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# Short-Term Dynamic Therapy of Stress Response Syndromes

*Handbook of Short-Term Dynamic Psychotherapy*

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# Contents

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.

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## Notes

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