies.

In general, the approach advised is one that begins at the surface, is anchored to the traumatic events, and gradually extends to related issues at a pace that is tolerable and useful to the patient.

Levels of Interpretation

Levels of interpretation range from surface to depth, as shown in table 5. At the top of the table the first of eight levels from surface to depth is called "Stressors and stress responses" and at the bottom of the table is "Warded off unconscious scenarios and impulsive agendas." In general, the shorter the therapy is and the more disturbed the patient is in his or her organizational level of inner working models of self and relationships, the longer the therapist must deal with the surface levels.

Any of the levels of attention that the therapist uses in helping the

patient establish a focus and goals for the treatment and in organizing sequences of his or her own interventions may focus on current situations, the in-treatment situation, and/or past historical and developmental events. Some aspect of the focus at a given level is also offered for each of these sectors in table 5.

Crisis intervention (Caplan, 1961; Jacobson, 1974; Kutash & Schlesinger, 1980) often successfully enables a patient to get through a crucial strain while staying at the top level of table 5. Establishment of the connection also enables the patient to examine experiences in a way that was too overwhelming to do alone or in an existing social network. Usually, dynamically oriented psychotherapy, however brief, advances to at least the next level of analysis, at which pending coping choices and conscious scenarios are examined. This includes a variable attention to current situations outside and inside the therapy and to varied clarifications of previous patterns. However it is done, this level of interpretation requires confrontation with conflicts: conflicting aims regarding how to master and integrate the recent stressors, dilemmas regarding how much to expose to the therapist, and possibly how goal conflicts and habitual conundrums relate to a current impasse in progressing toward the completion of reaction to a recent trauma.

Table 5

		Level of Analytic Focus		
	Content Areas	Current Situation	Therapy Situtation	Past
Link between external situation and personal responses	1. Stressors and stress responses	Intentions of how to respond	Expectations of treatment	Relevant experiences of previous stress events
	2. Pending coping choices and conscious scenarios	Conflicting aims of how to respond	Dilemma analysis of what to deal with first	Longstanding goals and habitual conundrums
	3. Avoidance of adaptive challenges	Threat and defense	Resistance to working through a conflicted issue	History of self-impairing character traits
Link between current problems and longstanding, individualized personality patterns	4. Repertoire of states of mind	Triggers to entry into problem states or exit from symptomatic states	States of therapeutic work and nonwork	Habitually problematic and desired states
	5. Expressed irrational beliefs	Differentiation of realistic from fantastic associations and appraisals		
	6. Repetitive	Interpersonal	Difference	Abreaction or

maladaptive interpersonal behavior patterns	problems and self-judgments	among social alliances, transferences, and therapeutic alliances	reconstruction of traumas and strains in relationship
7. Self-concept repertoires and role relationship models	Views of self and others	Differences among social alliances, transferences, and therapeutic alliances	Development of role relationship models
8. Warded off unconscious scenarios and impulsive agendas	Urges, dreams, and creative producs	Regressive, intense transferences	Episodes of regression that uncovered warded off aims in the past

Source: M. J. Horowitz, Stress Response Syndromes, 2nd ed. (Northvale, NJ: Jason Aronson, 1986)

As the patient can tolerate it and requires it to achieve maximal adaptation to a traumatic event, the therapist can deepen the analysis of conflicts. Frequently, especially in chronic or blocked passage through the phases of response to stressful life events, the patient will require some interpretation and confrontation with avoidance of the adaptive challenges carried from the event to current life-plan decisions. The threats projected to occur, were these avoidances set aside, can be analyzed with a focus on external situations. The resistances to discussing topics and emotions during the therapy can be interpreted, and when indicated, these can be related to

enduring and self-impairing character traits. Often, with the development of a sense of safety based on evolution of a therapeutic alliance, the patient alone will set aside many avoidances and resistances, but the linking of these to enduring character traits usually requires accurate observation and labeling by the therapist as the facilitator.

Unless the stress response syndrome is relatively simple, most dynamic psychotherapists will find it advantageous to deepen the level of interpretive work to include the patient's repertoires of mental state, irrational beliefs, and repetitive interpersonal behavioral patterns, insofar as these relate to (1) predispositions to the person's reaction to the event, (2) the actual current signs and symptoms of the stress response syndrome, and (3) current impediments to optimal adaptive life changes set in motion by the event.

Examining the patient's repertoire of states of mind allows the patient to put the symptoms of the stress response syndrome in a broader personal context and to study the specific triggers to activating the state of mind that contains the symptom. The importance of doing this in instances of chronic stress response syndromes cannot be overemphasized, because it leads the way to understanding the link between the past trauma and current realities and the occasional use of the past trauma as a screen that both depicts current conflicts and yet symbolically obscures aspects of their immediacy.

Example of a Screening Function

The patient was a seventy-year-old man who had been a civilian worker in the Philippines at the time of the Japanese invasion in World War II. He was interned in a concentration camp throughout the war, where he both experienced and witnessed atrocities. For several periods he helplessly anticipated his own death with panic and anguish. He also felt murderous rage states well up in him, but he had to contain any sign of hostility in response to provocations, in order to increase his chances of survival. Periodically, in the nearly forty years that had passed since his release, he had nightmares in which he relived aspects of these experiences. These usually were accompanied by panicky feelings but occasionally had surges of raw hatred as their affective components. Recently, the nightmares had increased in frequency, and he had other depressive symptoms. When these mental states were analyzed, he was found to vary in the degree to which he would enter a state of anger in which he struggled to control hostile expressive urges. His retirement had placed him in family circumstances in which he was goaded and humiliated by a son-in-law who wanted him to move out of a room he had in his daughter and son-in-law's house. When this happened, he was more likely to have the nightmares of his World War II experiences. Treatment did not eliminate these nightmares but did attenuate the overall situational difficulty, symptom picture, and frequency of sleep disruption.

The longer the time is from the stressor event to the present therapy, the more likely it is that the stress-event syndrome will involve complex problems of maladaptive interpersonal behavior patterns. There is a lock-in across levels of interpretive work, so that work at the surface levels will help maladaptive patterns based at the organizers of meaning at deeper levels. Early work in therapy may lead to improved interpersonal relationship patterns without proceeding to interpretive work at the level of self-concepts; role relationship models; and unconscious fantasy scenarios, scripts, and life agendas. Nonetheless, in complex cases the work is often necessary, and complex cases are the ones most often seen by dynamically trained psychotherapists; the simpler ones have already been treated. Thus, in the middle phase of therapy, the therapist may reformulate the case in terms of what has been learned thus far and deepen the level of interpretive work. This will mean exploring the usually unconscious meaning structures involved in forming views of self and others, including self-critical functions and their derivatives from developmentally important relationships.

SUMMARY

The treatment of stress response syndromes is centered on completing the information-processing cycles initiated by the stress event. The phase of stress response is recognized in an informed interview for signs and symptoms, and the treatment techniques are used according to the current

phase, in order to move forward. Sometimes this includes facilitation of warding off maneuvers, just as at other times the patient will be helped to set aside unconscious defensive operations. Transference and core neurotic conflicts will be a part of the therapeutic work but will often be interpreted according to their real relationship to the current stress. This will permit a clear focus for brief therapy. The nuances of the therapy technique, beyond the general strategies, will depend on the patient's and the therapist's character styles.

References

Basch, M. (1980). *Doing psychotherapy.* New York: Basic Books.

Caplan, G. (1961). *An approach to community mental health.* New York: Grune & Stratton.

Cohen, J. (1979). *Power analyses for the social and behavioral sciences.* New York: Academic Press.

Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self report scale. *British Journal of Psychiatry, 128,* 280-289.

DeWitt, K., Kaltreider, N., Weiss, D., & Horowitz, M. (1983). Judging change in psychotherapy: The reliability of clinical formulations. *Archives of General Psychiatry, 40,* 1121-1128.

Erikson, E. (1963). *Childhood and society.* New York: Norton.

Horowitz, M. J. (1973). Phase-oriented treatment of stress response syndromes. *American Journal of Psychotherapy, 27,* 606-615.

Horowitz, M. J. (1976). *Stress response syndromes.* 2nd. ed. 1986. Northvale, NJ: Jason Aronson.

Horowitz, M. J. (1979). *States of mind.* New York: Plenum.

Horowitz, M. J. (1983). Post-traumatic stress disorders. *Behavioral Sciences and the Law, 1,* 9-23.

Horowitz, M. J. (1987). *States of Mind: Configurational analysis of individual psychology* (2nd ed.) New York: Plenum.

Horowitz, M. J. (1988). *Introduction to psychodynamics: A new synthesis.* New York: Basic Books.

Horowitz, M. J. (1989). *Nuances of technique in dynamic psychotherapy.* Northvale, NJ: Jason Aronson.

Horowitz, M. J., & Kaltreider, N. (1979). Brief therapy of stress response syndromes. *Psychiatric Clinics of North America, 2,* 365-378.

Horowitz, M. J., Krupnick, J., Kaltreider, N., Wilner, N., Leong, A., & Marmar, C. (1981). Initial psychological response to parental death. *Archives of General Psychiatry, 38,* 316-323.

Horowitz, M. J., Marmar, C., Krupnick, J., Wilner, N., Kaltreider, N., & Wallerstein, R. (1984). *Personality styles and brief psychotherapy.* New York: Basic Books.

Horowitz, M. J., Marmar, C., Weiss, D., DeWitt, K. N., & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions. *Archives of General Psychiatry, 41,* 438-448.

Horowitz, M. J., Marmar, C., Weiss, D., Kaltreider, N., & Wilner, N. (1986). Comprehensive analysis of change after brief dynamic psychotherapy. *American Journal of Psychiatry, 143,* 582-589.

Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A study of subjective stress. *Psychosomatic Medicine, 41(3),* 209-218.

Hoyt, M. (1980). Therapist and patient actions in "good" psychotherapy sessions. *Archives of General Psychiatry, 37,* 159-161.

Hoyt, M., Marmar, C., Horowitz, M. J., & Alvarez, W. (1981). The Therapist Action Scale and the Patient Action Scale: Instruments for the assessment of activities during dynamic psychotherapy. *Psychotherapy: Theory, Research, and Practice, 18,* 109-116.

Jacobson, G. F. (1974, June). The Crisis Interview. In *Comparative psychotherapies.* Symposium conducted at the University of Southern California School of Medicine, Department of Psychiatry, Division of Continuing Education, San Diego.

Kaltreider, N., DeWitt, K., Weiss, D., & Horowitz, M. J. (1981). Pattern of individual change scales. *Archives of General Psychiatry, 38,* 1263-1269.

Kutash, I. L., & Schlesinger, L. B., (1980). *Handbook of stress and anxiety.* San Francisco: Jossey-Bass.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* New York: Basic Books.

Malan, D. H. (1979). *Individual psychotherapy and the science of psychodynamics.* London: Butterworth.

Marmar, C., Marziali, E., Horowitz, M. J., & Weiss, D. (1986). The development of the therapeutic alliance rating system. In L. Greenberg & W. Pinsoff (Eds.), *Research in psychotherapy.* New York: Guilford.

Marziali, E., Marmar, C., & Krupnick, J. (1981). Therapeutic alliance scales: Development and relationship to therapeutic outcome. *American Journal of Psychiatry, 138,* 361-364.

Oremland, J. D. (1972). Transference cure and flight into health. *International Journal of Psychoanalytic Psychotherapy,* 1, 61-75.

Rosenbaum, R., & Horowitz, M. (1983). Motivation for psychotherapy: A factorial and conceptual analysis. *Psychotherapy: Theory, Research and Practice, 20,* 346-354.

Singer, J. L., & Pope, K. S. (Eds.). (1978). *The stream of consciousness: Scientific investigations into the flow of human experience.* New York: Plenum.

Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy.* New York: Basic Books.

Thompson, L. W., Gallagher, D., & Breckenridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. *Journal of Consulting and Clinical Psychology, 55,* 385-390.

Weiss, D., DeWitt, K., Kaltreider, N., & Horowitz, M. (1985). A proposed method for measuring change beyond symptoms. *Archives of General Psychiatry, 42,* 703—708.

Weiss, D., Horowitz, M., & Wilner, N. (1984). Stress Response Rating Scale: A clinician's measure. *British Journal of Clinical Psychology, 23,* 202-215.

Zilberg, N., Weiss, D., & Horowitz, M. J. (1982). Impact of Event Scale: A cross validation study and some empirical evidence. *Journal of Consulting and Clinical Psychology, 50,* 407-414.

Notes

[1] Copyright 1989 Center for the Study of Neuroses, UCSF. Research on which this material is based has been supported by The Program on Conscious and Unconscious Mental Processes of the John D. and Catherine T. MacArthur Foundation and a Clinical Research Center and other grants from NIMH, each directed by the author.

This chapter appeared in slightly altered form in Horowitz, M. J. (1976,1986). *Stress response syndromes*. (Northvale, NJ: Jason Aronson) and is reprinted here with the permission of the publisher.