Brief Psychotherapy of Stress Response Syndromes

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Brief Psychotherapy of Stress Response Syndromes[1]

Stress response syndromes are neurotic reactions to serious life events such as loss or injury. The signs and symptoms include episodes characterized by intrusive ideas, feelings or behavior, as well as episodes which include periods or ideational denial, emotional numbing, and behavioral constriction (5). Preexisting sets of meaning, conflicts, and develop mental problems are invariably incorporated into how a person responds to the life event in question. When indicated by the severity or persistence of the reaction, brief psychotherapy can provide both symptom relief and restoration of ongoing personal development. We plan to present here the goals of such brief therapy and several aspects of the related technique.

Stress Response Syndromes

The word "stress" has connotations ranging from the aggravations of everyday life to the physiologic response states produced by acute and chronic trauma. Here, we discuss stress response syndromes as personal reactions when a sudden, serious life event triggers internal responses with characteristic symptomatic patterns. All persons would be expected to have some reaction to a disruptive event, such as the death of a loved one or a personal injury. Here we focus on responses that, because of intensity or special qualities, reach a level of painful neurotic symptomatology, that interfere with the integration of the event into the life schemata and thus lead the person to seek help. For several years, we have been evaluating and treating such patients in a special outpatient clinic at Langley Porter Institute, University of California at San Francisco. Our experience, theoretically drawing on the work of others (1, 9, 11, 12, 13) has led to formulation of a specific therapeutic strategy based on a pattern of phases and

modified by individual character style.

Phases of Response

As reviewed elsewhere (5), a sudden, serious life event may evoke a predictable pattern of response. The affected person may react with an outcry, such as “Oh no, no. It can’t be true,” or appear stunned and unable to take in the meanings of the loss. Especially in situations where the person has sustained a physical injury and must get help, or has to carry out functions such as planning for a funeral, there is often a phase of effective, well-controlled behavior. Over time, the multiple painful meanings of the event and its disruption of the patient’s homeostasis leads to other, less well controlled states of mind.

Particularly prominent is a state of mind characterized by intrusive symptomatology: unbidden thoughts, images, nightmares, pangs of emotion and compulsive behavior. The attempt to deflect such experiences may lead to avoidant symptoms such as conscious warding off of thoughts about the event, isolation of affect, overactivity and overt denial of the meaning and consequences of the loss. Eventually, the implications of the event are worked through, leading to relative completion of the stress response. This rough delineation of phases, with normal and pathological variations, is found in Figure 1. The typical signs and symptoms of the denial and intrusion phases are found in Table 1 and Table 2.

Figure 1
Stress Response States and Pathological Intensification

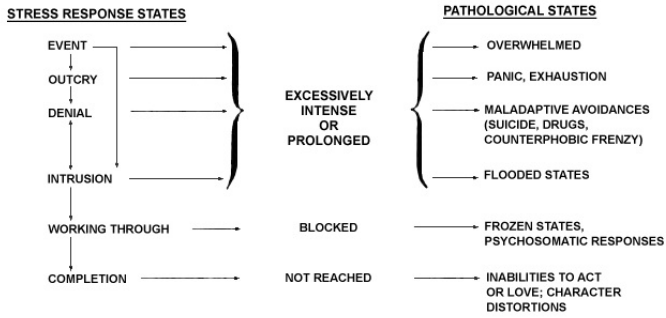

Table 1
Denial Phase

PERCEPTION and ATTENTION	Daze Selective inattention Inability to appreciate significance of stimuli
CONSCIOUSNESS	Amnesia (complete or partial) Non-experience
IDEATIONAL PROCESSING	Disavowal of meanings of stimuli Loss of reality appropriateness Constriction of associational width Inflexibility of organization of thought Fantasies to counteract reality
EMOTIONAL	Numbness
SOMATIC	Tension-inhibition type symptoms
ACTIONS	Frantic overactivity to withdrawal

Table 2
Intrusiveness Phase

PERCEPTION and ATTENTION	Hypervigilance, startle reactions Sleep and dream disturbance
CONSCIOUSNESS	Intrusive-repetitive thoughts and behaviors (illusions, pseudo-hallucinations, nightmares, ruminations and repetitions)
IDEATIONAL PROCESSING	Overgeneralization Inability to concentrate on other topics, preoccupation Confusion and disorganization
EMOTIONAL	Emotional attacks or “pangs”
SOMATIC	Symptomatic sequelae of chronic fight or flight readiness (or of exhaustion)
ACTIONS	Search for lost persons and situations, compulsive repetitions

Pathological Response

The pathological stress response syndrome is one that is prolonged, blocked, or exceeds a tolerable intensity. In other words, pathology is usually not the result of some qualitatively different response, but rather of responses that are of such magnitude that the person requires help, or they are responses that do not progress towards adaptive completion over an extended time. At this point, referral of the patient for psychotherapy is indicated.

A case vignette will be used as an example of a stress response syndrome.

> The patient was a 21-year-old female Italian-American college student referred to the Stress Clinic from a local general hospital. Twelve days previously, she and her finance were shot by her father, who disapproved of their relationship. Before losing consciousness, the patient recalled watching her fiancé fall to the ground and remembered seeing her father shoot himself. She awoke in the hospital and was told that both her fiancé and her father were dead. She had had surgery for a bullet imbedded in her skull with no impairment remaining other than recurrent headaches and dizziness. She reacted with disbelief, felt "numb," and spent most of the next several days ignoring the event and focusing on physical sequelae from the shooting. Three days prior to discharge, she began having recurrent, unbidden images of the shooting and her life with her fiancé. She also experienced anxiety attacks, crying spells, difficulty falling asleep, and night terrors. These continued until the day after discharge, when she came to the Stress Clinic.
>
> The patient was raised by her mother, whom she describes as hardworking but critical and sometimes emotionally distant. She had no siblings. Her father left the family when she was a few weeks old. The patient always believed he left because she wasn't born a male, an idea reinforced by her mother. She did not see her father until she was in high school, when he made a visit to her home city. She was immediately disappointed, describing him as "seedy-looking, crude, and macho." Although he sent her money and gifts and tried to visit her over the next few years, she managed to avoid him. After several months without communication, the father suddenly reappeared on the day of the shooting. The patient felt that he had learned about her and her relationship with her fiancé through "cronies" sent out to spy on her.
>
> The patient met her fiancé during their first year in college. He was a pre-med student, and she described him as extremely bright, well-liked, kind, and understanding. His intellectual interests motivated her to do better in school; in time, his influence awakened her interest in medicine. The patient described their relationship as unique in her life, in that she had not generally attracted many men since she was always a "tomboy" and preferred to dress "like a boy." Her only other serious boyfriend was someone she had dated for a few months in high school until he left her for another girl (8).

The pattern of treatment of this case will be examined in mote detail later on.

Treatment of Stress Response Syndromes

Goals

If we see the goal of brief therapy as working through a recent serious life event and all its related personal issues to a point of completion, then we can state three goals for therapy that are orienting ideals rather than generally achieved aims.

1. Despite the fact that a person may have experienced a loss or an injury, an ideal goal would allow him to retain a sense of his competence and self-worth. In doing so he would have to accept whatever unalterable limitations were placed on his life plans. This should be done without loss of hope or a sense of meaning in his life.

2. The person should continue realistic and adaptive action. This would include maintenance of available relationships and development of new, adaptively useful ones.

3. In terms of long-range experience and behavior, an ideal goal for completion of working-through reactions to a serious life event would be the use of that opportunity, even with its inevitable losses, for some type of growth.

The Pattern of Treatment

After a serious life event, persons usually reconsider the meanings and plans for response to that event in a manner that is systematic, step by step, and dosed. When emotional responses become excessive, or threaten flooding, the person initiates control operations. The intrinsic property of recollection of the unfinished processing of sets of meanings will tend to counteract these controls. When the person cannot handle both the repetition compulsion (3) and the defensive counters (2), he seeks help. The therapist, after establishing a working

alliance, assists the person in working through his natural responses to the event and the overall situation. In addition, efforts may be directed at modification of preexisting conflicts, developmental difficulties, and defensive styles that made the person unusually vulnerable to traumatization by this particular experience.

Therapy is dependent, in part, on establishing a safe relationship. Once this is done, work within the therapy alters the status of the patient's controls. With a safe relationship and gradual modification of controls, the patient can then proceed to reappraise the serious life event, as well as the meaning associated with it, and make the necessary revisions of his inner models of himself and the world. As reappraisal and revision take place, the person is in a position to make new decisions and to engage in adaptive actions. He can practice the altered models until they gradually become automatic. Overlapping with these processes is the necessity of working through reactions to the approaching loss of the therapist and the therapy.

As the person is able to accommodate to new levels of awareness, this process repeats itself. When he can relate in a still more mutual and intimate manner, he can examine himself more deeply, and controls can be modified further. Additional work of this sort may modify aspects of character structure.

Within the time limits of a brief psychotherapy, the therapist works to establish conditions which will be helpful to the processing of the painful event. There is an early testing by the patient both of the safety of the relationship and the therapist's ability to help him cope with symptoms. Most commonly, patients will seek help for intrusive symptoms. These symptoms can seem less overwhelming when the therapist provides support, suggests some immediate structuring of time and events, prescribes medication if anxiety or insomnia is too disruptive, and gives "permission" for the patient to work his feelings through one step at a time rather than as quickly as possible.

Patients who are more handicapped by their avoidance symptoms can be

helped by encouragement from the therapist to recollect the stress event with associations and abreactions, while working towards changing attitudes that made the controls necessary.

Frequently, symptoms subside rapidly with the establishment of a good working alliance. Then therapy can focus on the relationship of the stress event to the patient's various self-concepts.

Introduction of the plans for termination several sessions before the final one leads to a reexperience of loss, often with a return of symptomatology. But this time loss can be faced gradually, actively rather than passively, and in a communicative, 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 due, in part, to the time needed to process a major loss and to anxiety about the loss of the relationship with the therapist. Follow-up evaluations suggest to us that the therapy serves as a catalyst for both symptomatic and structural change over the ensuing year or more. This very global and generalized overview is diagrammed in Figure 2, for a modal 12-hour therapy.

Figure 2
Examples of Timing in Brief Psychotherapy

Sessions	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
Relationship Issues	Initial positive feeling for helper	Lull as sense of pressure reduced	Patient tests therapist	Therapeutic alliance deepened			Transference reactions interpreted, when seen and indicated, and linked to other configurations					
Patient Activity	Patient tells story of the event	Event related to life of patient	Patient adds associations	Work on avoidances			Working-through focus and termination					
Therapist Activity	Preliminary focus discussed	Therapist takes psychiatric history	Realignment of focus		Termination time discussed					Clarification of unfinished issues with recommendations		

Illustration of Treatment Course

The pattern of treatment in the case previously presented can new be considered, followed by a closer look at selected facets of the treatment process. The patient previously described was seen for 21 sessions over a period of about four months. No time limit was set at treatment onset, although there was a clear intent to complete a brief therapy. During the first three sessions, her symptoms gradually decreased as she regained control over her actions and thoughts. Following this, she avoided discussing the stress event. She also avoided encounter with angry feelings toward her father and any sense of loss of her fiancé. Instead, she focused on minor physical sequelae from her injuries and spoke idealistically of her fiancé as if he were still alive.

Although she began reexperiencing anxiety, anger, and intrusiveness just prior to and during her therapist's two-week vacation, which occurred one month after she began treatment, these symptoms disappeared on his return. The patient spent much of the next two sessions discussing her plans to return to school in another city. The night before she was to leave (two months after the stress event), she dramatically called her therapist at home, saying she was fearful and anxious about returning to the place where she and her fiancé had spent so many happy months. She admitted that part of her motive in leaving was to prove to herself she could "hack it." She calmed down as she spoke to her therapist and reaffirmed her intent to leave. One week later, she again called her therapist and stated she was experiencing anxiety and intrusive thoughts of her fiancé, and had decided to return to continue therapy.

Over the next month and a half, the patient first denied and then began dealing with feelings of anger and self-blame over the death of her fiancé. She began making connections between the two separations from her therapist, the permanent loss of her father and fiancé as a result of the shooting, and the emotions that resulted from "causing" her father to leave the family when she

was an infant. She discussed her feelings and viewed her fiancé's death in terms of its realistic meaning. She expressed a desire to date other men, discussed feelings of guilt at being unfaithful to the memory of her fiancé and expressed warm feelings for her therapist.

During the patient's intrusive stages, the therapist was supportive and encouraged her to reduce external demands. For example, she was encouraged to delay enrolling in school because it might activate painful memories. An anti-anxiety agent was prescribed when needed for occasional symptomatic relief. The therapist often tried to help her organise her thoughts. Once, when she felt she was "going crazy" because of intrusive thoughts, the therapist helped her put these thoughts into perspective by relating them to the severity of the stress event and to the universality of this type of response to stress. During the avoidance stages, when the patient eluded discussion of the importance of the stress event, the therapist focused on the event and encouraged her to be aware of her emotions and make associations to past conflicts. It was sometimes necessary to interpret her use of denial and relate it to its defensive purposes.

The patient had several dynamic conflicts triggered by the stress event. She had a long history of losses related to men, beginning with her father's abandonment and continuing with her difficulty in maintaining relationships with boyfriends. She blamed herself for her father's desertion and felt both angry and guilty at his leaving. The stress event caused her to lose the two significant men in her life, thus reactivating the theme of loss and its attendant unresolved conflicts. This theme was again demonstrated in the transference during the two separations from her therapist, and was reviewed for reality-fantasy comparison in that context.

In addition to these object loss issues, the bodily injury she suffered in the shooting also activated old themes. Her tomboyish dress and manner represented a reaction to the anxiety and insecurity she felt at being born a female. She had always been concerned with her body image. As a result of the

stress event, she not only had real physical sequelae, but, after her hair was shaved off for skull surgery, she was often mistaken for a male. These old areas of conflict were explored during the course of therapy in relation to themes associated with the recent stress events.

The final two sessions were devoted to issues of termination. The patient exhibited some transient anxiety at leaving her therapist but was able to admit she was feeling much better and was "ready to go" (8).

Relationship Issues

If we think of a person as coming in after a loss: to the self (as in surgical removal of an organ); of another person (as in the response to the death of a loved one); or after a work situation (as in being fired), then it is obvious that he will test the therapist to see if the therapist will deplete, leave, or insult him. He consciously (and/or unconsciously) will also want to see not only if the therapist is competent to help, but if the therapist will go beyond helping him with this problem to personally replace that which has been lost.

We see the therapeutic alliance as a pathway, with other potential relationships falling to either side. On one side lies the social relationship used as a deflection from work; on the other side of the pathway lies the potential for various transference relationships.

Instead of beginning to communicate the kinds of ideas and feelings that he has been avoiding on his own, the patient may attempt to engage the therapist in ordinary levels of social discourse. He may do this by telling his story, by maintaining a kind of bantering manner, or by trying to find out details about the therapist's personal life and experience with similar life events.

When there is stress response syndrome where the person wears the badge of a recent serious loss, he may tend to do the social things naturally done at those times, such as requesting sympathy and advice on how to manage. To some

extent, these requests are realistic, but they also may be tests to see if the therapist expects the relationship to go beyond ordinary social interchange. As the patient tests to see if he is going to be expected to deepen the relationship to the level of the therapeutic alliance, he is also alert and is testing to see if the therapist will do more than this.

In the mind of each person there are certain role relationships that contain feared self-images. The loss implied by most serious life events tends to reduce the stability of more developmentally advanced or compensatory self-images. He now may feel weak, bad, or worthless. Even though his goal is recompensation of a competent self-image, he will sometimes test to see if it is possible that the therapeutic alliance may, in a sense, go too far for him. That is, he may be concerned about reaching some excessive degree of exposure that would be threatening to him. The patient may fear falling in love or being enthralled with the therapist, becoming too needy, or becoming dependent upon exhibiting himself for the therapist. The patient may also fear, as he begins to establish a real attachment to the therapist, that the therapist might then desert him, scorn him, or use him.

In other words, even in a brief therapy focused on the patient's recent serious life event, there are all the various tests and trials that establish the network of communication in a long-term therapy. If the therapeutic alliance is like a pathway, then the patient and therapist can step to either side of the path. Stepping to one side would preserve an excessively social relationship and not deepen it to the usually open communication of a therapeutic alliance; stepping to the other side would intensify transference reactions.

Formation of a therapeutic alliance does not mean that transference reactions will not develop, nor does it mean that the patient and the therapist may not at times engage in social interchange. It does mean that there is a relatively secure and agreed upon model of the roles of each person and the ground rules they will follow. When a transference reaction occurs, it can be

examined in contrast to this therapeutic alliance. The image that the patient has of the therapist in the transference can be contrasted with the image that the patient has of the therapist as his therapeutic ally. His self-image within the transference can be contrasted with his self-image in the working relationship. These contrasts and challenges allow the patient to revise or subordinate the self-images and role relationships that have been projected into the transference reaction.

As the therapy progresses, even if it is very brief, the safe relationship is deepened because both parties, but particularly the patient, learn that risks can be taken and result in good outcomes. The patient may work out new levels of awareness, especially about primitive self-images and role relationships activated in response to the life event. Through the therapeutic communication, he may learn new ways of thinking through immediate problems. He may learn these skills, not only directly by insight, but also by identification with the therapist. As in other therapies, the brief treatment of stress response syndromes often produces a period in therapy in which the patient reverses roles. After initial relief he tends to make the therapist feel helpless, just as he has been made to feel helpless by the stressful event. He then watches very carefully to see how the therapist handles helplessness. He copies the therapist's coping maneuvers. If the therapist appears intact he may then allow himself to experience the feelings he has warded off. For example, he may tell about the loss of a loved one in such a moving manner that the therapist feels sad. He watches this very carefully, and if the therapist can feel sad and can tolerate feeling sad, then the patient may allow himself to feel sad and to begin a mourning process.

Information Processing Issues

Let us assume now that the therapeutic alliance is established and within that safe relationship there is work on modifying the status of the patient's controls. Once again, talking particularly about stress response syndromes, one notices two common variations from the ideal path of naturally working through

reactions to a serious life event. One is that the person is in a state of relative failure of controls; he feels and acts flooded and overwhelmed by ideas and emotions related to the stress event. The other is that he cannot permit contemplation of the event and its personal implications.

When the person experiences relative failures of control, the activities of the therapist are geared toward helping him to regain a sense of his ability to be self-regulating. This is done through the everyday methods of psychotherapy: by helping the patient to focus attention, by asking questions or repeating comments, and by clarifying statements. Most importantly, it is helped by reconstructive interpretations—interpretations that help the patient to order facts in a sequence of time (7), to make appropriate linkages, and to separate reality from fantasy in order to reduce the threats of reality by reducing the adherence to fantasy expectations. Even when a person is frightened by his own impending death, as when he has a serious and fatal illness, he can often courageously cope with the reality of this, if he is helped to dissociate the real loss, real sadness, and real tragedy from imagined, fearsome consequences such as being entombed while alive, being helpless and deserted by people, and endlessly falling away from life with continued panic-stricken consciousness.

One aspect of working-through a serious life event is review of the various self-images and role relationships that are associated with it. Because of the emotional pain aroused by this review, most patients will have interrupted some aspects of it. In therapy the controls used in that interruption are set aside in a sequential manner. Most of this is done automatically by the patient himself, once he has established a safe relationship with the therapist. When there is reluctance to do so, the therapist, using the repertoire of customary psychotherapeutic interventions, may alter the defensive deployment by interpreting defenses and the reasons for them, by increasing attention to warded-off material through interpretation and labeling, or by simply creating evocative situations into which the patient will bring the ideas and feelings that have been avoided.

The goal is to allow the patient to reappraise and revise his inner thoughts so that models of the world now accord with new realities. This may be reached by establishment of a safe relationship or by additional interventions to alter the status of the patient's control.

As he examines warded off ideas, the patient may find, even after a serious life event where he has sustained a loss, that he is not as vulnerable or as incapable of coping with this event as he had thought. He may also become aware of other real available resources.

Every life event will set in motion a process of analysis of the changes caused by that event, as the mind seeks to maintain a reasonably accurate inner model of the external reality. Therapy will deal with the themes or constellations of meaning that the person cannot process on his own. Certain themes are relatively universal, as indicated in Table 3. The person will examine many of these themes independently and without difficulty. One or another theme, however, will either be accompanied by flooding of emotions, be warded off by pathological defensive maneuvers, or a combination of both. These themes will be a primary focus in therapy.

Table 3
Common Concerns After Stressful Life Events

Fear of repetition.

Fear of merger with victims.

Shame and rage over vulnerability.

Rage at the source.

Rage at those exempted.

Fear of loss of control of aggressive impulses.

Guilt or shame over aggressive impulses.

Guilt or shame over surviving.

Sadness over losses.

Realignment of the Therapeutic Focus

The patient will have presented a problem state as a chief complaint or motivation for seeking help. The first focus or agreement between patient and therapist will be to help attenuate this state, or avoid reentry into it. This state will be seen in relation to other states of experience and behavior. A broader analysis of the situation, with the patient, will include examination of the reasons for entry into problem states, as well as other even more threatening states that are warded off. A more detailed analysis of this issue, with a verbatim account of a brief therapy of a stress response syndrome is available in the literature (5).

As this process occurs, there is modification of the focus agreed upon by patient and therapist. At first the focus is a problem state, such as intrusive ideas and pangs of emotion which exceed tolerable limits. As these symptoms are resolved, the focus is on when and why the person enters such painful states. This revised focus often has to do with particular self-images and inner models of role relationships. If the focus is not modified, then the patient tends to move towards termination or avoidance of treatment when he achieves enough control to enter a relatively stable denial phase. We see separation from treatment at this time as an error because the patient has not worked through some of the most difficult issues of his response, and may not do so on his own.

A clinical example may illustrate this point.

> 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 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 found a substitute for the idealized, positive relationship with her father in the relationship with the therapist, and experienced a realistic hope 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 accomplish in the therapy and if therapy was worthwhile. The focus gradually shifted from recounting the story of his death, her responses, and the previous relationship with the father to understanding what her current inner relationship to her father was and how her view of that relationship affected her shifts among a variety of self-images. The focus of therapy became her vulnerability to entering states governed by defective, weak, and evil self- images.

Her defective self-images related to feelings that her father had scorned her in recent years because she had not lived up to the ideals that he valued both in himself and in her during an earlier, formative time. He died before she could accomplish her goal of reestablishing a mutual relationship of admiration and respect by convincing him that her modified career line could lead to its own worthwhile accomplishments.

This image of herself as defective was matched by a complementary image of him as scornful of her. Reacting to that interpretation of the relationship, she felt ashamed of herself and angry at 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 saw his death as his deliberate desertion of her. These ideas had been warded off because of the intense humiliation and rage that would occur if they were clearly represented. But contemplation of such ideas, in the therapeutic alliance, also allowed her to review and reappraise them, revising her view of herself and of him.

Every person has multiple self-images and role relationship models. In this patient, an additional important self-image of herself was 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 or domino effect. As she returned from the funeral for her father, she turned to her lover for consolation and sympathy. She had, however, selected a lover who, like her father, was superior, cool and remote. When she needed care and attention he was unable to comfort her, and they separated. Establishment of a therapeutic alliance provided needed support, but termination threatened her once again. In the mid-phase of therapy, it was also necessary to focus on these weak self-images in order to test them against reality and her other self-images as competent and capable of independence.

In addition, a focus was also established on her self-image as an evil, destructive person. It was her belief that persons of sound mind and psychological well-being did not fall physically ill. Her father had died suddenly of a cerebrovascular accident and was thought to be in perfect health until that time. Before his death she had indicated to her father that he was too cold and remote, and had detached himself from a relationship with her that ought to be warm and loving. She now felt as if she had caused him emotional conflicts that had contributed to his hopelessness, guilt, and self-punishment, as well as to his somatic reactions. Her anger with him for deserting her before his death was activated by rage responses at his deserting her by dying. Recognition of incipient hostile thoughts tended to bring forward her evil, destructive self-images. Confrontation with this theme allowed separation of reality from fantasy, reduced guilt, and enabled her to complete this aspect of reviewing implications of the death.

To recapitulate, early in therapy this patient rapidly established a therapeutic alliance, focused on relieving her of the acute distress of the intrusive phase of a

stress response syndrome. This alliance led to rapid attenuation of the problem states. With symptom reduction, the focus shifted to the agreed upon aim of working through various aspects of her relationship with her father. In addition to the primary meanings around grief, that is, the loss of continued relationship with her father and hope for working further changes in 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-images, present before the death, were worked with during the mid-phase of therapy. They were related not only to her father, but to other past figures (mother and siblings), current social relationships, and transference themes. As she developed controlled ability to recognize and work with these themes, the focus shifted from past and current versions of these constellations to future issues. Were she to continue with these self-images 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 into the ideal figure she remembered from early adolescence. This prospective work also included examination of her reaction to separation from the therapist and how she would in the future interpret that relationship.

The focus in the therapy shifted from her responses to the death, to four major themes connected associatively to the loss. One theme was the mourning itself: herself as bereaved and her father now as lost except to her memory. Exploration of this theme could not be completed in a brief therapy. The issue in therapy was to normalize the grief process so that she could continue on her own, feeling dejected and sad, but not uncontrollably overwhelmed by the process.

Another theme focused on her self-image as being too weak without the inner model of her strong father to sustain her. Active confrontation with this fantasy was enough to restabilize competent self-images which allowed her to enter and continue mourning.

A third problem image was herself as worthless and defective, in relation to scornful men. She held this preexistent self-image in check by having relationships with older, “superior” men. Their admiration for her was held as an effective but brittle rebuttal to the other premise she held that she was as worthless to them as she had been to her father. This was a core neurotic theme examined in the therapy and related to her future prospects. It was not worked through in the brief therapy. There was, however, the possibility that once she recognized the issue, she might be able to work it through herself in the course of her later life experiences, with resulting structural personality change.

A fourth self-image was herself as evil because she had experienced anger with her father and the associated premise that anger harms others physically. Once this idea was encountered with clear consciousness, it could be dissociated from magical thinking and lo:-e its power to make her feel guilty.

Working with Control Operations

Every person has his own style for controlling the flow of ideas in order to avoid entry into painful states. The shifts in focus just discussed in the case evolved gradually because the person had warded off threatening ideas about herself as guilty for the death, as too weak to cope with it, and as too defective to have a future. Once she contemplated these ideas in the therapeutic alliance, which strengthened and stabilized her competent self-image, she could tolerate and deal with them. But en route to this position, various controls interrupted her associative processes.

Each person will exert different control patterns. While all persons may inhibit some ideas and feelings, switch between reversed ideas and feelings, or slide around the interpretation of an important idea or feeling, each person may favor certain avoidances and certain ways of representing ideas and feelings. Even in a focal therapy aimed at working through ideas and feelings responsive to a serious life event, the technique of the therapist should be sensitively geared to these habitual modes. It is beyond the scope of the present communication to go into detail on varied approaches to the facilitation of information processing. However, three tables (Tables 4, 5, and 6) summarize some of these issues. Relevant discussions may be found elsewhere (4, 5, 6).

Table 4
Some "Defects" of the Hysterical Style and Their Counteractants in Therapy

Function	Style as "Defect"	Therapeutic Counter
Perception	Global or selective inattention	Ask for details
Representation	Impressionistic rather than accurate	"Abreaction" and reconstruction
Translation of images and enactions to words	Limited	Encourage talk Provide verbal labels
Associations	Limited by inhibitions Misinterpretations based on schematic stereotypes, deflected from reality to wishes and fears	Encourage production Repetition Clarification
Problem solving	Short circuit to rapid but often erroneous conclusions Avoidance of topic when emotions are unbearable	Keep subject open Interpretations Support

Table 5
Some "Defects" of Obsessional Style and Their Counteractants in Therapy

Function	Style as "Defect"	Therapeutic Counter
Perception	Detailed and factual	Ask for overall impressions and statements about emotional experiences
Representation	Isolation of ideas from emotions	Link emotional meanings to ideational meanings
Translation of images to words	Misses emotional meaning in a rapid transition to partial word meanings	Focus attention on images and felt reactions to them
Associations	Shifts sets of meanings back and forth	Holding operations Interpretation of defense and of warded-off meanings
Problem solving	Endless rumination without reaching decisions	Interpretation of reasons for warding off clear decisions

Table 6
Some "Defects" of Narcissistic Style and Their Counteractants in Therapy

Function	Style as "Defect"	Therapeutic Counter
Perception	Focused on praise and blame Denial of "wounding" information	Avoid being provoked into either praising or blaming Tactful timing and wording to counteract denials
Representation	Dislocates attributes as to whether of the self or another person	Clarify who is who in terms of acts, motives, beliefs, and sensations
Translation of images into words	Slides meanings	Consistently define meanings, encourage decisions as to most relevant meanings or weightings
Associations	Overbalanced in terms of finding routes to self enhancement	Hold to other meanings; cautious deflation of grandiose meanings
Problem solving	Distortion of reality to maintain self esteem, obtain illusory gratifications, forgive selves too easily	Point out corruptions (tactfully), encourage and reward reality fidelity Support of self esteem during period of surrender or illusory gratification (real interest of therapist and identification with therapist as non-corrupt person help) Help develop appropriate sense of responsibility Find out and discourage unrealistic gratification from therapy

Termination

Overlapping with these processes is the recognition by both patient and therapist, especially if a time limit is used, that they must work through detachment from each other. In our work, we now generally set a time limit of 12 sessions; the patient and therapist then know how to pace topics and can relate themes of termination to themes of loss involved in the prior stress event. For example, the approach of an agreed upon endpoint of therapy may be misinterpreted by the patient as a rejection because he is unworthy, as a separation that he is too weak to tolerate, or as a retaliation for his hostile ideas and feelings. Interpretations of transference reactions involved in such views can be related to reactions to the life event and configurations of the developmental past. In this linking work the focus on the stressful event is not lost, but intensified by meaningful linkages to recurrent patterns of self- image and role relationship. These patterns, especially during a termination period, can be examined from different points of view, from the ‘‘here and now” of therapy, the “there and now” outside of the therapy, and the “there and then” of the past as reviewed “here and now” in the therapy.

Towards What End?

While there has been general clinical agreement on the gains of working through a focal problem, there has not been agreement on the types of change in character structure that are possible through brief therapy. Some say that radical changes can be made in psychic structure as a result of processes initiated although not completed in brief therapy (10, 11). Others believe such changes in personality structure can only take place in the context of extended psychotherapy or analysis.

In our own treatment of stress response syndromes, we have not yet accumulated sufficient research data to say, on the basis of evaluations, what structural changes generally are possible. We have, however, seen some

instances where some personality changes have been set in motion and then accomplished by the patient through life development in the ensuing year or two. We speculate here on some reasons for these observations.

In the previous discussion, we briefly described a process concerned with completing the reaction to a serious life event. This involved working through not only the meanings of the event itself, but its implications for one's relationships, self-images, and behavior in the world. Such work entailed not only reappraisal of the event and reappraisal of the self, but revision of core inner models of self, role relationships and future plans. During this process the person decides to make revisions, plans different types of actions and attitudes, and finally practices new attitudes until new models become as automatic as previous models. This practice continues after termination.

In the course of this work, the patient studies his own responses, not only to this event, but to a series of related life events in the past. Thus, the patient is learning something from the therapy that goes beyond the focal working-through of the specific event. When he is following the more directive interventions of the therapist, he is learning new skills such as the ability to use reflective awareness to think in new ways. When he is following the interpretive line suggested by the therapist, he is learning how to be insightful and how to modify habitual avoidances that usually operate preconsciously or unconsciously.

Patients sometimes become aware, in the course of these brief therapies, of a particular style they have of not thinking about events, and they are able to deliberately alter that situation. It may be possible for them, by continued work on their own after the therapy, to live out changes that may gradually be incremental in altering habitual controls.

When a person experiences the impact of a serious life event, such as a loss or injury, there is threat of undermining his most advanced, adaptive role relationships. There may be regression to earlier role relationships or the

meaning of the event itself may tend to create some new role relationship, perhaps with unattractive, dangerous or undesirable characteristics. The person may then enter a series of painful, strongly affective states based on the altered self-images and the changed role relationship. As a consequence of therapeutic facilitation of normal processes, the disturbing role relationships or self-images can once again be subordinated to more adaptive, mature self-images and role relationships. Intensive work in a brief therapy model may both alter the symptomatic response to a stressful life event and facilitate further progress along developmental lines.

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