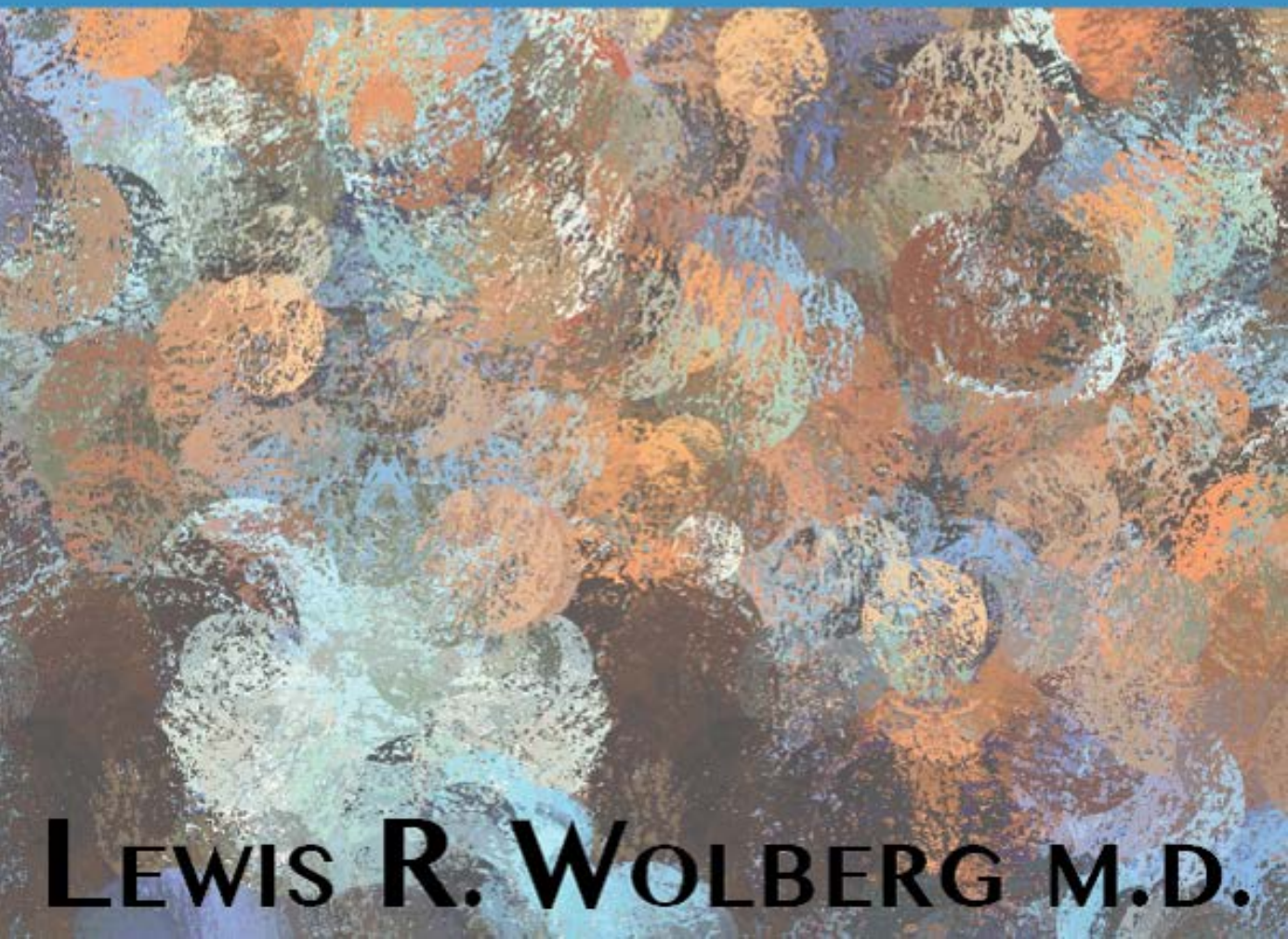
THE TECHNIQUE OF PSYCHOTHERAPY

STRESS AND ITS MANAGEMENT



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Stress and its Management

A common denominator in all mental illness is stress, which is a trigger that can set off many deleterious physical and psychological reactions. It is a potent precipitant of emotional disorders and therefore of vital concern to the psychotherapist.

In the course of daily living a certain amount of stress is unavoidable. To an extent this is constructive since it "oils up" the physiological mechanisms essential to adaptation, much as a machine requires periodic use to prevent the constituent parts from drying up and rusting. People often seek ways of stressing themselves temporarily with some pleasurable excitement like competitive sports and games, or exposing themselves to mildly frightening experiences like horror movies or murder mysteries. This not only helps keep the various body organs and systems in tune, but also enables the fight-or-flight mechanisms of the organism to hold themselves in preparation for some more-than-normal stressful emergency.

What we are concerned with in mental health practice are not these adaptive responses to everyday stress, but the effects on the individual of stressful events to which a proper adaptation cannot be made. Specifically we want to know what to do for the patient who is being victimized by abnormal and incapacitating stress reactions, and more importantly, how to modulate or remove the stressful stimuli that are causing the problems.

PHYSIOLOGICAL CONSEQUENCES OF STRESS

It is estimated that stress reactions are a major factor in the etiology of physical illness like heart disease, stomach ulcers, and even cancer to name a few. Knowledge of the involved physiology may be

helpful in understanding how this comes about. Simply put, what stress does, as Selye (1956) has shown, is to activate a massive conditioned non-specific reaction to prepare for appropriate coping with an actual or anticipated threat. The psychological component of this response is part of our animal heritage having evolved over millions of years as a survival mechanism in the face of danger. Once a situation is *perceived* and *evaluated* by the brain as dangerous, several subcortical centers come into play. Two systems are primarily involved that ordinary operate to regulate the normal functions of the body. Both depend on complex chemical compounds (hormones) in the hypothalamus. One of these hormones, cortisol, is so essential to life that its concentration in the blood must be steadily maintained within narrow limits. Cortisol is vital in preparing the body physically to overcome a threatening stress stimulus. What cortisol does is break down amino acids from muscle and connective tissue into glucose to supply the body with energy. In addition, it regulates cell metabolism, stabilizes plasma membranes, elevates the mood, and has an anti-inflammatory effect. This over a short-term period is helpful in dealing with stress. But if excessive cortisol manufacture continues over an extensive period, which is the case in prolonged and continued stress or chronic intermittent stress, cortisol starts doing damage. It breaks down too much muscle tissue, produces clotting failure, weakens bone structure encouraging fractures, depresses the body's immune reactions causing susceptibility to infection, and sometimes produces bizarre behavior. In recent years it has been discovered that another brain hormone liberated by the same adrenal steroid feedback mechanism responsible for cortisol is beta-endorphin, which has a pain-killing morphine-like action, but that in too great concentration, that is when stress is prolonged, may also have an unwholesome effect.

Additionally important to body function is the second system, the sympathetic nervous system and the catecholamine hormones epinephrine and norepinephrine released by the adrenal medulla. In short-term stress this system is activated to increase cardiac output, help respiration by dilating the bronchioles, distribute blood from the inside of the body to muscles and the heart, lessen fatigue, increase alertness and

facilitate energy supplies by liberating glucose from muscles and liver and releasing fatty acids from fat deposits. This is all to the good in dealing with temporary stress, but if this action goes on over an extended period, physiological damage can occur in the form of hypertension, gastric ulcers, cardiac arrhythmia, and other organ malfunctions. Increased plasma cholesterol and elevated low density lipoprotein may predispose to atherosclerosis and coronary insufficiency.

SOURCES OF STRESS

Sources of stress are legion and it would be an insuperable task to list all of them since they vary with each individual. On an environmental level we need merely to catalogue the kinds of problems social agencies deal with to realize that endless troubles stressfully plague human beings apart from cataclysms of climate, war, accidents, and catastrophic physical illness, which after all are not too common in the lives of most people. Noteworthy for the majority are tensions caused by difficult interpersonal relationships with families, spouses, authorities and peers, bereavements, material or fancied threats to the safety, security, and life of the individual such as violent assaults, rape, serious accidents and illnesses, blows to self-esteem, undermining of autonomy and identity, anger that is blocked in expression, and the inability to fulfill important personality needs which may in susceptible persons become stress sources. The origins of many of these difficulties are rooted in past conditionings. Incomplete separation-individuation, devaluated self-esteem, accumulating hostilities, guilt feelings, and personality drives that interfere with harmonious interactions are a few of the surviving anachronisms and traits that generate troubles.

Belief systems sometimes contribute anomalous sources of stress even though the individual recognizes their irrational source. Authentic cases of death may follow the breaking of a taboo or the spells cast on a victim by shaman, voodooist witch doctor or medicine man. Among civilized people, a deep conviction of hopelessness, with expectation of death may bring on irrecoverable illness with loss of

appetite and a wasting away, with a calm acceptance of one's inevitable doom. Years ago Walter Cannon wrote about how supernatural fear can bring about a fatal outcome, and he pointed out the fact that some surgeons refused to do a major operation on a patient who was terrorized by the conviction that he or she would not survive.

There are additionally a plethora of aversive events and factors in daily life that can have a cumulative stressful effect. The individual may to some extent be aware of the damage these mischief-mongers cause and may force himself or herself to tolerate them, either on the basis that the problems are insoluble and there is no escape, or because one feels destined to endure them. More often there is no awareness of the damage they cause and years may go by before the victim realizes that something is wrong and can no longer go on physically or emotionally.

A good deal of literature has been published on selective areas of stress a most interesting contribution having been made by Holmes and Rahe (1967) who developed a Social Rehabilitation Rating Scale designating areas of stressful changes in one's life situation in hierarchical order, assigning to them "life change units" from 100 to 11. At the top of the list, the first three items are the death of a spouse, divorce, and marital separation. These are followed by a large number of other damaging incidents, with somewhat lesser scores. The authors found that a total of 200 or more life change units in a year was matched by an increased incidence of myocardial disease, infections, peptic ulcer, and assorted psychiatric disorders.

Bereavement as a stress source commonly occurs with the death or permanent departure of a person with whom there has been a close relationship (parent, spouse, child, lover). It may develop with removal from one's home, neighborhood, or work situation as in relocation and retirement. The reaction of grief may appear immediately after the critical separation incident, or manifest itself following weeks or months. The classic investigation of Erich Lindemann (1944) revealed five main reactions: (1) somatic symptoms (physical distress, shortness of breath, muscular weakness, tension, subjective discomfort); (2) preoccupation with the image of the lost object; (3) guilt (self-accusations for the situation); (4) hostile

reactions (anger at being abandoned; irritability at people in general); (5) behavioral alterations (restlessness, forcing oneself feverishly into activities; enhancement of dependency, feelings of unreality, imitation of attitudes and behavior of a deceased through identification). Reaction formations such as forced cheerfulness or stoicism may mask some of these symptoms.

Grief that follows a lost home precipitates similar reactions to those resulting from the death or permanent departure of a valued person (Fried, 1963). Clearance of urban slum areas, the devastation caused by tornadoes and floods, invasion, and the massive destruction of war has resulted in forced relocation and massive bereavement and personal suffering. The sense of loss of intimacy with one's surroundings, disruption of customary social networks, absence of familiar groups of people, results in a sense of disorientation, the fragmentation of identity, and a grieving for the lost familiar neighborhood.

Retirement, without adequate preparation or training for postretirement activities and hobbies can impose stressful burdens on a person whose sense of importance, worth, and self-esteem has been contingent on gainful employment. Lacking methods of restoring feelings of being needed the individual may respond with despair, depression, and a longing for return to the previous status. The sense of grief and bereavement parallel those that follow the loss of an important love object.

Why bereavement and separation have such intense effects on people has engaged the attention of many observers. It is the belief of some that these are tangentially related to the fear of death that exists on some level in all people. No satisfactory formula has ever been evolved to neutralize this death fear in spite of such expediencies as belief in immortality, reincarnation, soul survival, and the like. There are those who contend that fear of dying cannot be avoided since it is a biological and evolutionary phenomenon residing within the structure of man. There are others who believe that such fear is not biological, but rather bound to the peculiarities of human development. At its core is the infant's primitive reaction to object loss precipitated by separation from the mother. No matter how secure the individual may seem, the terror of abandonment-separation-death slumbers ominously in the unconscious and

symbolically fastens itself to later separation experiences and to any bereavement contingency that threatens personal physical and emotional security. Obviously the more wholesome the rearing of the child, and the more stable the personality structure, the better the coping tactics in dealing with separation. But even in well adjusted individuals the repressed death obsession may awaken with severe deprivations and life-threatening crises. In unstable persons, fears of annihilation can appear explosively with minor separations and insignificant losses which are interpreted as threats to one's integrity.

Terminal cancer patients and those experiencing severe myocardial disease may be realistically confronted with the imminence of death; such patients often barricade themselves from the terror of dying by denial mechanisms, a conspiracy entered into by visiting persons who, dealing with their own anxieties of mortality, try to flourish a false facade of hope. Slips of speech and disturbing dreams only too pointedly indicate the patient's distrust of such denial maneuvers.

We cannot dismiss the fact that constitutional factors sometimes enter into the generation of stress through hypersensitive biochemical and neurophysiological systems that fire off excessively with even minor stimuli. Nor can we neglect cultural elements that endow certain events with a portentous meaning. *The meaning the individual imparts to any stimulus, external or internal, will determine its stressful potential*. The most insidious sources of stress issue from unconscious conflicts, the individual attempting to rationalize inner turmoil by attributing it to outside sources. Indeed, disturbing stressful situations may deliberately be created to provide objectivity for one's inner feelings.

REACTIONS TO STRESS

Research on stress has shown, sometimes to the exasperation of the experimenter, that the severity of the stresses bear little relationship to the intensity of the resultant physiological and behavioral disruption, even in the same experimental subject at different times. A number of intervening variables appear to be operative, some of which are confoundingly elusive. What is of primary importance is the cognitive set that imparts special meaning to the stressor. The reaction of any individual to stress is regulated by the sense of one's own vulnerability and the perception of one's capacity to cope with, adjust to, or overcome the source of trouble. Mastery of a stress situation in the past akin to the present one, is a positive factor, while failure is a negative element in determining stress tolerance. Most individuals will react to a life-endangering situation with fear or panic. But a suicidally inclined soul, intent on self-destruction, or a religious martyr, who expects rewards in heaven, may actually promote a life-terminating event. Highly motivated, well doctrined soldiers exposed to skilled pre-battle morale building will enter stressful combat with fierce enthusiasm. Soldiers who do not know what they are fighting for are deplorably handicapped during combat.

Are there any personality measures that can tell us how an individual will react to stress? Coping adequacy is related to flexibility of defenses, one predictive measure being the stability of the individual in the face of previous life crises. Andreasen et al. (1972) studied hospitalized burn patients, and found that patients with adjustment difficulties prior to the burn and those with premorbid psychopathology coped poorly with their injury. In an interesting piece of research on physiological and psychological responses to stress, Katz et al. (1970) have shown that "the ego's defenses are obviously able to buffer the individual from threat with great efficiency" and, even to block expected biochemical reactions. So far no reliable test has been found that can measure defenses and that can predict what an individual will do under certain stressful circumstances. Responses are highly specific. In this author's practice, both amateur and seasoned actors on screen, stage, and TV have been seen whose stage fright prior to the opening night performance approached shock reactions, yet with the arrival of doomsday, before a live audience,

performed brilliantly with scarcely a whisper of anxiety. On the other hand, the author has seen composed, self-confident individuals including some veterans, decorated for bravery in battle, fall apart when asked unpreparedly to make a speech before a group. No prior psychological test could have predicted these transformations.

Cultural attitudes often determine reaction patterns. For instance, tolerance of pain and the ability to disregard it stoically may be considered virtuous in some societies, contrasting with the complaining, demanding, groaning, angry responses found in other cultural groups. As Zborowski (1977) has stated, stress in part is "a cultural experience in perception as well as in interpretation, and as such is responded to by behavior and attitudes learned within the culture in which the individual is brought up." Such philosophical defenses as a penchant to accept adversity as inevitable, the endorsing of a fatalistic attitude that man is destined to suffer pain and discomfort, and confidence in faith and prayer as ultimate means of gaining protection through the divine order can greatly subdue reactions to stressful stimuli. Accordingly, stress is subject to the psychological embellishments of the responder who draws on inherent physiological and psychological sensitivities. In individuals with a tendency to depression, stress often functions as an important precipitant. Controlled studies have shown that stressful life events precede the outbreak of major depressions in predisposed individuals. Other syndromes than depression may be precipitated by stress, and it is a challenging hypothesis that predispositions to a specific response may exist in such persons. Brown and Birley (1968) found that 60 percent of patients suffering from a schizophrenic episode had experienced strong stressful situations some weeks prior to the onset of the illness. Only 19 percent of the control group were similarly affected. Past conditionings also provide a fertile paradigm for behavioral patterns. Thus an individual victimized as a child by the abandonment or death of a parent may respond to mild separations in adult life intensely, even catastrophically.

Where physiological responses to stress continue over a period of time, we may expect complications of physical illness and organ damage (Rahe & Arthur, 1977). What inspires the choice of organ afflicted is

still hard to say. On the surface we would assume that the weakest link in the physiological chain would break down under the stressful pounding. This then would be a matter of hereditary weakness of an organ system, or previous damage to the organ wrought by a past illness or pathological assault. Because chronic stress affects immunological reactivity and predisposes to autoimmune reactions, some authorities believe that non-specific damage can occur, postulating as one example rheumatoid arthritis. However, here too a genetic predisposition cannot be ruled out.

Many authorities believe that variant personality typologies generate different degrees of stress and show different modes of coping with adversity. While most authorities downplay the thesis of Alexander (1950) that the organ disrupted by stress is determined by the basic character structure, there may be some tendency in certain dependent, "orally" disposed individuals whose dependent need is frustrated, to over secrete digestive juices as if they seek to incorporate food, which from infantile associations is equated with love. Continued gastric hyperacidity may thus result in peptic ulcer. Special personality constellations are believed to activate selected organ systems. A hard driven, time-hungry, competitive, restless personality, type A personality described by Friedman and Rosenman (1959, 1974), is said to be predisposed to coronary disease. There seems to be some experimental evidence for this. Van Egeren and his coworkers (1983) found that social stresses, like competitive rivalry and goal frustration affected the ventricular myocardium differently in type A than the less driven, calmer type B persons. Computer analysis of the electrocardiograms revealed in type A persons a statistically significant depression of the ST segment and a reduction of T wave and R wave amplitude. There are additional studies that show that type A individuals in comparison with type B individuals have more frequent arrhythmias, and increased sympathetic adrenergic responses (rises in blood pressure, accelerated heart rate, and mobilization of epinephrine and norepinephrine) to stress which provide added evidence for greater liability to cardiac illness in type A individuals.

Attempts have been made to correlate other personality typologies with diabetes, ulcerative colitis, cancer, asthma, migraine, and arthritis. One example is the study of a large group of patients with chronic insomnia in different parts of the country (Kales et al, 1983). A consistent pattern was the handling of stress and conflicts, especially about aggression, by internalizing rather than expressing emotions, which apparently promoted physiological disturbances during sleep.

Important to differentiate in evaluating this complex data are physical manifestations of conversion reactions that fulfill defensive psychological needs and are products of the voluntary sensorimotor system. Here the physical symptom (e.g., paralysis, anesthesia, etc.) constitutes a symbolic communication coached in body language. We are inevitably led to the conclusions that organ choice is multifactorial and must be individually evaluated.

Physiological reactions to stress that result in organ damage are obviously inimical to adequate coping. Psychological defenses similarly may be maladaptive. The adequacy of the coping method depends on a number of factors, principally whether the defense employed succeeds in halting the deleterious effect of the stress response on the physiological level, and whether, on a psychological level, it compromises the present or future adjustment of the individual. A stressed executive earning a large salary and enjoying tenure in an organization can achieve temporary peace of mind by resigning his or her position, but in the long run may be cutting one's own throat and become even more severely stressed while waiting for the meager unemployment check in line with other job hopefuls. Studies indicate that adequate methods of coping include humor, anticipation, rationalization, and philosophizing (Ford 1975; Vaillant, 1971).

MANAGEMENT OF STRESS

There is enough research evidence[12] to make plausible the following facts about stress: (1) the impact of a stressful event, physical or social-psychological is modulated by the expectations, perception, and the unique meaning given the stressor by the subject; (2) the reaction of any individual to stress is regulated by a sense of one's own vulnerability, and the perception of the capacity to cope with, adjust to, or overcome the source of the trouble. (3) Mastery in the past of a stress situation akin to the present one, is a positive, failure a negative factor in determining stress tolerance; (4) graded exposure to a stressful situation, with mastery of some aspects, tend to desensitize the subject to the effects of the stressor; (5) stressful reactions following failure to cope with a threat, or missing the mark on an assigned task, encourage deterioration of responses at later trials; (6) verbalization about one's feelings, and the presence of people who the individual trusts, increases tolerance of stress, reducing psychological and psychosomatic symptomatology. These research findings, paralleling what common sense would tell us, form the basis around which the management of stress can be organized.

The first step in management is to identify the operative stressors. If they are purely environmental, a counseling approach may do more good than depth-oriented psychotherapy. In most cases, however, it is rare that external stressors are not reinforced by the motivational connivance of the patient who may even have initiated the troubles and then subversively sustains them. Here attempts to deal with the stressors by counseling and milieu therapy will be blocked by the emotional needs of the patient. Should this happen, the therapist will have to institute an approach focused on rectifying the personality operations of the patient.

Initiation of an effective treatment program will depend on the condition of the patient when first seen. A four-part "stress response syndrome" (Horowitz, 1976) is commonly experienced by persons exposed

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12 A good bibliography on stress research may be found in McGrath JE (ed): Social and Psychological Factors in Stress. New York: Holt, Rinehart and Winston, 1970; and McGrath, JE: Settings, measures and Themes: An integrative review of some research on social-psychological factors in stress. In Monat A, Lazarus RS (eds): Stress and Coping. New York: Columbia University Press, 1977, pp. 67- 76.

to an acute traumatic event such as bereavement, surgery, a serious accident, a catastrophic blow to security or self-esteem, or anything that is interpreted as an irretrievable loss. The first phase is characterized by an initial shock reaction with a dulling of perception and feelings of unreality. Second, there is an attempt at denial in order to push out painful emotions related to the incident. The person may act and talk as if nothing has happened, or there may be a minimization of the incident. Following this, a third phase occurs with gradual intrusive feeding into consciousness of the true significance of the event and an experiencing of previously blocked emotions like pain and deprivation. This may alternate with bouts of emotional withdrawal when anxiety is too strong. Fourth, the change in life status that the traumatic event makes inevitable is accepted. This working-through cognitive processing phase may go on for years. It may never be completed being interrupted by images and phantasies of the lost object or previous stabilizing life situation. Patients react uniquely to each phase in accordance with their personality needs and neurotic defenses.

During the first phase of the reaction, therapy is best focused on terminating, if possible, any identifiable stressful stimuli. This may necessitate removing the patient physically from the stress source provided such rescue will not complicate matters. Where it is essential to live with and adapt to a stressful environment, the person will need to desensitize to its effects and develop ways of modifying or eliminating its most hurtful elements. A relationship with an empathic, knowledgeable person here is most important and the degree of directiveness, support and empathic reassurance must be titrated against the existing confusion, helplessness, and disorganization. In severe reactions, psychotherapy may be necessary. Hypnosis and the *temporary* administration of an anxiolytic medication may be helpful. The objective is to bring the patient back to a realistic appraisal of the situation. If possible, one should avoid anxiolytics especially in addictive personalities. Should they have to be prescribed, their use must be terminated as rapidly as possible so that the patient does not become dependent on them.

By the time the patient presents for help to a psychotherapist he or she will undoubtedly have made some attempts at self-regulation and environmental manipulation through control, attack, or escape measures. These will show up in manifestations of denial, detachment, displacement, projection, and rationalization. Such defenses are implemented with the aim of dealing with, neutralizing or removing the perceived threat. An insidious escape measure is the use of mind-altering drugs (sedatives, tranquilizers, alcohol, marijuana, cocaine), which will complicate therapy. As soon as some stabilization occurs and the relationship with the therapist is sufficiently firm, resort to substance use or abuse will need to be terminated and this may require aggressive handling. Other untoward defenses are acting out manifestations, outbursts of anger and violence, masochistic activities, unusual sexual practices, withdrawal, and restless agitation. Complications may have ensued as a result of these responses, which, though disturbing and requiring handling, should not sidetrack the therapist's pursuit of mediating the initiating stress.

If the patient is in the denial phase of the stress reaction, during which an attempt is being made by the patient to blot out the presence of the threat by acting as if it did not exist or by minimizing it as through humor or joking, the therapist will have to alter the approach. Without withholding support and reassurance, denial is countered by continued careful confrontations interpreting the purpose behind the patient's disputative maneuvers. In acute stress reactions denial may be so severe as to practically paralyze the person. Phobias and conversion symptoms may be pressed into service to avoid reminders of the stressful situation. Amnesia, fugue states, delirious attacks, tremors, paralysis, sensory disturbances and paralyzing phobias may develop and constitute the immediate reason why the patient comes to treatment. Repression is never complete and periodically the repressed stressful experience or conflict will feed back into consciousness stimulating bouts of anxiety. So long as denial exists, this back and forth movement will continue. It is essential here to dose the patient with increments of the disavowed or repressed material through confrontation and interpretation of existing fantasies, dreams, and behavioral distortions.

Where denial is extreme, hypnosis and narcosynthesis may be of some help in breaking through the resistance, but will require administration by a professional skilled in their use.

The next phase of therapy may well be the most difficult one since it requires a working through of the insights gained in treatment and putting these into corrective practice. During this phase there will be periods of anxiety and depression as the patient re-experiences the trauma, as well as repressive renunciatory interludes.

Therapy is usually performed under a handicap because of continued stubborn distrust of one's environment and of authority in general. This promotes detachment, easily aroused anger, and reluctance to engage in psychiatric or psychological treatment. Where therapy is attempted, the transference may become so ambivalent as to interfere with treatment.

Enjoining the patient to verbalize feelings, the temporary use of medication, and perhaps exposure to hypnosis may open the way to establishing a relationship with the therapist who is then in a better position to institute counseling, cognitive therapy, or dynamically oriented psychotherapy. Should transference still interfere with treatment, group therapy may be tried which, because transference is split and more diffused, may be better tolerated than individual treatment in these highly stressed individuals.

While less dramatic than acute gross stress reactions, but no less devastating in their effects are *chronic stresses of an intermittent nature*. Stress here is due either to an environment from which the individual cannot or will not escape and to which one responds adversely, or to disturbed relationships with significant others like parents, siblings, spouse, children, employer, etc. Usually personality problems are basic and are subsidized by intrapsychic conflicts which sponsor such defenses as projection, fantasy, dissociation and obsessive rumination that interfere with adequate coping.

A prime goal in dealing with chronic intermittent stress is evolving defenses aimed at a more constructive adaptation and, if possible, the elimination of the sources of tension. Of vital importance is

the shoring up of morale, which has usually become vitiated because of the long period of suffering. Regular relaxing exercises, meditation, or self-hypnosis can help a person avoid resorting to tranquilizers, hypnotics, alcohol and smoking.

Attitudes can influence one's physiological and psychological responses. For example, in physical illness an optimistic outlook, the will to live, faith in one's physician, commitment to achievement and conviction of recovery help stimulate the immunological system, speed healing in surgery, shorten physical illness, and, according to some recent research, even inhibit the growth of cancer cells. On the other hand, abandoning hope, giving up one's claim on life, a belief that one is doomed, apathy, and the unwillingness to fight puts a damper on recovery, heightens tension, and hastens death. Norman Cousins (1976) has written an excellent article on the value of a positive outlook. In all cases of stress some form of cognitive therapy is usually called for, which adds an important dimension to the other interventions being employed. In working with such terminal ailments as AIDS this boosting of morale is especially important.

Attitude change through cognitive therapy may also be helpful in prolonged and obdurate *bereavement reactions* aiding in the resolution of grief. The grief work seems to be essential in liberating the individual from the bondage of the cherished object, preparing for a different outlook, and the development of new relationships. What interferes most with a working through of the separation crisis is denial of one's true feelings in the attempt to insulate oneself from painful stress. It may require a good deal of effort on the part of any helping person to gain the individual's confidence, counter the hostility, and break through the wall of detachment that prevents the victim from enduring the pain essential in coming to grips with the loss.

The development of a relationship with some trusted person or counselor is almost mandatory to help the individual acknowledge and accept feelings and to begin to move toward other relationships. Discussions of misgivings, guilt feelings, idealizations, and memories encourage emotional catharsis. In

most cases improvement will come about within a period of about 6 weeks. Where there is denial of one's feelings of guilt and pain, the somatic symptoms, restlessness, insomnia, and nightmares may go on for a prolonged period. A kind of paranoidal distrust often prevents the individual from getting close to people and it will require a good deal of tactful persuasion to promote resumption of close social contacts. The most extreme reaction to bereavement is precipitation of a deep depression with suicidal ideas or actual attempts to kill oneself. One usually encounters a history of previous depressive incidents in such extreme reactions. Antidepressive medications and, where suicide is a possibility, ECT may be required.

A question often asked is how much social support should be rendered in dealing with the effects of stress? In most cases where the stressful situation overwhelms the coping capacities of the victim, social support bolsters up the reserve of the individual. However, it should be withdrawn as soon as possible lest it reinforce helplessness and dependency. In chronic stress especially one should avoid operating as a good genie taking over responsibilities that should be handled by the patient. Indeed there is evidence, as shown by work with cancer patients that supportive activities for patients not undergoing chemotherapy or radiation treatments may "increase negative mood and decrease self-perceptions of worth, mastery, acceptance of the patient role, and acceptance of death." (Revenson et al, 1983). The very rendering of social supports in some persons acts as a stress source (Dunkel-Schetter & Wortman, 1982; Brickman et al, 1982).

Another question relates to the value of prevention. There is a good deal of evidence that anticipating impending stress may be helpful in dealing with it when it comes. For instance according to a study at the Harvard Medical School retirement is a risk factor in coronary heart disease (Gonzales, 1980). Job-related dissatisfactions are also a risk factor that may lead to a decision to leave one's work as the lesser of two evils. Cultivating proper attitudes toward retirement may prove to be a saving grace. A conception of retirement as a worthy reward for years of dedicated work helps overcome the stressful conviction that it is a punishment for growing old. Where the individual faces an inevitable loss, behavioral practice sessions

with role playing and encouraging the person to verbalize feelings may serve a valuable purpose. On the basis of the theory that people can adapt to any stress if they acquire adequate coping facilities, training in stress management may be a priority item in those in high-risk situations (Meichenbaum et al, 1975; Ford, 1975; Vaillant, 1971). Despite unsubstantiated claims of psychological cures rendered by exercises like running and calisthenics, there is evidence that regular exercise and other measures to improve physical fitness help individuals cope better with a high proportion of life changes like divorce, death of a loved one, and switching jobs (Science News, Vol. 130, August 2, 1986).

If an impending stressful event is anticipated such as subjection to major surgery, the expected death of a spouse or family member suffering from an incurable illness, fearful reactions to forced retirement, etc., there is no substitute for counseling sessions with a respected person who is able to supply realistic information in advance and reassuringly to handle the individual's anxieties and concerns. High morale is an important factor in stress coping, and it is best obtained by proper prior preparation or realistic indoctrination. Excessive fears or denial of concern are both conducive to poor coping. Studies show that "A moderate amount of anticipatory fear about realistic threats is necessary for the development of effective inner defenses for coping with subsequent danger and deprivation." (Janis, 1977). During counseling or psychotherapy, contingencies are assessed, resources and supports assayed, and appropriate options and adaptations reviewed.