SECOND EDITION

TREATMENT OF STRESS RESPONSE SYNDROMES

MARDI J. HOROWITZ, M.D.

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Mardi J. Horowitz, M.D.
Distinguished Professor of Psychiatry
School of Medicine and Weill Neuroscience Center
University of California, San Francisco

AMERICAN PSYCHIATRIC ASSOCIATION PUBLISHING

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Second Edition

Manufactured in the United States of America on acid-free paper
24 23 22 21 20 5 4 3 2 1

American Psychiatric Association Publishing
800 Maine Avenue SW
Suite 900
Washington, DC 20024–2812
www.appi.org

Library of Congress Cataloging-in-Publication Data

Names: Horowitz, Mardi Jon, 1934– author. | American Psychiatric Association, issuing body.

Title: Treatment of stress response syndromes / Mardi J. Horowitz.

Description: 2nd edition. | Washington, D.C. : American Psychiatric Association Publishing, [2020] | Includes bibliographical references and index.

Identifiers: LCCN 2020022173 (print) | LCCN 2020022174 (ebook) | ISBN 9781615373055 (paperback) | ISBN 9781615373673 (ebook)

Subjects: MESH: Stress, Psychological—therapy | Life Change Events | Stress Disorders, Post-Traumatic—therapy

Classification: LCC RC455.4.S87 (print) | LCC RC455.4.S87 (ebook) | NLM WM 172.4 | DDC 155.9/042—dc23

LC record available at https://lccn.loc.gov/2020022173

LC ebook record available at https://lccn.loc.gov/2020022174

British Library Cataloguing in Publication Data

A CIP record is available from the British Library.

Contents

Preface to the Second Edition

IN DSM-5, THE AMERICAN PSYCHIATRIC ASSOCIATION (2013) introduced a new grouping of diagnoses called *trauma- and stressor-related disorders*. These include PTSD, acute stress disorder, and adjustment disorders. That clustering was envisioned in *Stress Response Syndromes* (Horowitz 1976) and in the first edition of this book (Horowitz 2003). This second edition updates treatment recommendations for these disorders and emphasizes formulation for determining appropriate therapeutic strategies.

I take an integrative and transtheoretical approach in this second edition. Unlike treatment guidelines for PTSD and acute stress disorder issued by such organizations as the U.S. Department of Veterans Affairs/Department of Defense (VA/DoD), the American Psychiatric Association, and the American Psychological Association, this work does not compartmentalize its recommendations into treatment modalities such as cognitive-behavioral therapy, prolonged exposure, cognitive processing therapy, eye movement desensitization and reprocessing, dialectical behavior therapy, interpersonal therapy, short-term dynamic therapy, and cognitive-dynamic therapy. Research studies confirm that these modalities are effective but also can be improved on (Brom et al. 1989; Merz et al. 2019). I describe an integrated approach based on repeated assessments and formulations that lead to individualized plans for the patient.

This assessment-based approach can be used throughout all phases of treatment and leads to the possibility of enhancing emotional control, advancing attachment models, and consolidating identity. It addresses conscious contents and unconscious structures of memory and meaning. This book and these treatment methods will be useful for clinicians who are already familiar with diagnosing and treating patients but who want to advance their techniques for providing psychotherapy.

Many treatment guidelines for PTSD focus on brief therapy. In the final section of a review of treatment guidelines by a committee of the VA/DoD (Ostacher and Cifu 2019), the authors emphasized the need to improve psychotherapies and pointed out a conflict of interest. They noted that their selection of brief treatments related to the fact that they had to operate within a projected limited budget for delivering care in the VA system and the needs of the DoD to keep military personnel on active duty in a fighting force. I do not share that bias toward brief treatment. In contrast, my values lead to supporting therapies of whatever length is required in order to provide full benefit to patients and lead to personality growth.

Readers specializing in the field of stress response syndromes might find a historical perspective on the diagnosis of PTSD to be helpful. The relevant background may be found in *Stress Response Syndromes*, 5th Edition (Horowitz 2011), *Essential Papers on Posttraumatic Stress Disorders* (Horowitz 1999), and *PTSD: A Short History* (Horwitz 2018).

Note Concerning COVID-19

While this book was in production, the world was impacted by global stress imposed by the coronavirus disease 2019 (COVID-19) pandemic and the related economic recession. As complex and collective threats unfold, individuals may need help in three areas.The first area is heightened demand for self-care and family and community support. I wish for the readers of this book and their patients that they have resilience, courage, stamina, and connection to others. However, description of how to attain those attributes is beyond the scope of this work. The second area of concern is that patients with preexisting psychiatric disorders, including psychoses, mania, and serious depression, who are under stress may develop exacerbations of their symptoms, leading to immobilization and suicidality. The third area is the focus of this book: Some patients may develop stress response syndromes related to the COVID-19 pandemic and the failing economy. The chapter on renarration and reschematization will be especially relevant to clinicians who are treating this group of patients.

Severe stress can lead to adaptive and maladaptive states of mind. Focusing attention on realistic appraisals of threats and developing useful coping strategies is adaptive. In contrast, extreme anger that focuses blame on others or oneself can be maladaptive. States of righteous indignation or self-disgust interfere with the ability to effectively deal with crises. My hope is that readers of this book will be able to help their patients move from maladaptive states of mind to more adaptive ones.

Mardi Horowitz
San Francisco, April 2020

Acknowledgments

I AM GRATEFUL FOR THE SUPPORT FOR MY RESEARCH ON stress response syndromes provided by the National Institute of Mental Health (NIMH) and the John D. and Catherine T. MacArthur Foundation. I am also thankful for the encouragement given to me by awards such as both the Pioneer and Lifetime Achievement Awards (International Society for Traumatic Stress Studies), the Strecker Award (Institute of Pennsylvania Hospital), the Royer Award (University of California), and both the Hibbs and Foundations Fund Awards (American Psychiatric Association).

I would like to thank Zachary Vanderbilt, who did an excellent job of bibliographic research, editing, and word processing. William Zhu, M.D., contributed content ideas and editing. Edwin Flores complemented this work with his excellent figures. Steven Walsh, M.D.; Beverly Lehr, Ph.D.; Andreea Seritan, M.D.; Renee Binder, M.D.; Earth Hassari, M.D.; and the San Francisco Veterans Administration Medical Center's PTSD treatment team led by William Wolfe, M.D., and Brian Molenhoff, M.D., also contributed valuable ideas and edits.

CHAPTER 1

Principles of Psychological Responses to Stressor Events

PSYCHOLOGICAL TRAUMA CAN OCCUR WHEN

dire events affect individuals to the degree that they experience overwhelming fear, helplessness, horror, or a need to blot out feelings and memories. Memory fragments may not adequately contextualize the actual series of events. As a result, the potential to experience states of terror with a sense of helplessness and perceptual disorientation can live on in the mind after the conclusion of the original events.

At one extreme, denial may occur. At the other extreme, intrusive memories and fearful expectations may cause social dysfunction. The self and the world may appear to have changed, and the person may report depersonalization and derealization experiences. Subsequently, the patient may experience physical health consequences such as exacerbation of preexisting medical conditions or gastrointestinal and cardiovascular symptoms (Croft et al. 2019; Kessler et al. 2018). Certain brain modules, circuitries, and hormonal neurotransmitter systems may be sensitized to alarm reactions or disrupted control (LeDoux and Pine 2016; Lehner et al. 2016).

Stress response syndromes may be diagnosed when the aforementioned denial and intrusion states of mind do not subside with time and support. The aim of treatment is both to restore equilibrium and advance coping capacities. An important aspect of treatment is support for restoration of equilibrium through reduction of entry into states of emotional turbulence.

Various degrees of cognitive processing of the meanings of the events and the consequences to the self may occur in phases (see section "Phases of Response to Traumas and Losses"). In this book, I emphasize that psychotherapy can assist individuals in making such restorative changes. In addition to symptom relief, attitudes formed during a process of working through can lead to more self-efficacy and enhanced emotional regulation. The treatment of an impacted person may help that individual achieve personality growth (Horowitz 2016, 2019).

Memories of Trauma and Loss Events

Incompletely assimilated memories are retained in various strata and categories of storage. The intensity of potential meanings and feelings associated with the events can mark some memories for later conscious representation, review, and reappraisal. The potential for unthinking rage, anxiety, shame, guilt, and prolonged sadness may remain until the completion of that processing.

Disturbances in identity, relationships, and emotional regulation may occur and may undergo phases of resolution or return. Social connection may be disrupted just when the impacted person needs more support. Self-esteem may collapse, and self-coherence may falter.

Stress response syndromes may include a sense of being unable to rely on one's previously learned capacities for how to solve current problems. The mismatch between the trauma and the coping skills that previously had been effective may lead to self-criticisms and blaming. Loss of coherence in self-organizing beliefs may contribute to dissociative experiences.

Extreme affective potentials may continue as disturbed states of mind. The person may have attacks of confusion, rage, or despair. An individual may experience a sense of loss of control over feelings just when he or she needs heightened capacity to regulate emotions. However, with successful assimilation and accommodation, memory systems can be integrated, and a coherent sense of past, present, and future can be achieved.

Avoidance Symptoms

Emotional blunting and dissociative states can alter patterns of social interaction. The individual may develop phobic avoidance of places and situations that remind him or her of the trauma, even inhibiting exposure to colors and odors associated with the trauma. Socially, members of an individual's support network may take offense with what appears to them as

withdrawal due to numbing of feelings and avoidance of previous levels of warm connections. Family life, friendships, and work relationships may deteriorate. If this happens, others' withdrawal may limit support and repair of the individual's sense of coherent self-organization.

Intrusive Symptoms

Memories tend to repeat in conscious representation in spite of avoidance maneuvers. Intrusive experiences include nightmares, bad daydreams, flashbacks, perceptual memories, and frightening expectations of "What's next?!" Recurrent cycles of avoidance and intrusive states of mind are common (Horowitz 1976, 2011; Horowitz et al. 1979). Processing takes longer than most people expect. For example, when in someone is mourning, it may take a year or more before the individual feels that a new equilibrium is in place.

Individuals may maintain hyperalert attention deployment as if they were in perpetual danger even though they are not in danger. Compulsive behavioral reenactments may occur. For example, after an assault, an individual may provoke a fight with a stranger or assume the role of an aggressor instead of a victim.

Recurrent intrusive memories and imaginary elaborations can range from a minor fragment of the traumatic perceptual experience (such as a flashback to a single smell or image) or a larger complex of experiences (such as seemingly reliving a sequence of events). They can also take the form of the individual compulsively engaging in risky behavior as if to prove to himself or herself that the trauma or loss cannot recur. Intrusive trauma memories may also include imagined scenarios of what the individual wishes he or she had been able to do or would want to do should a similar event ever happen again.

Cognitive Processing

In nonpathological reactions to stressor events, individuals can expect to see a decrease of intrusive, avoidance, and alarm states of mind over time. This is due to a combination of automatic mental processes that include *habituation* (getting used to the safety of a somewhat similar situation in which the threat does not repeat), *extinction learning* (learning that the perceptual stimuli associated with the trauma are no longer associated with traumatic probabilities), and *desensitization* (the body learning to remain calm in similar perceptual situations).

In psychopathological syndromes, alarmed reactions in response to trauma-associated percepts may be intense, frequent, and prolonged. For

example, a person mugged in a dark garage may feel his or her heart race and stomach clench when driving into the same garage years later or even any dark place with cars. The goal of adaptation is the controlled review of experiences with cognitive reappraisals until acceptance occurs, coping strategies are fully mobilized, and new schemas are formed. The revised schematization affects the person's sense of identity and connectivities to significant others as well as beliefs about attachments to social communities.

Reactions to stressor events can take several forms. Clinicians should look for the five Ds: dissociation, disavowal, denial, depersonalization, and derealization. *Dissociation* can reduce terror by effectively telling one's mind, "I am not really here." *Disavowal* of aspects of traumatic experiences can be used to lessen negative emotions that otherwise threaten to disorganize thought. *Denial* can include misappraisal of the meanings of the event. *Depersonalization* can be a sense of no longer being the same person as before the event, and *derealization* can be a sense that current perceptual reality is unreal or somehow dreamy. The five D experiences are maladaptive and distressing when the individual reflects on them, but they are part of defensive coping because emotional flooding may be reduced for a time.

Case Example: A Shattering Bodily Injury

Sophia, age 26, worked as a successful model until a car accident resulted in severe injuries that caused permanent blindness and required amputation of one of her legs. She also emerged with severe facial scarring. Sophia spent a long time in the hospital followed by months in a rehabilitation facility. The medical team sought psychiatric consultation because of what seemed to be irrational levels of denial.

Initially, Sophia did not allow herself to be aware of her blindness; she would not discuss the topic with any physician, nurse, staff, or family member. She did, however, think and talk about the loss of her leg. Sophia's lack of recognition of her blindness was astonishing to staff members given that she required constant assistance with many functions. Despite her denial of her blindness, she remained poised and not psychotic.

Sophia's sense of identity had not shifted to accommodate the terrible news of her altered body. She repeatedly asked staff members when she could schedule her next modeling appointments. She was able to talk about how to cope with being blind only after several weeks had passed. The topic of her facial disfigurement and loss of her modeling career could not be broached with her until an even longer period had passed.

Sophia was diagnosed as having a severe adjustment disorder and extreme dissociation. She finally accepted a long-rejected recommendation for psychotherapy. The therapist shared with her an initial formulation and the goals of therapy. Agreement on focus led to discussions about the changes in her body and their social implications. An extreme discord was present between Sophia's internal mental model of herself and her physical

alterations. Mourning and identity growth would take a long time with extended support from lpsychotherapy.

In the context of this therapy, Sophia required 2 years to recover psychological equilibrium and to develop an identity that was coherent with her altered bodily functioning and social opportunities. She learned new self-concepts through a variety of means, including identification with the competence and positive attitudes she observed in various health professionals.

Eventually, Sophia was able to tolerate her suffering and reduce it. She trained as a rehabilitation therapist specializing in music therapy. Later, she was able to form a successful long-term relationship and became a teacher who trained rehabilitation workers.

Phases of Response to Traumas and Losses

Patients often seek a first clinical evaluation long after the conclusion of a stressor event and perhaps midway in the phases of reaction. The prototypical phases of reactions after a stressor include the following (Horowitz 2011):

- Outcry—The first emotional response is often intense and uncontrolled.
- Denial, numbing, and avoidance—Excessive emotional regulation strategies may be used in the phase that follows initial emotional expressions.
- Intrusions, pangs, and repetitions—Memories of and associations with conscious representations emerge, giving rise to more sorrow, anger, remorse, or fear than was felt in the previous phase of denial and numbing.
- Working through—The trauma story is renarrated, the meaning of the trauma to the self is reappraised, and attitudes are revised. Swings between intrusion and avoidance may occur and gradually attenuate as new coping skills are acquired.
- Restoration of equilibrium—A person who has regressed under stress may progress to a pre-event level of functioning. Some people may exhibit an increase in self-coherence, self-esteem, and confidence as signs of posttraumatic personality growth (Horowitz 2016).

These general phases of stress response syndromes may seem similar to the five stages of grief described by Kübler-Ross (1969) as denial, anger, bargaining, depression, and acceptance. However, control of thought and regulation of emotion are emphasized in the phases of reaction of stress response syndromes, whereas the ideational and emotional content is emphasized in the progression through the Kübler-Ross stages of resolving grief. In addition, in psychotherapy, patients move in and out of the different phases of stress response syndromes, and each of these phases is worked through while taking into account the patient's preferences, cultural beliefs, and social supports.

Personality Factors

Individuals experience trauma in terms of their prior life experiences and personality characteristics. Appraisals and reappraisals are influenced by patients' identity and schematic structure of relationships between self and various others, including ethnic and spiritual communities. In addition, their experience of prior stressor events will have left enduring and only slowly changing attitudes. Adverse childhood events may have inscribed a sense of excessive vulnerability (Caspi and Moffitt 2018; Herman 1997; Horowitz 2002). These are reasons why recovery from trauma often involves reorganizing narratives about the self in the world in the time frames of past, present, and future (Classen et al. 2006; Cloitre et al. 2009).

Schemas for relationships develop throughout life and build toward wisdom with life experiences. Various personality configurations can lead to adaptive responses to trauma and loss, such as seeking help and building self-supportive connections with others. Preexisting personality problems can lead to maladaptive responses, as shown in Figure 1–1. The individual may seek risky, exploitative supports for self-coherence or react too negatively to possible helpers.

The next case example illustrates how a stressor event can become entangled with preexisting personality issues.

Case Example: The Trauma of a Fire

While traveling on business in another country, 44-year-old Harold and his wife narrowly escaped a frightening hotel fire with only minor smoke inhalation injuries. Harold and his wife agreed that she would return home at once while Harold remained, rescheduling his local appointments.

In the ensuing days, as he engaged in his business activities, Harold experienced feelings of unreality and felt numb. He also experienced a state in which he became too talkative and was rebuked for inappropriately touching the women he encountered in business. Five nights after the fire, Harold awakened from a nightmare, screaming, "Help me, help me!" During the sixth day, he was tense, felt anxious, and had a sense of chaos about his life roles. He canceled his business appointments, flew home, and sought professional help.

When he was evaluated, Harold was found to have intrusive memories of the fire, of seeing his wife off at the airport, and of being embarrassed by his conduct during his engagements with businesswomen. He felt phobic and avoided planning future business travel even though his work depended on it. He experienced nearly constant tension and had a few episodes of hyperventilation.

Harold received a diagnosis of acute stress disorder. The evaluating clinician inferred that Harold had under-modulated states organized by vulnerable self-concepts and roles of dependency in relationships. Although

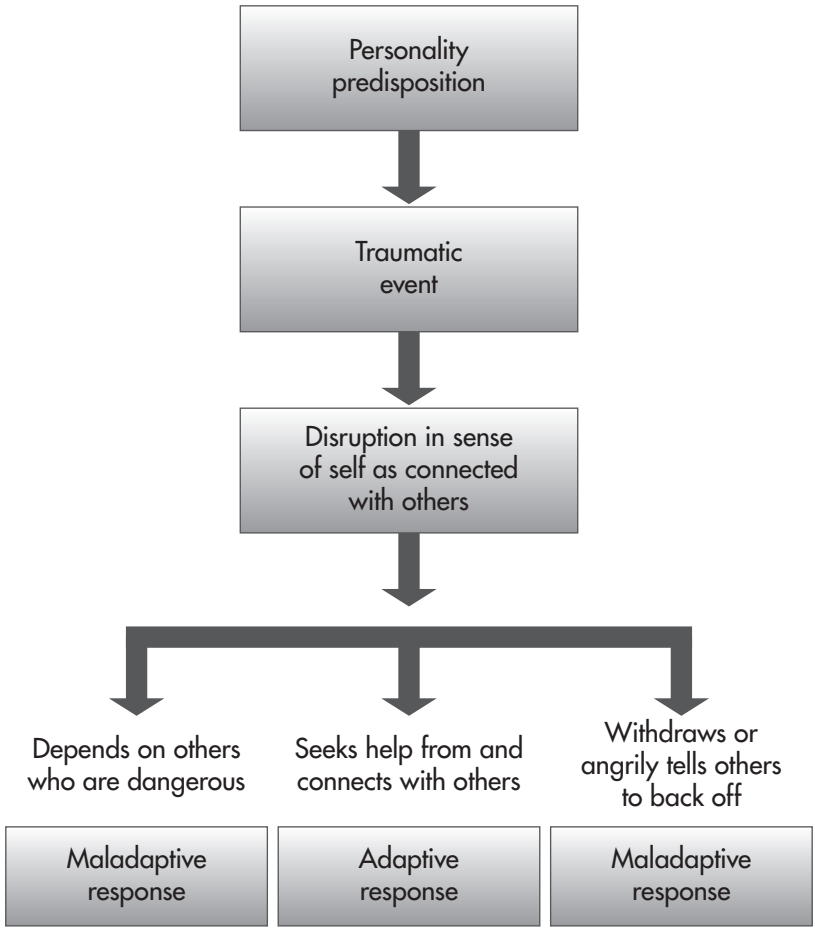

FIGURE 1–1. Development of responses to trauma.

these person schemas had been present (but latent) before the trauma, they were reactivated by the stressor context. It was decided to focus a brief therapy on the topic of the fire and Harold's subsequent reactions. Part of this focus would be how and why the fire and its sequelae led to an activation of Harold's schema of feeling like a needy child who required maternal attention and who felt abandoned and frightened without it.

The task of restoring equilibrium was rapidly accomplished. After a few weeks of psychotherapy, Harold's intrusive, avoidant, and hyperarousal symptoms had diminished, although he still felt vulnerable and lacking in his usual intelligence, verve, and self-confidence. Additional therapy sessions then focused on aspects of dependency in Harold's relationship with his wife and his need for her attention. This work increased Harold's sense of self-confidence and identity coherence. It enabled him to engage more mutually

TABLE 1–1. Types of stress response syndromes

Type	Characteristics	Treatment actions
Simple	Stress response caused by a specifiable traumatic event that occurred before symptom formation in a previously well-functioning person	Help patient deal with his or her story and the consequences of the traumatic event
Comorbid	Posttraumatic problems compounded by substance abuse, anxiety, depressive disorders, or brain injury	Prioritize which problems to treat first
Complex	Prior severe/multiple traumas reactivated by current stresses; comorbid personality disorders	Establish aims to increase a sense of self-coherence and enhance capacities for relationships and emotional regulation

with his wife than he had been able to do before the event. He recovered all of his pretraumatic functional levels of self-esteem and self-confidence.

Pathological Syndromes

Traumatization may result in a variety of psychopathological syndromes (Horowitz 1976, 2011; Spiegel and Classen 1995; van der Kolk et al. 2005). In DSM-5 (American Psychiatric Association 2013), the common disorders are posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorder. Trauma can occur with comorbidities of traumatic brain injury (TBI), mood and anxiety syndromes, and substance use disorders in addition to PTSD (Aupperle 2018; Berenz and Coffey 2012; Kaysen et al. 2014). Reactions to recent traumas may also be influenced by the occurrence of previously unresolved personality issues, which can cause complex reactions, described in ICD-11 as complex PTSD (CPTSD; Herman 1997; Maercker et al. 2013; World Health Organization 2018).

Treatment stages are described in this book in terms of syndromes that are simple, comorbid, or complex. Table 1–1 depicts these typologies.

Treatment

Psychotherapy is an effective treatment for stress response syndromes. The patient in psychotherapy goes through various phases of change, and the therapist uses various teachings in each phase. These phases are described in the ensuing chapters and are summarized in Table 1–2. Formulation and therapy techniques are typically revised as the treatment proceeds.

TABLE 1–2. Overview of common phases of therapy

Phases	Patient activity	Therapist activity	Therapeutic relationship
Assessment	Reports events and personal responses, symptoms, problems, and goals	Obtains history and makes early formulations Provides educational information if needed Discusses treatment indications and options	Patient and therapist agree on initial frame, with hope fostered by expertise and empathy
Support	Expands story and focuses on how to cope with current stress	Acts to stabilize states Establishes preliminary focus of the traumatic event and its meaning to self	Roles and scenarios of a therapeutic partnership are defined
Exploration of meanings	Expands on meaning of the trauma and its sequelae to the self	Clarifies how emotions and ideas are linked to stressor events and the patient's appraisals of them	The therapeutic alliance is deepened by experience of safety
Improving coping	Works on themes previously avoided	Acts to encourage tolerance of emotional reactions Helps the patient modify dysfunctional beliefs	Patient negotiates how to handle difficult situations and maintain state stability
Working through	Renarrates story to restore a sense of self-efficacy	Helps patient modify attitudes	Attitudes toward the future are examined and negotiated realistically
Terminating	Considers gains and unfinished issues and charts how to cope with future situations	Highlights the most helpful new attitudes and changes that occurred	Emphasis is placed on safe separation, and possible booster sessions are determined

Summary

Stress response syndromes are characterized by intrusive mental experiences and avoidant behaviors with psychological numbing and inhibitory operations. These signs and symptoms may be prolonged in individuals

who have comorbid conditions or predisposing complications from personality configurations. The use of phase-oriented therapy techniques and individualized formulations will lead to symptom amelioration and even personality growth. The goals of treatment are providing sufficient support, helping cognitive and emotional processing, and providing ways to learn how to enhance capacities for coping and reflective reasoning.

CHAPTER 2

Assessment and Treatment Planning

DURING THE FIRST CLINICAL ENCOUNTERS, the clinician listens, observes, and organizes information into diagnostic formulations. The clinician then shares these impressions and discusses treatment options with the patient. When indicated, these impressions can also be shared with members of the patient's family and with other members of the clinical team. The therapist and patient review options and select initial steps.

Three principles are important when doing evaluations. First, in eliciting the patient's reasons for coming for help at this time, the complaints and symptoms are put into a historical context. The current precipitants are considered; then the clinician asks questions about other past traumas and losses that may relate in some way to the current crisis. Second, initial formulations are considered to be tentative and will likely be revised and augmented as information from more than one session accumulates. Third, the clinician provides some information on the likely course of stress response symptoms and the possible progress in treatment. The clinician provides the patient realistic hope of a positive outcome from treatment.

Evaluation

In evaluating stress response syndromes, the clinician should follow the usual process of psychiatric interviewing. The clinician needs to take a history, observe mental status, assess current level of cognitive and emotional functioning, and document differential diagnoses. It should be noted that some patients will find it difficult to discuss the stressor event and its linkage to symptom formation.

People's memories of traumas are often fragmented. The experiences may seem dissociated, and the pieces of memory may seem contradictory. In addition, reporting the story may evoke pangs of emotion, and these may lead to inhibitions of dialogue and thinking. Under-modulated states of mind may also be precipitated by recall of the event and perhaps may interrupt the flow of clear communication. For example, as a patient cries uncontrollably, a shift in state may occur, and the patient may need some time to restore equilibrium.

During the evaluation sessions, patients with over-modulated states of mind may provide intellectualizations that do not connect to their potentially intense feelings of sadness, fear, anger, guilt, or shame. For example, rather than discussing their present personal traumatic experiences, patients may discuss the fluctuating stock market as a cause for their anxiety. Distortions of cause and consequence are common, and stories may fluctuate (Andrews et al. 1999; Elliott 1997; Spiegel 1997; Williams and Banyard 1999).

When the patient is talking about the story of stressor events and subsequent disruptions in social functioning, the clinician should ask questions judiciously. It is important to let patients proceed to elaborate ideas and feelings at their own pace; allowing the patient to proceed without rapid questions from the clinician provides an opportunity for the clinician to observe for signs of excessive or insufficient emotional regulation when certain topics emerge. The clinician can use such observations to assess which topics are unresolved and to consider the patient's degree of irrationality, distortion, and suppression of recall or response. Then the clinician can gradually introduce a more structured approach by asking focused questions.

In an evaluation or treatment session, the clinician frames his or her own attention with an *observe*, *formulate*, *act* model of the present moment. The clinician listens, observing verbal and nonverbal communications. He or she then formulates why and how the messages are transmitted. The clinician acts with a remark based on his or her intuitive formulation and then observes how the patient responds to the message. This observe, formulate, act cycle is preconscious and is amplified by experience.

Experience also suggests the principle of asking about adverse childhood and adolescent experiences during early evaluations. This may be important for several reasons. First, such a history is associated with a higher incidence of posttraumatic stress disorder (PTSD), with multiple previous adverse events having the strongest effect (Breslau et al. 1998). Second, the person is likely to have retained special sensitivities, beliefs, and attitudes of self as related to others. Personality traits are also important to assess. Negativism, neuroticism, and low self-confidence have all been implicated as possible risk factors for PTSD in epidemiological studies (e.g., Bramsen et al. 2000; Card 1987; McFarlane 1988).

Assessing the patient's current deficits and need for support is vital. Low socioeconomic status increases the likelihood of depressive and other symptoms (Adler et al. 1998). Displacement, inadequate family cohesion, and an absence of supportive relationships in which to communicate all are likely to reduce recovery from the impacts of traumas and losses (Hammen et al. 1992; Laor et al. 2001).

Symptom Description

Many patients do not possess the adequate vocabulary and capacity for reflective self-awareness needed to describe in words their mental experiences. Therefore, it is up to the clinician to ask questions about possible symptoms that the patient may have been experiencing. Asking for sensation memories may be evocative (Wilson et al. 2016). For example, the clinician might ask, "Are there any especially vivid pictures that have come to mind? Any odors, any sensations that occurred in your body?"

Feeling dazed about the flow of images coming in from perception of the outside world and the auditory and visual images within the representational systems of the mind may occur more frequently during avoidant states of mind, just as flashback images may occur more frequently in intrusive states of mind. Startle reactions may be reported more frequently when the patient is in hypervigilant, highly aroused states.

The patient's self-observational reports of symptoms may include attention, consciousness, information processing qualities in trains of thought, emotional experiences, and patterns of action with the body. A summary of common symptoms about which the clinician might decide to ask direct questions is provided in Table 2–1.

As shown for information processing in Table 2–1, a patient may be telling the stressor event and internal impact story as experienced so far. This story may be fragmentary, distorted, and incomplete. As treatment goes forward and evaluations are repeated, puzzlelike pieces will be put together and the narrative elaborated, and patients will begin to process the story. Memory is seldom completely accurate. That is why the word "story" is helpful because narratives may evolve as time progresses (see Chapter 6, "Renarration and Reschematization").

Posttraumatic Stress Disorder

DSM-5 lists eight required diagnostic criteria for PTSD (Table 2–2; American Psychiatric Association 2013). Each criterion may be met by any one of a cluster of symptoms. The following case example of Bill's PTSD illustrates

TABLE 2–1. Common symptoms and signs during avoidant, intrusive, and hyperaroused states

	Symptoms during avoidant states of mind	Symptoms during intrusive states of mind	Symptoms during hyperarousal states of mind
Perception and attention	Sense of confusion Selective inattention and feeling dazed	Sleep and dream disturbances, flashbacks	Hypervigilance, startle reactions
Consciousness of how ideas and feelings relate to traumatic events	Amnesia (complete or partial) Noncontemplation of topics that ought to be considered because of emotional potentials	Intrusive thoughts, emotions, and behaviors Feeling disorganized when thinking about event-related themes	Feeling time-pressured; racing thoughts; panic
Information processing	Disavowal of meanings associated with the event Loss of realistic sense of self-connection Constriction of range of thought Inflexibility of purpose Major use of illusions to counteract realistic appraisals	Overgeneralization of stimuli so that they seem related to the event Preoccupation with event-related themes, with inability to concentrate on other topics	Persistent bias toward information with negative emotional connotations
Emotional experiences	Numbness	Sudden pangs of feelings	Gastrointestinal irritations, muscle pain, palpitations
Action patterns	Withdrawal	Compulsive repetition of actions associated with the event (e.g., search for lost persons or situations)	Frantic overactivity

how each individual with this diagnosis is different and the importance of individualized case formulation in treatment planning. In Table 2–2, the DSM-5 PTSD diagnostic criteria are listed on the left and Bill's specific experiences are listed on the right.

Case Example: DSM-5 Criteria for PTSD

Bill was a 29-year-old single man employed full time who was not taking any medications and had no previous psychiatric diagnoses, medical illness, or trauma history. He received a phone call telling him his brother had been decapitated in a farm machine accident. Bill reported unbidden memory repetition of the phone call, intrusive memories of vomiting after hanging up, and thoughts about family phone calls regarding the funeral. He felt "upset again and again" and experienced nausea when reminded of his brother. He refused to attend the funeral because he knew he would find it too upsetting. When trying to sleep, he ruminated on expected criticism from his family. He was ashamed about wanting to avoid all memories of his brother. He felt worthless and cowardly and had vague ideas he would die young. Bill felt remote and disconnected from others, stopped looking at family postings on Facebook, and did not call friends and family. He reported significant anhedonia and feeling numb. He drank and watched TV to excess, although his drinking was not so excessive as to warrant a substance use disorder diagnosis. He had anxiety, depressing thoughts, and distracted states that noticeably interfered with his work. His difficulty concentrating on necessary tasks became intense during the months following his brother's death. He sought help because he felt preoccupied and feared losing his job and being unable to pay his rent.

Formulating Bill's Case With a Biopsychosocial Model

In formulation, biopsychosocial interactions are considered in relation to *predisposing*, *precipitating*, *protective*, and *perpetuating* factors. Predisposing factors are those that were in place before the current stressors that are the precipitants of symptoms. Protective factors influence resilience, and perpetuating factors reduce coping capacities. Each factor can have biological, psychological, or social factors in interaction.

Biological Factors

Bill's family history did not suggest any genetic factors as a possible predisposition for PTSD. Alcohol produced a dulling mental effect on Bill, and he used it as a way of coping with intense emotions. Excessive consumption of alcohol impaired his information-processing capacities, leaving memo-

TABLE 2–2. DSM-5 criteria for posttraumatic stress disorder and Bill's related experiences

DSM-5 criteria	Bill's experience
Criterion A: stressor (one required)	
The person was exposed to actual or threatened death, serious injury, or sexual violence in one or more of the following way(s):	
Direct exposure	NA
Witnessing the trauma	NA
Learning that a relative or close friend was exposed to trauma	Bill received a phone call telling him his brother had been decapitated in a farm machine accident.
Exposure to aversive details of the trauma, such as during professional duties (e.g., first responders, medics)	NA
Criterion B: intrusion symptoms (one required)	
The traumatic event is persistently reexperienced in one or more of the following way(s):	
Unwanted upsetting memories	Bill reported unbidden memory repetition of the phone call, intrusive memories of vomiting after hanging up, and thoughts about family phone calls regarding the funeral.
Nightmares	NA
Dissociative reactions (e.g., flashbacks)	NA
Emotional distress after exposure to traumatic reminders	Bill felt "upset again and again" when reminded of his brother.
Physiological reactivity after exposure to traumatic reminders	Bill experienced nausea.
Criterion C: avoidance (one required)	
Avoidance of one or both of the following stimuli after the trauma:	
Trauma-related memories, thoughts, or feelings	Bill refused to attend the funeral because he knew he would find it too upsetting.
Trauma-related external reminders	Bill felt ashamed about wanting to avoid all memories of his brother.

TABLE 2–2. DSM-5 criteria for posttraumatic stress disorder and Bill's related experiences *(continued)*

DSM-5 criteria	Bill's experience
Criterion D: negative alterations in cognitions and mood (two required)	
Negative thoughts or feelings that began or worsened after the trauma, as evidenced by two or more of the following:	
Inability to recall key features of the trauma	NA
Overly negative thoughts and assumptions about oneself or the world	Bill felt worthless and cowardly and had vague ideas he would die young.
Exaggerated blame of self or others for causing the trauma	NA
Negative affect	NA
Decreased interest in activities	Bill stopped looking at family postings on Facebook and did not call friends and family.
Feeling isolated	Bill felt remote and disconnected from others.
Difficulty experiencing positive affect	Bill reported significant anhedonia.
Criterion E: alterations in arousal and reactivity (two required)	
Trauma-related arousal and reactivity that began or worsened after the trauma, as evidenced by two or more of the following:	
Irritability or aggression	NA
Risky or destructive behavior	NA
Hypervigilance	NA
Heightened startle reaction	NA
Difficulty concentrating	Bill was unable to meet usual work deadlines. He felt numb and drank and watched TV to excess.
Difficulty sleeping	When trying to sleep, Bill ruminated on expected criticism from his family.
Criterion F: duration (required)	
Symptoms last for more than 1 month	Bill's symptoms continued for months after his brother's death.

TABLE 2–2. DSM-5 criteria for posttraumatic stress disorder and Bill's related experiences *(continued)*

DSM-5 criteria	Bill's experience
Criterion G: functional significance (required)	
Symptoms create distress or functional impairment (e.g., social, occupational)	Bill felt vulnerable to being fired at any moment because of his reduced work productivity and quality.
Criterion H: exclusion (required)	
Symptoms are not due to medication, substance use, or other illness	Bill's drinking was not so excessive as to warrant a substance use disorder diagnosis. He was not taking any medications and had no previous psychiatric diagnoses, medical illness, or trauma history.

Abbreviation. NA=not applicable.

Source. American Psychiatric Association 2013.

ries incompletely processed and conflicts unresolved. Cloudy thinking also reduced his competence at work. Bill's drinking and craving for alcohol may be considered a *perpetuating factor*.

Psychological Factors

Bill's memory of the phone call was articulated with preexisting ambivalence about his brother and family members, which was both a *predisposing* and a *precipitating* factor. This matrix may include preexisting attitudes such as vulnerabilities in Bill's sense of identity and concern that others may respond negatively to him, causing potential shame, guilt, and isolation. Expectation of family criticism for not attending the funeral was intrusive and repetitive because this topic was incompletely processed. Bill had not reached a self appraisal of his actions and how to act next to ameliorate remorse.

Social Factors

Bill was criticized by his family because of his response to his brother's death. In therapy, it would be important to help him process issues of embarrassment and potential survivor's guilt. In a supportive psychotherapy, he can be helped to talk to his family about the meaning of his brother's death to him and conveying to others that he now seeks better connections with them. Otherwise, isolation may become a disorder *perpetuating* factor. Bill's work and social relationships could be regarded as *protective* factors if

TABLE 2–3. Configurational analysis of stress response syndromes

Component	Description
Phenomena	Select the symptoms and problems that need to be explained and describe the stressor events that may have precipitated them.
States of mind	Describe states in which the symptoms and problems do and do not occur. Indicate triggers to problematic states. Include states of avoidance.
Topics of concern	Describe unresolved stress-related topics and how they evoke problematic states. Indicate patterns of dysfunctional beliefs. Describe how expression is obscured by defensive operations.
Identity and relationships	For each recurrent state, infer roles of self and others and schematized transactions between self and others. Describe desired and dreaded role relationship models as well as compromise role relationship models that ward off danger.
Integration and therapy planning	Explain how attitudes about self and other lead to problematic states and how any pathogenic defenses operate to prolong symptoms. Plan how to counteract dysfunctional beliefs and plan adaptive future actions.

Source. Horowitz 2005.

therapy helps him discuss his experiences and feelings with his coworkers and family and gain their support.

Formulation in the Context of Psychotherapy: Configurational Analysis

Configurational analysis (Horowitz 2019) can be useful in planning and revising psychotherapy. The method has five steps from surface to depth, as summarized for stress response syndromes in Table 2–3.

The first step in configurational analysis is to identify the phenomena. In the case example, the phenomena are Bill's symptoms and problems as described in Table 2–2, including intrusive memories of the call and vomiting, feeling ashamed, insomnia, work anxiety, and excessive alcohol intake. The second step relates these complaints to Bill's *states of mind*. For

example, stress at his job resulted from Bill's uncontrolled states of distracted thinking. This undesirable state is contrasted with a desired state of concentration on work tasks. Another common and dreaded state that may be inferred in a configurational analysis is that of feared humiliation. In addition, Bill exhibited signs of avoidance and numbing, a defensive state, that was possibly connected with his coping by excessive consumption of alcohol.

The therapist should note when Bill shifts into distracted states of mind during psychotherapy. This might lead Bill and the therapist to the third step, *topics of concern*. During this step, Bill and the therapist identify themes that are related to the unexpected violent death of Bill's brother, his memory related to avoiding the funeral, and his fear of job loss.

The fourth step of configurational analysis, *identity and relationships*, involves formulating Bill's attitudes toward himself and others. These were unclear at initial evaluation, but the therapist can observe attitudes about self, brother, and family and learn about historical transaction patterns. Bill might feel incompetent, abandoned, shamed, scorned, abused, or unworthy. When discussing these topics, the therapist should observe Bill's patterns of self-regulation, identity, and relationships.

The fifth step is *integration and therapy planning*. The clinician might suggest to Bill that a psychotherapy to explore meanings is indicated. The expectation is that Bill needs help to develop several important new narratives in order to understand what his brother's death meant to him, the history of his relationship with his brother, and his new future with his family after the loss.

Bill's case was evaluated in the following sequence: diagnosis; consideration of biological, social, and psychological factors; and surface-to-depth steps of formulation of psychological aspects of the case. Another case of a single traumatic incident inciting prolonged social dysfunction further illustrates how individualized formulation using the steps of configurational analysis can lead to treatment planning.

Case Example: A Crisis of Responsibility

Frank was a 25-year-old lifeguard at a neighborhood pool. One busy summer day, in addition to the many people in the water, children and adolescents were running around on the slippery deck. Frank was quite busy and realized that he was so overloaded with demands for his attention that he could not make sure everyone was safe. He blew his whistle and ordered the pool cleared.

To his horror, there was an inert body at the bottom of the pool. He dived in at once and brought a small, limp, nonbreathing child to the deck.

Frank began cardiopulmonary resuscitation, but it failed to revive the small boy, who was later pronounced dead. Overcome with remorse, Frank went to the funeral of the deceased child. He was greeted with many angry scowls and was upset by the grief-stricken faces of the child's parents.

After the drowning, Frank felt extremely stressed and developed a variety of psychological symptoms, including seeing images of the drowned child and experiencing anxiety about his own imminent death. On evaluation, Frank was diagnosed with PTSD, including symptoms of intense and persisting intrusive and avoidant experiences interfering with social functioning related to this event.

Phenomena to Explain

Frank went through turbulent periods of remorse, insomnia, attacks of anxiety, guilt, and shame, and he developed a dread of dying. He quit his job, had difficulty concentrating, and avoided pools, children, and the neighborhood where he had worked as a lifeguard. Frank had intensely frightening nightmares with visual images of a dead body in a pool, a blurred child's face, and angry adult faces. Pangs of memory and remorse disturbed his behavior at his new job. He had outbursts of anger with his friends.

States of Mind

Frank could not sustain attention on tasks in either his job or his recreational activities. He could seldom achieve a desired state of focused concentration. Instead, he felt that everything in his world was cloaked in fog. He felt empty of meaning. At times, he had a dreaded under-modulated state of panic—he felt as if he were about to die. At other times, he was irritable. These states were markedly different from his usual equanimity, diligence, amiability, and enthusiasm before the incident.

Topics of Concern and Emotional Control Processes

Frank felt horribly guilty and ashamed, and the therapist communicated empathic and compassionate recognition of his suffering. To get at the complex of associated beliefs that connected to Frank's feelings, the therapist needed to move beyond his withdrawal and avoidance. For example, Frank made avoidant statements asserting that he had already worked through these issues, expressing rationalizations such as "It is over and that's that."

Identity and Relationships

Frank viewed himself with antithetical sets of self-concepts. His dreaded state had a sense of self as an irresponsible, negligent, self-centered caretaker. Frank entered this state episodically and feared reentry into its powerful and distressing feelings. He wished instead to regard himself as a truly caring person who was competent at protecting others. Frank reduced his guilty feelings by externalizing blame onto the pool directors, who did not care enough to hire additional lifeguards or control the number of people allowed to use the pool. In his defensively avoidant state, he saw himself as a loner without need for connections to others.

Treatment Planning

Psychotherapy extending beyond initial support was chosen as the treatment of choice. First, the therapist would establish a nonjudgmental relationship. In this context, the associating themes Frank might bring up would be connected to a central focus on the appraisal and reappraisal of the chain of events surrounding the drowning episode, with full expression of negative emotions likely to emerge during such topics of attention.

Case Example: Coping With the Death of a Parent

Samantha, a 55-year-old woman, appeared for a psychiatric consultation at the insistence of her husband. Her mother, age 90, had died of cancer 1 year earlier. Samantha had been close to her mother, and they had spoken by telephone daily for decades.

Samantha consulted clairvoyants in an attempt to communicate with her mother in the spirit world. The expense of these clairvoyants caused friction with her husband because they were of limited means and he was nearing retirement. He was disgusted with Samantha's irrationality and derisively handed her a Ouija board that he had purchased "so you can save money by communicating with your mother without clairvoyants." They had an intense and verbally abusive argument.

Samantha felt agitated, depressed, and desperate after this argument. She felt that she no longer loved or was loved by her husband; she blamed him and decided she might get a divorce. Samantha's husband was startled when she threatened to leave him. He then told her he loved her but was very concerned about her being so sad and irrational. She agreed to a consultation with their primary care physician.

Samantha told the physician that she missed her mother but felt no grief, just an intense personal emptiness and excruciating yearning to be in communication with her. Life seemed empty and gray without her mother. Samantha exhibited signs of emotional overcontrol, loss of appetite, weight loss, anhedonia, and sadness. When the physician asked about her mother's death and the funeral, Samantha's thinking became blocked, and she changed the topic. The physician said he wanted Samantha to have the opportunity to work on grieving her loss with a therapist and arranged the referral. The diagnosis was adjustment disorder and a bereavement-related depressive episode.

After completing an evaluation, the psychotherapist concurred with the diagnosis. Samantha came to each appointment on time, but she wanted to discuss only her anger and disappointment with her husband. She did not like it when the therapist repeated statements describing either herself or her mother. When the therapist asked questions about Samantha's past relationship with her mother, Samantha entered into an agitated state and seemed slightly confused. The therapist tactfully noted that it seemed to her that Samantha had some unfinished business, and their further talking would provide a chance for Samantha to deal with it. Samantha accepted this plan. She began to engage in a discussion of her mother's death and its effects on her and her marriage.

Complex PTSD

Complex PTSD is an ICD-11 diagnosis and is under consideration for the next iteration of DSM (Maercker et al. 2013). Complex PTSD is a syndrome that can be seen in patients who have experienced multiple adverse events that have affected development of self-organization. These patients may present with intrusive and avoidance types of symptoms plus disturbances in sense of identity, relationships, and regulation of emotion.

Although the diagnosis of PTSD may be made on initial evaluation, during treatment the therapist may make additional observations about the current level of personality functioning that suggest complex PTSD. Observations that lead in this direction include the following:

- The patient sometimes conveys confusion between what has been thought and what action he or she has taken
- The patient reports many impulsive decisions
- The patient excessively and persistently blames others and never self
- The patient seems cognitively disorganized when angry
- The patient often misreads the therapist's communications, intentions, and motives

Identity Disturbances

A person with complex PTSD may experience impaired, unworthy, or victimized self concepts from childhood that have been reactivated by traumatic or bereavement events (Briere and Rickards 2007; Dalenberg et al. 2012; Horowitz 2014). The clinician may note dissociated self-states. Dissociative states such as derealization and depersonalization are listed in DSM-5 as specifiers that the clinician can use when making a PTSD diagnosis (Friedman et al. 2016; Hoge et al. 2017).

Adverse childhood events such as sexual abuse, loss of a parent, and other traumas may have led to formation of impaired identity and attachment models. These early events and identity problems have been significantly associated with a later increase in the diagnosed rate of several psychiatric disorders (Cloitre et al. 2013; Keyes et al. 2014; Maercker and Perkonigg 2013). Identity disturbances are also included in the proposed diagnosis of persistent complex bereavement disorder (PCBD; Casey and Strain 2016; Horowitz and Sicilia 2016; Horowitz et al. 1993a, 1996; Lodi-Smith et al. 2009; McLean and Fournier 2008; Prigerson et al. 2009; Thompson and Tuch 2016).

Patients often do not explicitly report identity disturbances. The therapist can ask specifically if the patient has experienced any of the following:

- Shifting into states with a "different self" or a chaotic sense of not being an intact person
- Shifting excessively from an intuitive sense of self as the agent of action to a sense of being robotic, helpless, or immobilized
- Despairing and giving up because of a sense of self as having no future
- Shifting excessively from attractive to unattractive images of self
- Shifting excessively from strong and competent to weak self-concepts
- Feeling irrationally harsh and dangerous self-blame

When indicated, therapy includes repeated attention to appraisals of what events mean with respect to the patient's beliefs and attitudes at the present time and in the projected future. As suggested by Herman (1997) and Horowitz (2011a, 2016), the aims in therapy in such cases include helping the patient learn more coping skills for emotional regulation and realistic appraisals of the intentions of others. Supportive interventions in therapy can help stabilize identity, as described in Chapter 3, "Providing Support." The evaluation and treatment judgments suggested so far in this book are summarized in an assessment decision tree (Figure 2–1).

Summary

Traumatic memories are often fragments that need to be pieced together. Often this is a slow process. The clinician and the patient, working on a dialogue together, develop a narrative about the event in the context of what preceded and followed it, gradually coming to understand the story of the event and its consequences. In doing so, both parties are learning when and, as far as possible, how and why symptoms were formed and severe problems developed. Patients will become more hopeful as it becomes clear that the therapist is empathic, knowledgeable, and trustworthy and is trying to understand them.

Formulation is important in every case, and it should be shared with patients and, when appropriate, with other people in a support system such as the health care team and family members. Formulation leads to psychoeducation as well as discussion of treatment options and preferences. Of course, early formulation is tentative and often incomplete. Reformulation occurs down the line as the clinician makes observations during treatment.

The types of formulation discussed in this chapter include diagnostic formulation; personality factors such as identity problems; and biopsycho-

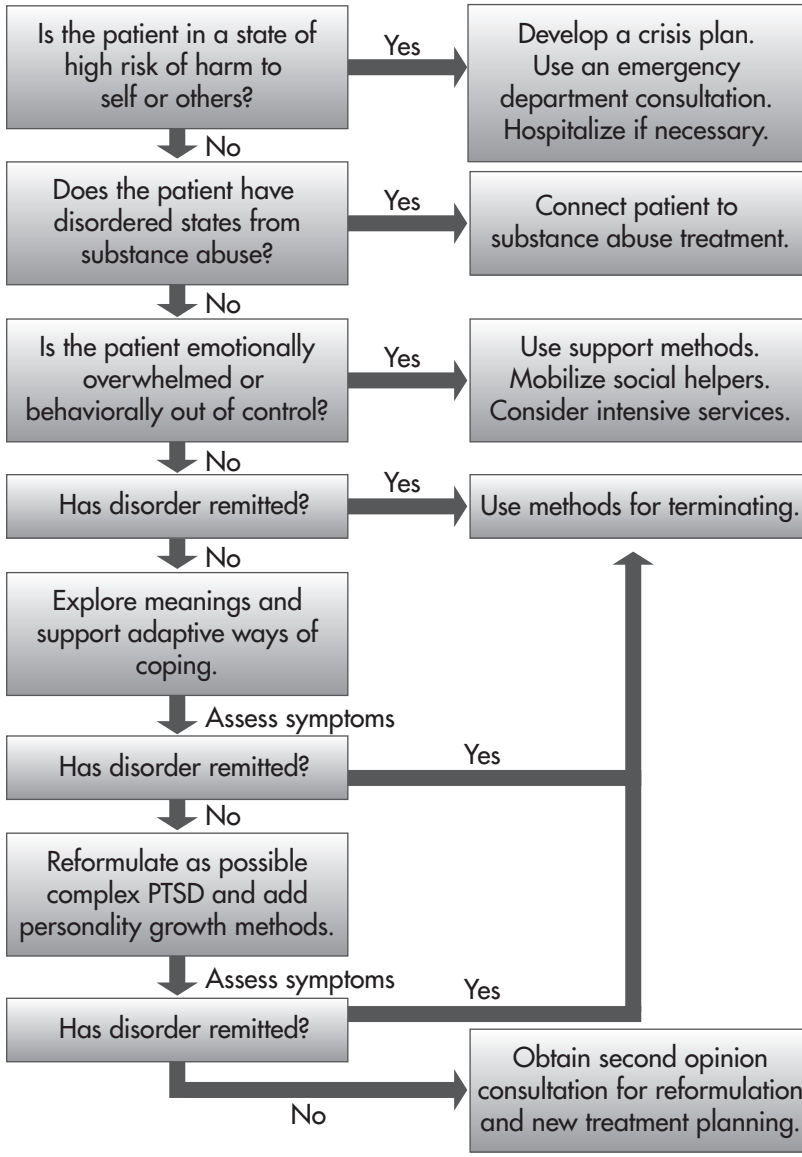

FIGURE 2–1. Flowchart for evaluation and treatment planning.

social factors in precipitation, predisposition, perpetuation of symptoms, and protective factors for coping well. The chapter also includes the states of mind approach characterized by a surface-to-depth approach to formulation in the configurational analysis method. This states of mind approach will be amplified in the following chapters.

CHAPTER 3
Providing Support

PATIENTS MAY SEEK PROFESSIONAL HELP

immediately after a catastrophic event. In such cases, they may need a team or social network to provide essential needs for food, shelter, and protection. However, many patients do not seek help right away. Instead, they seek professional help weeks or months after a traumatic event because they have symptoms and an intuitive sense that they have not fully processed memories and feelings.

After a period of resuming life as usual, the patient may have passed through a phase of denial and numbing. As these avoidance maneuvers are reduced and reminders occur, the patient may have intrusive symptoms and increased disorganization of thinking and self-reflection. For example, one patient described the pangs of feeling that followed a numbing period as having a sense that he was about to "drown in a deep lake of potential sorrow and hopelessness."

The first phase of support for current living may be indicated either immediately after a catastrophe or after a long period of incomplete restoration. The therapist creates a zone in which the patient can experience a safe enough tolerance for expression of difficult feelings in sessions. Within this containment zone, the therapist and patient plan and undertake gradual work toward prosocial behaviors, self-care, and dose-by-dose integration of memories.

The therapist begins this supportive phase during the evaluation sessions, establishing the aim of increasing safety by asking questions in an empathic manner, talking about the patient's history, and providing psychoeducation. Explaining the general patterns of how people process trauma and loss expe-

riences may already have provided the patient with a useful intellectual road map. That general way forward provided in the evaluation leads to providing more individualized understanding in the support stage of therapy. Building the therapeutic alliance relationship can reduce feelings of isolation, nameless irritability, and despondency. Describing successful treatments of similar cases increases motivation and hope.

The therapist and patient should consider together how much and what kind of support is indicated. The therapist can offer help with rational appraisals and planning as necessary if and when the patient wants this to happen. The therapist can also share the opinion that the patient might be confusing rational and irrational appraisals about what occurred or is currently occurring.

Reducing symptom acuity may be essential to increasing emotional regulation and rational organization of thinking and decision making. In some cases, patients may often forget decisions made in a session. Providing written information allows the patient to repeat what was said or decided on in sessions after departure from the setting.

The therapist continues to envelop the patient in a sense of acceptance, expertise, and open receptivity as the patient tries out doses of reviewing memories, current stressors, and future plans. The therapist offers a supportive frame of conversation, and the patient helps choose the current focus of attention. Through these dialogues, the patient and therapist may gradually encounter all relevant immediate issues, including alarm triggers, social stigmatizations, physical illness, and medications.

The therapist frames the treatment as a partnership with specific roles for each party. For example, the therapist might say, "When you told me about how you were frightened, you seemed to once again feel very uneasy. Do you think we should go into this more now, or would it be better later on?" On the topic of feeling out of control with respect to thinking and moods, the therapist might say, "You said you are taking an antidepressant and feel it is not helping. Is this a moment you want to discuss medications?" Asking these questions can slow down the impending thoughts and in-therapy transactions on threatening topics to prevent retraumatization.

In this support phase, the patient may be able to use some techniques of graduated exposure to desensitize associations to traumatic experiences. The goal is to recall a memory or exposure to threat while remaining relatively calm. However, excessive exposure techniques can lead to retraumatization in some patients. These patients may again connect feeling out of control with representation of a particular memory fragment. The patient is a partner in deciding if, when, and how much to use such techniques.

Sometimes, a patient may seem too demoralized to think clearly about the best next steps to cope with the traumatic situation. In this situation,

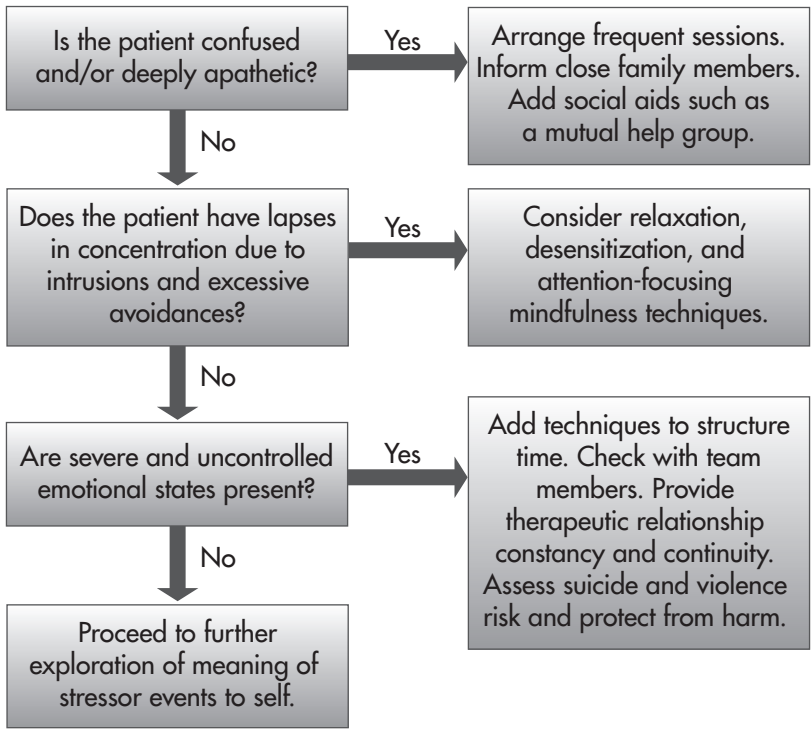

FIGURE 3–1. Clinical decision tree for providing support.

the therapist may talk more and may give advice about immediate positive steps toward feeling more effective in self care. During supportive stages, the therapist can repeat shared plans for the goals of therapy and say they aim to gradually, safely, and nonjudgmentally address the disorganized states, dark moods, and deep apathies in order to achieve more stable and rational states of mind as well as enhance capacities for prosocial behavior.

Decisions about how and when to provide various degrees of support are generalized in Figure 3–1. For the most disorganized patients, longitudinal case management may be necessary in order to avoid harm and to coordinate the efforts of multiple professional providers.

Individuals exposed to traumatic events often feel overwhelmed. Thus, effective interventions may involve advising their less-overwhelmed close companions such as family, friends, and roommates on how to be helpful. Some examples of advice are listed below.

- Many persons under high stress benefit from increased opportunities for communication with others. However, there is considerable individ-

ual variation on what to talk (and not talk) about. Asking about the details of the traumatic event is not always helpful, and discussion of events that leads to intense under-modulated states of mind (moods flooded with emotion) may seem overwhelming.

- It is often helpful to restore the individual's rest by supporting regular sleep habits.
- Activities that aid others can also help survivors of calamities in their own recovery by restoring a lost sense of self-efficacy.
- Psychoeducation of close family can be used to counteract the expectation in some work environments that the traumatized person should return to his or her usual level of function within a short time. The patient should have regular access to his or her workplace, which can sustain interests and social support, but should not be expected to immediately return to his or her previous level of occupational functioning.
- The patient may be at increased risk of having an accident while driving or operating machinery. For these reasons, protecting the patient from driving unwisely or doing hazardous work may be advisable for a limited time. This should be tactfully implemented to avoid activating feelings of incompetence.
- A variety of techniques for relaxation may be useful. For example, mindfulness encompasses practices such as deep breathing, muscular relaxation, meditation, and yoga.
- Participation in a support group can increase a sense of social connection (Bormann et al. 2018; Davis et al. 2019; Goldstein et al. 2018).

Case Example: Survivor Guilt

Harry, age 47, was a truck driver. One day while carrying a load of pipe to a destination, he picked up a young female hitchhiker. Harry swerved to avoid a road hazard, and his truck ran off the road and struck a tree. Some of the pipe lurched forward, piercing the unarmored section of the cab where the passenger was riding. The woman was killed instantly. Harry was aghast but physically unhurt.

His employer, the company's insurance company, and the police all interrogated Harry because he had violated rules against carrying passengers. Harry told them he had feared for her safety if he did not pick her up. He managed to cope with his immediate situation and ultimately did not lose his job. Harry's employer's human resources department was very supportive, providing legal and management advice.

Harry continued to work with the support of his employer, family, and friends. Four weeks after the accident, Harry had a nightmare in which mangled bodies appeared, and he awoke with an anxiety attack. Throughout the following days, he had recurrent, intense, intrusive images of the dead woman's body. These images, together with ruminations about the woman, were accompanied by pangs of fear of the unknown.

Harry's habitual weekend drinking increased to nightly alcohol use to excess. He had temper outbursts at home in response to minor frustrations with his wife and children and found it difficult to concentrate while driving. After Harry had a panic attack while driving, his supervisor reassigned him to a desk job as a dispatcher, which he was able to do.

The employer's human resources department referred Harry to a mental health clinic for evaluation and treatment. His sense of potential lapses in self-control, what he called "mental instability," was his foremost topic of concern. Quickly, other concerns were identified. These topics included the implications of the accident and the death of his passenger, but the memories and their consequences evoked feelings of mental instability and lack of control, so Harry tried to avoid thinking about the event and his work. He continued to use alcohol to blot out ideas and feelings about the accident and to stifle thoughts about its future implications to his life.

In supportive psychotherapy, it was helpful to enable Harry to describe different states of mind to himself and others. The therapist's tentative formulation included an under-modulated state of horror in response to reminders of the accident, an under-modulated rage in which Harry blamed any currently irritating person, and a defensive but dangerous substance-aided avoidance of feelings of fear, sadness, anger, and guilt.

Harry experienced and soon could label a dreaded state of horror, a problematic state of rage, and a defensive numbing state in which he contemplated the traumatic event and its consequences. The state of horror occurred intrusively, with pangs of guilt and shame, and was difficult to dispel. It was triggered by any stimulus that could possibly be associated with the woman's death.

The state of rage was also intrusive, even explosive, and therefore problematic. It was triggered by any work-related accusations or domestic demands made on him. An avoidant-numb state was preferable to rage, and Harry fostered these states of mind through excessive use of alcohol. He drank while driving his own car.

Harry desired to feel safe, competent, moral, and respected by others. Clarifying this goal with him motivated him to stop drinking, but he still experienced shame, guilt, and fear states about the accident. Harry's self-esteem was degraded by his feeling stigmatized for breaking the rules, picking up a female hitchhiker, and driving after alcohol intake. Harry felt guilty about being glad to have survived, as if this relief were an aggressive act, and through magical thinking, he felt he had chosen his passenger to be the one who had to die. This served as a dysfunctional belief about his role in the sequence of cause and effect.

Harry found it hard to tolerate the shame, guilt, and horror aroused by discussing with the therapist his memories and their implications. He felt too out of control and desperate to contemplate these themes. To maintain some sense of equilibrium and to prevent entry into these dreaded states of mind, he inhibited thought and drank alcoholic beverages imprudently.

The first goals of the supportive phase of treatment were to stabilize Harry's state of mind, increase communications with supportive others, and reduce his alcohol abuse. An observable measure of change would be improvement in his sleep and reduction of his fatigue and anxiety. An expert

helping relationship and a focus on present-day coping would support these aims. Harry and the therapist clarified and agreed to these goals as a way of helping him eventually to regain self-esteem, stability, and respect from those surrounding him.

The therapist suggested a topic on which to focus their attention. The theme would be to help Harry plan how to answer questions from people about the accident by using role-play with the therapist. Working on this topic helped Harry to feel more secure in the therapeutic alliance and to gain insight into answers that might be inappropriate to his self-interest. Harry and the therapist repeated various scenarios, including clarification of possible answers to potential questions from others, anticipatory questions that raised his anxiety.

Harry learned how to reveal facts about what had happened and, when he felt uncomfortable, to limit conversations with a phrase such as "I prefer not to go into those details." Harry extended this practice of what he might say in a new kind of conversation with his wife. Harry told the therapist that he and his wife also experimented with what she might say about the accident and their subsequent experiences. Harry reported that this preparation for expected situations helped him maintain a sense of dignity when his self-esteem was very much under threat. This reduced some aspects of his anticipatory anxiety states.

The therapist recommended that Harry join a 12-step group-oriented program to support his sobriety. Harry told the therapist that going to Alcoholics Anonymous meetings scared him. He felt awkward about saying either too much or too little. The therapist helped Harry plan how to tell his narrative about the accident and its consequences. Having rehearsed a safe-enough way to share parts of his story, he decided to agree with the plan for a support group in addition to the therapy.

Self-Medication

In supporting patients with stress response syndromes, careful attention should be paid to substances used for self-medicating symptoms of hyperarousal or fatigue (Norman et al. 2019). Patients may increase their consumption of alcohol or use opioids as sedatives, nicotine or cocaine as stimulants, or marijuana or psychedelics as mood-altering agents. Patients should be advised against such self-medication in favor of physician-prescribed regimens, social support, and psychological treatment (Gerger et al. 2014).

Focusing attention on a patient's substance use patterns can be done in a noncritical, supportive, and advice-giving manner. It may include psychoeducation about alternative positive psychology practices as well as information about ways to taper off and eventually discontinue substances. Part of providing support is encouraging the patient to tolerate states of craving and withdrawal without resorting to substances.

The case of Harry included dealing with the challenge of his excessive use of alcohol. For some addictions, especially opioids, referral to specialized rehabilitation centers may be indicated (as mentioned in Figure 2–1). Disturbed states from intoxication and withdrawal from addictive brain-changing substances may occur, and these states may interfere with the patient's cognitive and emotional capacities.

Mind-Brain Interactions

Hyperarousal from chronic stress increases the metabolism of sugar, and this stress may lead to fatigue and weight loss. The stressed person is less inclined to prepare balanced meals, and clinicians should take this into account when providing nutritional advice. Sound nutritional advice includes encouragement to eat regular meals and avoid strict diets. Seemingly obvious advice about hydration, nutrition, exercise, social contacts, and sleep should be repeated in a noncritical, matter-of-fact way. Recommendations should include eating regular meals of healthy foods.

Stress can affect the autonomic nervous system and many neurotransmitters and hormones, as well as their interactions (Wingo et al. 2016). Changes in electrochemistry can affect neural networks that connect the limbic, frontal cortical, basal ganglia, and hypothalamic structures. Disturbances in the physiology of these networks can disrupt arousal control (as manifested in increased frequency of startle reactions and irritability) and diminish the person's capacity to regulate emotion and memory. The amygdala may alter danger recognition set points, the hippocampus may alter memory-encoding properties, and the medial prefrontal cortex may alter higher-level capacities to establish and facilitate new linkage patterns or reduce (desensitize) emotion-intensifying associational connections.

Sleep disruption is one of the most frequent symptoms in stress response syndromes, although it is not specific to these disorders. Sedatives for sleep are usually not indicated because of the potential for overuse and addiction. Restoration of unmedicated normal sleep is the best way to support a patient. The goal is to restore the patient's circadian rhythm. Patients should be taught how to develop good sleeping patterns. Such advice may include instruction on how to alter their daily habits and routines to allow for stable bedtimes and uninterrupted sleep (as in CBT-I, mentioned earlier). In addition, relaxation or mindfulness techniques may reduce the frequency and/or duration of states of hyperarousal and under-modulated dysphoric states. If nightmares have recurrent themes, their content should

be reviewed, understood, and counteracted in psychotherapy, as discussed in Chapter 6, "Renarration and Reschematization."

Seemingly Imperative Questions

Clinicians can help patients clarify their pressing questions. Interviews may conclude by listing unanswered questions and clarifying the information that patients may be able to obtain in later phases of therapy. The eventual narratives that arise later in treatment will include ambiguities such as "Who did it?" and "Was I somehow to blame?" However, in the supportive phase of treatment, patients sometimes demand to know how the therapist understands the details of the events. In these situations, it may be helpful to discuss tentative answers.

A patient in the dark passage of grieving may feel that real events are unreal. We find that the less that is known, the more difficult the process of mourning. For this reason, some societies have ritual explanations for what happens to the deceased. The grieving person can revisit the loved one's grave or site of scattered ashes to advance a sense of understanding. It can also be helpful to visit walls inscribed with the names of lost soldiers, sailors, and airmen. In the United States, the Tomb of the Unknown Soldier and the Vietnam Veterans Memorial Wall with the names of the lost ones are examples of monuments meant to help the perplexed find a place of acknowledgment.

Therapists may need to help with initial questions along this line, including spiritual questions such as why prayer has seemed to fail or how and when an ardently desired restoration or reunion will occur. Therefore, understanding a patient's individual cultural background may be vital to providing effective support. For a child, a parent who disappears may be an "angel of God," a ghost, or a phantom who may reappear at some point in the future. In distraught states, the child self part of adults can have similar ideas. If the loved one is regarded as being neither living nor dead, imperative unanswered questions may persist. Some support can be provided through clarification of the realistic need to accept and tolerate the unknowable. Further exploration then occurs in subsequent phases of therapy.

Traumatic events may have killed others and spared the patient. Imperative questions may include why was the patient spared and can extend to who will now be punished? The therapist cannot provide an answer but can recognize and clarify the question. This may reduce irrational fantasies and vengefulness and model patience for eventual explorations, clarifications, and reappraisals.

Summary

Therapists listen for where the patient is at, in the moment, on a range from danger to safety. They then work conversationally to increase a sense of security in the frame of joint clarification of realistic opportunities, in and beyond the sessions of dialogue together. It is hoped that the improved security leads to a gradual reduction in the sense of dread, derealization, dissociation, or confusion. The therapist continues to listen, encourage, provide information, and express compassion and empathy.

The patient may learn from the therapist how to listen to his or her own expressions. By repeating and adding his or her own reaction while listening to the patient, the therapist helps the patient reexamine what was just expressed. Negative intense feelings, flashbacks, and other forms of reexperiencing are reduced in intensity because they feel contained in the therapist's dose-by-dose attitude and expertise in understanding. Both parties work together to obtain more positive experiences for the patient, aiming to increase activities that provide a sense that life can be worthwhile.

CHAPTER 4

Linking the Meanings of Stressor Events to the Self

ONCE THE PATIENT CAN TOLERATE WORKING

in states with intense and unpleasant emotions, he or she can move on to retelling the story of the trauma and exploring the personal meanings related to these events. The therapist can help the patient express feelings and beliefs in a titrated, dose-by-dose manner by framing this expression within the safety of an established therapeutic alliance. In a deepening dialogue, patient and therapist explore feelings that were previously warded off and potentially overwhelming. Raw emotions can be confusing until they are translated into words, at which point the patient and therapist can appraise the clarified meanings.

Initially, some patients focus on an externalized review of memories. Their engagement with memory fragments thus far may have focused on reporting to others, such as authorities, family members, and friends. They may have told and retold the story without having all the ideas and feelings pieced together.

The therapist focuses some attention on the topic of how the self was involved in the causes and consequences of the events. These personal meanings may have been left out of previous reports or may have been partially present but inadequately expressed. The therapist helps the patient understand that memories of the event may have been remembered as mental snapshots.

Parts of these memories may have been dissociated. Fragments of recall may range from bodily sensations to auditory, olfactory, gustatory, and visual experiences. If these are not translated into verbal symbols, the patient

may experience the memory fragments as if reliving the stressor events. In the safe context of dialogue with the therapist (or group), the patient's feelings can be translated from bodily sensations and mental snapshots into explicit verbal representations. Dialogues with the therapist can be used as a special tool for this translation across systems for conscious representation. The therapist helps the patient reach his or her own rational evaluation of the implications of the stressors for the present and future self. The goals of these attention-focused clarifications may include the following:

- Reappraisals of cause-and-effect sequences
- New interpretations of social attitudes and self-attributions
- More adaptive plans for self in the future

A decision tree (Figure 4–1) can help the clinician, together with the patient, make choices in this phase of therapy.

The clinician helps the patient clarify and moderate excessive self-blame. The patient learns by identification with the clinician's nonjudgmental but thoughtful way of sorting out multiple meanings of the events. The patient's telling and clearer understanding of the stressor events lead to realistic time framing. By placing storylines into a time frame (past, present, and expectations for the future), the therapist facilitates integration of the patient's sense of identity.

A practical suggestion for therapists to support this process is to rephrase patients' statements in their own words, tentatively encouraging the addition of "I." For example, the patient may say, "You see that kind of body and it is so shocking!" The therapist may reply, "Another way to say that is to own and understand your emotions, as in 'I was shocked because I never expected to see someone with such serious injuries.'"

Another practical suggestion is to help the patient move beyond vague stereotypes such as *anxiety* and *depression*. The patient may repeat in many sessions, "I felt anxious last night when I came home to an empty apartment." The therapist can explain that renarration is improved by using specifics, suggesting that the patient can rephrase this thought as "I was afraid my loneliness would not just be last night at home without anyone there but that I might be alone forever." This strategy tends to work better than using blanket reassurances such as "You have nothing to be anxious about."

Case Example: Bereavement-Induced Acute Stress Disorder

Maria, a 40-year-old widow, sought consultation 1 week after the death of David, her husband of 20 years. He had had terminal cancer, and she had

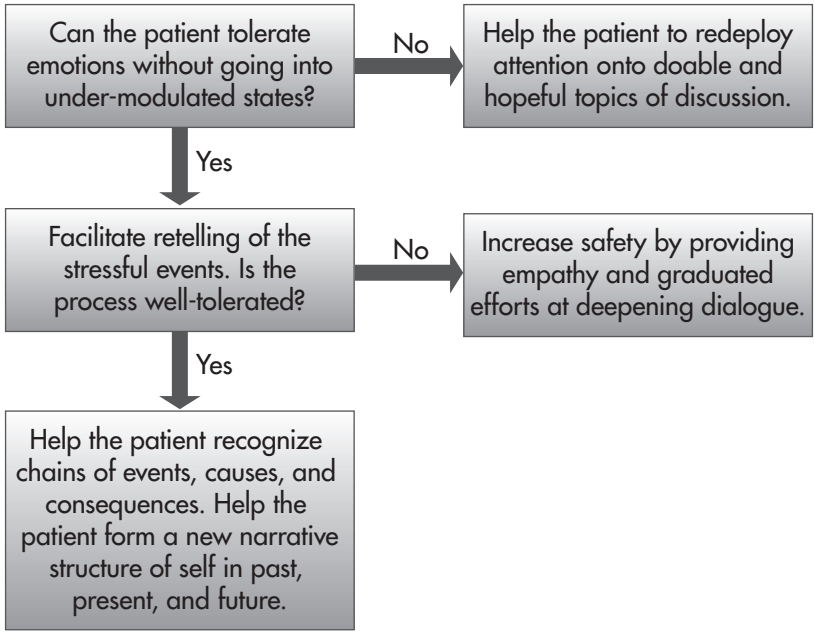

FIGURE 4–1. Decision tree for exploration of meanings.

anticipated his death for some months. Maria thought she was ready for his passing, and they had gone through some anticipatory mourning together by reviewing their marriage and what it might be like for him to die and her to be a widow. However, she was surprised by the intensity of her symptoms after David's death. Maria sought psychotherapy because she felt stagnant in a miasma of emptiness and apathy.

Maria's chief complaints were disrupted sleep, extreme daytime fatigue, and intrusive feelings of agitation. These symptoms surprised her because of her period of anticipatory grief. In her under-modulated states of mind, she experienced intrusive images of David's vacant eyes when he died in a hospice bed and an imperative but unanswerable urge to "just do something."

Most of the time, Maria was in a more avoidant state of mind. This over-modulated state of mind caused her to conduct her daily life in a ritualized manner with feelings of numbness. Domestic rituals were repeated as when David was still alive. She set the table for two and slept only on "her" side of the bed. His grooming products remained on the bathroom sink.

Maria experienced under-modulated states only when attempting to sleep, with repetitive worry about her behaving as if David were still alive. This became one topic of concerned attention in therapy. Another topic of concern was why she had remained stoic and tearless at the funeral while relatives wept. It seemed to her that people who attended the service and cried thought she did not love her husband. She described this concern as embarrassing but restrained her personal feelings and recognized that she also felt "dry-eyed" while telling the story to the clinician.

The therapist told Maria that she would be available to help her grieve and had information that might be useful. The therapist explained that Maria had grief work to do for herself, as well as for David and their marriage.

The therapist said she could sense empathically that Maria loved her husband deeply and missed him greatly. It seemed to her that Maria expected to grieve at the same rate as the mourners at the funeral. This was not a reasonable expectation. Maria had been more involved with David than other people had been, and he was still a large part of her mental life. The therapist went on to say that people who cared deeply needed a long time to mourn; they sometimes had a period of emotional numbing until it felt safe to start grieving with more feelings. Dry eyes at or after the funeral were not an indication that Maria did not care.

Maria asked questions about this therapeutic intervention and gradually seemed to understand it. She felt relieved of her shame about not crying. She also described feeling guilty about her thoughts of being relieved that David's last days of suffering, as well as her own tension, were ended by his death. The therapist listened nonjudgmentally in a manner that normalized Maria's feelings of relief as acceptable. She told Maria that evolving feelings about her loss and her new identity as a widow would gradually develop as time passed. Emotional recollections and future vitality-restoring work had yet to be done.

Maria expressed a change in her dysfunctional belief about not crying at David's funeral. Her mourning process was expected to take a while, and sessions were scheduled for some weeks ahead to allow a growing sense of safety and self-coherence, with a stepwise focus on Maria's emotional experience.

Case Example: A Couple's Consultation

Alex and Andrea were tormented by a terrible event, the death of their only child. Six months earlier, their 8-year-old son, Noah, had fallen while playing on a cliff and had died after a neurosurgical attempt to save his life. To make matters worse, they were experiencing a fracture in their marriage during this time of intense need for mutual support. Both parents felt depressed and lost interest in sexual relations. Each felt damage to their inner self.

Alex exhibited denial and numbing at times, but he also experienced intrusive thoughts and pangs of complex feelings that seemed to the therapist to contain shame and guilt about the loss. His symptoms met criteria for PTSD. Andrea experienced continual pining for her lost son, along with other symptoms such as anhedonia, apathy, hopelessness, and loss of appetite. Her symptoms met the criteria for adjustment disorder with depressed mood. The diagnoses did not dictate the recommended treatment, which was couples therapy.

In sessions, the therapist noted and clarified their discord on several topics. Andrea wanted to talk with Alex about memories of their son, but he avoided these discussions because they increased his overwhelming sense of loss, and he feared making her more depressed. Andrea felt isolated, rejected, and angry at Alex's avoidance of these topics. The therapist told them about individual differences in the rate and style of processing losses and traumas.

The situation was serious, with both husband and wife moderately to severely disrupted in their social functioning. Feeling unsupported, each now considered divorce. The therapist expressed empathetic understanding for both of them. He repeatedly explained that it was normal for them to have different phases and ways of responding, as well as different styles of coping with such a stressful and traumatic event. He advised individual psychotherapy with different therapists in addition to their couples therapy with him. Their joint therapy would focus on sharing ideas and feelings about Noah and developing shared attitudes about the accident and their loss. They were different people, so the meanings for each self were important to explore.

For these reasons, the therapist told Andrea and Alex that with their permission, he would maintain contact with their individual therapists. The individual therapies would also focus on what the loss meant to the maternal and paternal aspects of identity for each partner. The conjoint therapy would focus on their marital interactions as they talked about their experiences of the loss. In the meantime, the therapist suggested that the topic of divorce be postponed until various possible futures could be explored.

In addition, the therapist offered a practical suggestion. It was not useful for the couple to "never talk" about Noah, nor could they expect to both benefit from talking a great deal about him. Instead, the therapist suggested they agree to a time limit for such a conversation to take place when they were together and not in a therapy session. Andrea and Alex discussed this idea and came up with a "5 minutes per dose" agreement. They both seemed relieved and felt closer after having decided on this strategy, and they accepted referrals for individual work with different therapists.

Summary

In reveries and dialogues, a person is gradually associating the meanings of stressor events to overall self-organization. This activates many topics to explore in a therapy. Roles of self may be considered in past, present, and future. This includes the various roles of self in a community, as well as selfhood in an autobiographical sense.

After loss events, especially, some patients feel that adding a focus on personal meaning may be an inappropriate emphasis because someone else has died, and the deceased ought to be the focus of sole concern. The therapist should clarify such attitudes and, as a challenge, emphasize the importance of self-reconstruction as a part of the mourning process.

CHAPTER 5
Improving Coping Skills

THERAPISTS MAY FIND AN OBSERVATIONAL stance toward states of mind helpful. As discussed in Chapter 2, "Assessment and Treatment Planning," patients may have a repertoire of recurrent states, ranging from over-controlled to under-modulated. Their coping skills may be improved if therapists enable patients to stabilize well-modulated states in which negative ideas and feelings can be better processed.

In therapy, many patients are motivated to maintain well-modulated states. Patients may fear under-modulated states and may switch into over-modulated states as a defense. In doing so, they may steer away from important topics that need to be addressed in therapy. The therapist may be of particular help in counteracting these defensive obstacles in the moment when avoidance maneuvers are observed. The therapist's actions may include, for example, interpreting the patient's attitudes that have caused the anticipated feelings to be emotionally overwhelming. As explorations deepen, related maladaptive relational patterns may be identified for the patient, and these patterns may be highlighted for self-observation in life outside therapy.

Once the patient experiences the therapeutic alliance as a way to contain distressing feelings and a safe environment in which to express usually warded-off thoughts and feelings, the therapist may share observations of moments of defensiveness. If the patient agrees with the view that he or she is avoiding something, then the ensuing dialogue may lead to expressions of emotional ideas. This in turn can lead to tentative interpretations of what thoughts and feelings made avoidance maneuvers seem necessary.

Repeated patterns may reveal habitual styles of defensive control. The therapist can encourage the patient to now think what was previously unthink-

able. The patient may learn new capacities for tolerating negative emotional states, and this can lead to better discussions with others in his or her life.

Case Example: A Marital Assault

Teresa sought treatment for intrusive thoughts, anxiety, and depression fears after an instance of physical abuse from her husband, Aaron. Prior to the beating, he had exhibited episodes of rage but expressed them only by yelling insults. During this violent episode, Aaron punched Teresa several times. She saw for the first time an expression of destructive hatred on his face. She was shocked and overwhelmed by that image and memory. Afterward, although she had only limited physical injuries, Teresa experienced recurring and intrusive mental pictures of Aaron's villainous face.

Teresa's self-esteem wavered. Her case was complicated by a related preexisting personality configuration. She expressed emotions impulsively without a plan for controlling behaviors and was unclear on her ideas and beliefs. The early phase of therapy focused on helping Teresa plan to protect herself from potential harm from Aaron. This included preparing for a new separate living arrangement if urgently necessary.

In a later phase of therapy, Teresa felt safe enough to explore her past, present, and potential future relationship patterns with Aaron. Her previous view of him had been one of a loving husband who lost his temper a bit when frustrated; it had never included the shocking moment of his seemingly wanting to annihilate her. Part of the shock of the abusive event was that she had no way to think about how to handle such an unexpected and dangerous situation. Although Aaron had apologized and had sought his own psychotherapy in order to change, Teresa continued to feel afraid of him. He seemed sincerely solicitous and caring, but she felt alarmed by any sign of his feeling irritable and frustrated.

Aaron curtailed his use of alcohol and did not enter into under-modulated states of mind, so Teresa remained in the relationship and continued to live with him. The therapist told Teresa that he believed she was ready to understand more about each spouse's patterns in their relationship, which she had now tended to discuss only with optimism and rationalizations.

Teresa avoided exploring the topic of a possible return of Aaron's dangerous rage. The therapist knew that Teresa's coping could be improved if she were able to expand her dialogue on possible futures. By contemplating the totality of the situation, she would be further enabled to form realistic goals for changing her marital relationship, including whether she wanted to remain married or could tolerate a divorce.

Teresa feared a divorce would precipitate even more under-modulated states of mind in Aaron and hopelessness, shame, and depression in herself. The therapist said Teresa was learning how to observe Aaron's sudden shifts from a positive to a negative mood and what triggered them. The therapist also helped Teresa understand the patterns of her own shifting states of mind. He helped her observe varied states of interaction between herself and Aaron, and she became better able to predict and negotiate each of their grievances and frustrations.

Counteracting Teresa's typical inhibitory avoidance maneuvers such as "I just don't want to think about that right now" and "Do I have to go on with this?" seemed to expand her ability to express feelings related to ideas. She could clarify expectations that she previously had felt only intuitively, such as that repetition of Aaron's destructive violence could occur. She could consider plans for self-protection and possible separation.

Teresa was able to sometimes put into words her pattern of dysfunctional beliefs for reappraisal, such as "I must be with a husband to be a worthwhile person," "I must never express my anger or I'll be rejected," or "If I don't fill all his needs, I am a total failure or deserve punishment." When these beliefs emerged, the therapist helped Teresa clarify them and compare them with alternative and more adaptive role concepts for the present and future. Teresa was prepared with her own assertive plan of what to do and whom to call for help should another assault occur. Because Teresa came up with such plans, the therapist expected her to feel more self-efficacious and have identity concepts of being more worthwhile, independent, and successful. From this more grounded stance, Teresa could feel capable of continuing her negotiations and assertiveness with Aaron. They then might be able to experiment with improving mutual kindness and compassion, as well as sensuous relations such as hugging, cuddling, and sexual intercourse.

The therapist emphasized a process of having a variety of contingency plans to prepare Teresa for handling future situations. This was a valuable strategy because Teresa had habitually avoided ideas that led to distressing feelings. Inhibiting certain themes from clear representation kept her from the lucid thinking that led to more adaptive plans for various eventualities. In addition to helping Teresa prepare stances for handling future stressful situations, the therapist helped her learn to think about the usually unthinkable topics about her identity and relationships.

Coping With Emotion

In stress response syndromes, most patients have some difficulty coping with frequent, intense, and negative valence emotions. Agitated feelings tend to be expressed in states that feel out of control to the subject and appear under-modulated to observers. The shift from usual experiences to under-modulated states motivates avoidances, and numbing states that feel inauthentic to subjects and over-modulated to observers occur.

Therapy techniques that counteract specific avoidance maneuvers can help a patient express emotion safely and thus gradually connect feelings to thoughts. This heightens reflective self-awareness. Patients may develop a greater sense of self agency.

Personality traits play a role in such processes for increasing coping. Some people habitually inhibit or distort thinking about highly emotional themes in order to avoid entry into under-modulated states of mind. Obstacles to working through traumas and losses to form new self-narratives

may stem from habitual automatic avoidances. Therapists can observe these defensive operations by noting how a patient minimizes, partially confronts and partially avoids, distorts, or dismisses specific topics that might be important to a self-reconstructive effort. Replacing avoidance maneuvers with more adaptive conscious controls is a goal in this phase of psychotherapy, as in the case example of Teresa.

If a patient experiences alarm reactions in situations reminiscent of a traumatic event, then desensitization procedures, such as graduated exposures with relaxation exercises, are indicated. The patient may be encouraged to learn meditation, mindfulness, stretching, biofeedback, tai chi, guided imagery, or somatic patterning retraining as ways to restore access to calm states of mind (Siegel 1996; van der Kolk 2015). However, the main interventions usually aim to enable the patient to restore self-esteem and become more constant in responsibly working and caring for himself or herself and others.

In therapy, the patient explores all ways of coping. Obstacles to thinking about topics and tolerating the emergent feelings may be counteracted. In previous studies at the University of California, San Francisco (summarized by Horowitz [2011]), three of the most common obstacles observed during psychotherapy sessions were found to be as follows:

1. Excessively inhibiting ideas about distressingly emotional topics (found in 69% of the clinical research subjects with stress response syndromes)
2. Excessively switching back and forth between attitudes to avoid emotion (64%)
3. Unrealistically distorting reality to preserve narcissistic self-investment and avoid deflations of self-esteem (41%)

Counteracting these habitual defensive maneuvers for coping with emotion can allow a fuller exploration of the emotional meanings of stressor events. The clinician can interrupt with therapeutic interventions. In the previous case example, Teresa habitually inhibited some trains of thought to avoid emotional flooding. Table 5–1 illustrates some such defensive obstacles, as well as therapist techniques that can promote progress.

A different set of traits was noted in Chase, who avoided emotion with intellectualization, rationalization, and role-reversal types of habitual defenses after he was assaulted.

Case Example: A Stranger Assault

Chase, age 30, was in therapy after being beaten and stabbed by a stranger in a bar. He talked about the possibility of future repetitions and how he was

TABLE 5–1. Obstacles to therapy with people who habitually inhibit ideas

Defensive style	Therapeutic approach
Global or selective inattention with impressionistic rather than accurate discourse about the events	Encourage talk and provide verbal labels for feeling states. Ask for memory details and then construct cause-and-effect sequences.
Limiting disclosure due to inhibitions of ideas	Gradually confront inhibitions with supportive interpretations of what may be warded off.
Short-circuiting to erroneous conclusions	Keep the topic open and emphasize rational and hopeful decision-making.
Misinterpreting based on past stereotypes	Differentiate realistic appraisals from illusory concepts. Clarify time frames and distinguish past from future possibilities.

now unafraid because he was carrying a concealed pistol. He told the therapist that he was now coping well. "Problem solved," he said. The therapist asked, "What problem is solved?" Chase replied, "I was cowering; now I am courageous." Gradually, the therapist challenged this false solution of carrying a gun. She asked that they review together how Chase felt very scared and vulnerable in some memories and was now trying to be invulnerable by carrying a gun.

The therapist asked, "Is it OK if we spend some time discussing future possibilities?" Chase said yes. As they did so, the therapist counteracted Chase's intellectualizations, generalizations, and flat affect by asking him to imagine scenarios of what might happen in between the extremes of "safe with a gun" and "cowering because defenseless." The therapist challenged the false binary of either being destroyed or being a destroyer.

Generalizations about the counteraction tactics available to therapists when patients do not fully elaborate on feelings are summarized in Table 5–2.

Self-aggrandizing concepts can also distort thinking, as in the following case example with Morton.

Case Example: A Friend Killed in Combat

In psychotherapy, Morton, 29, was reviewing the memory of a combat mission that had put his platoon under fire from an ambush. He sheltered in place with the group. Another member of the team, Tom, stood up to throw a grenade and was shot in the stomach. No one pulled Tom to safety from this exposed position, and he bled to death. All members of the squad agreed that emerging from their position would have meant another casualty. Morton talked in a way that avoided shame, guilt, or responsibility, as-

TABLE 5–2. Obstacles to therapy with people who habitually avoid emotion

Defensive style	Therapeutic approach
Excessively detailed but peripheral approach to talking about emotional stressors	Ask for personal impressions and meanings.
Avoiding disclosure of emotion	Focus attention on mental images, emotions, and felt reactions, including body sensations.
Juggling opposing sets of meanings back and forth	Clarify and interpret a binary dissociation.
Endlessly ruminating	Interpret warded-off but dreaded possible negative consequences of seemingly positive choices.

serting repeatedly that, in contrast to his own intelligent actions, Tom was an idiot, that he was reckless and stupid and had risked all of their lives. The therapist gradually challenged this externalization of blame, not as being untrue but as being not psychologically true to potential feelings that Morton was gradually able to contemplate in therapy.

The therapist clarified the pattern in other topics, including Morton's attitude with other clinical staff. When Morton spoke of a psychiatrist who was helping him moderate his excessive use of alcohol, he said things like "She doesn't have a clue how much I need to drink to be a part my group. I have to do that to belong. That motivational interviewing stuff is just stupid. Why'd you refer me?"

It was important to protect Morton from damage to his self-esteem while simultaneously counteracting his tendency to externalize blame. The therapist did so by preparing Morton for subsequent work examining all sides of a topic. The shared aim was to find the most helpful ways to interpret a given set of his memories.

The therapist suggested that Morton tell him about Tom as he thought over whatever memories came to him during the session. The therapist said, "I know you do not want to do this, but I hope you and I can give it a try. Do you agree that we might take on together a review of what happened when Tom died?" Morton said he was reluctant but would give it a try. The therapist said, "OK. The part I thought we could consider is that although it was too risky to go to Tom, now when you remember that moment, you feel bad that no one could rescue him." Morton made eye contact and seemed to be asking the therapist to go on speaking. The therapist said, "We want to maintain your sense of dignity as we consider your own self-criticisms. Our goal is clarification, not my judging you in any way, even though you may think so at times. Please tell me if and when you think that kind of external judging is happening here."

TABLE 5–3. Obstacles to therapy with people who distort reality for self-enhancement

Defensive style	Therapeutic approach
Focusing on blaming others for everything	Support, encourage, and praise efforts at truthful reconstructions of memories. Do not blame or accuse of lying.
Avoiding information that deflates self-esteem	Use tactful timing and wording to counteract deceits.
Sliding meanings about who did what to whom (e.g., exaggerates the importance of others' actions to reduce self-criticism)	Encourage realistic appraisals of responsibility while bolstering against shame or humiliation.
Paying excessive attention to finding routes to self-enhancement	Emphasize realistic skills and capacities, thereby cautiously deflating grandiose self-concepts.
Dislocating bad attributes from self to another	Examine the patient's actions and expectations as a way to clarify these attributes.
Forgiving self too easily when some remorse is realistically justified	Support self-esteem with a genuine interest in the patient while working toward an appropriate plan for realistic acts of remorse.

Morton remained silent, and they sat together. Then he started asserting defensively that everyone agreed it would have been fatal to try to rescue Tom. Morton then allowed himself to experience a blend of emotions, cringing and crying and feeling angry. He talked about what could have been done and what should have been done and expressed a plague of self-doubt. The therapist repeated, clarified, and emphasized realistic thoughts. The dialogue seemed to advance the trauma story. Therapist and patient returned to the present state narratives about this memory multiple times, in ways considered in more detail in Chapter 6, "Renarration and Reschematization." Progress was made because the therapist helped Morton go through some obstacles of avoidance and projection of all blame.

Table 5–3 illustrates some potential obstacles to treatment and the therapeutic techniques useful in working with patients like Morton, who distort self-conceptualizations for self-protection or enhancement.

General choices in the phase of improving coping and counteracting avoidances are presented in the decision tree of Figure 5–1. Some techniques are presented for use with patients who habitually inhibit ideas (see Table 5–1), those who habitually inhibit emotional expression (see Table 5–2), and those who habitually distort reality for self-enhancement (see Table 5–3).

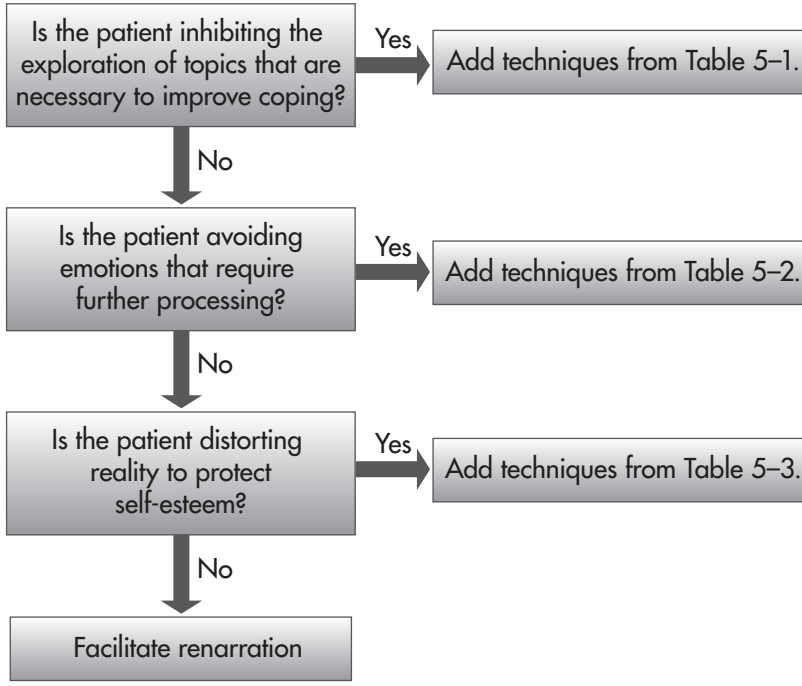

FIGURE 5–1. Decision tree for improving coping.

Reducing Phobic Anticipations and Alarm Reactions

As defensive obstacles to processing are reduced, it may be useful to introduce additional gradated types of exposure to counteract phobic anticipations of future feared situations. Many patients worry that trauma repetitions will occur, and such fears may be justified. For that reason, the therapist should provide the patient a rationale for exposure to threatening stimuli. Results need to be assessed collaboratively with the patient.

The most common exposure technique is retelling the experience of the traumatic event. Another common technique of exposure is the use of guided imagery. During such *imaginal exposure*, gradations of sensory imagery experiences that activate bodily emotions from mild to intense are used (Horowitz 1998). The therapist suggests images for review, moving gradually from trials of less distressing image experiences toward more painful and distressing ones (Foa and Rothbaum 1998). The goal is prolonged reexperiencing while feeling relatively calm. A calm state of mind

can be induced or augmented with the use of relaxation techniques (Foa et al. 2010).

Another technique for improving coping by establishing new, less phobic mental expectations is in vivo exposure, which involves directly confronting feared situations or places that trigger alarm reactions by associative connections to the traumatic event. The patient first confronts situations that are likely to induce a mild level of anxiety. When the patient can successfully manage the anxiety in these situations, he or she can then confront situations that might bring about more distress. As the patient is led through a progression of increasingly feared situations in calmer states of mind with appropriate support, he or she undergoes a learning experience that can help promote a sense of self-efficacy in situations that were previously avoided or perceived to be threatening.

After any recollection, it is important to review the experience in the session. This review may be repeated in subsequent sessions. Review includes assessing associations, clarifying any dysfunctional beliefs, and counteracting those beliefs with rational ideas. The therapist may have to repeatedly contrast dysfunctional beliefs with more adaptive alternative beliefs.

Preparing Scripts

The therapist may use role-playing techniques to help patients plan how to tell their story to coworkers and family members and how to limit further discussion when they are not comfortable talking about it. For example, the therapist can be a stage director, noting when an emotionally risky topic enters the stage and when it leaves the theater of the mind. Or the therapist can request that a pleasant topic be invited onto the stage. Eventually, methods for attention control can be implemented without the presence of a therapist. New capacities for emotional regulation may be learned, using principles of attention control and enhanced mindfulness and mentalization (Fonagy et al. 2005).

Renarrating the Hard Topics

At the start of therapy, the clinician and the patient will have identified hard topics to deal with. These unresolved themes are a consequence of the trauma and its personal implications for the patient. For example, a hard topic may be reconsideration of aspects of the trauma story in which self-preoccupation prevented the patient from helping others survive. The patient may be told that hard topics require time to think through and fully understand.

Writing about these topics may help. Journaling can be a form of homework or a general way of working through events (Pennebaker and Smyth 2016). The patient can then review these writings with the clinician or a trusted confidant. After a sequence in therapy in which the patient learns to organize an otherwise confusing jumble of ideas and images, the journal can be used to help the patient work on a topic about which he or she feels conflicted. Table 5–4 provides a useful outline that can be simplified or altered according to the patient's needs. It can then be provided to the patient as an instructional guide for journal writing. The patient and therapist together can also follow this format for therapy dialogues.

Improving Capacities for Rational Decision-Making in the Midst of Future Dilemmas

With the reduction of global defensiveness and the heightening of selective conscious control, the patient's sense of restored self-efficacy can be enhanced by helping the patient take increased levels of responsibility for rational decision-making. Such decisions include whether, when, and how to remember traumatic events, how to cope with present situations, and how to handle changed relationships with others.

A patient may be oscillating between guilt over harming or not protecting others and rage at people who did not protect the patient and others. The patient may blame others to reduce his or her own guilt or shame. However, the thought that either oneself or factors external to the self, such as other people, are totally to blame is a form of extremist false-binary thinking. Instead of activating rage to stifle guilt, the patient can be helped to acknowledge both the blaming and the personal remorse. The therapist can interpret the attitude that the self is either totally to blame or not at all to blame as irrational. Instead, a reexamined and reappraised middle ground softens extreme attitudes.

In cases with components of realistic responsibility for harm to others, acts of remorse and routes to forgiveness become useful topics. For victims of stressor events, coping with guilt and shame is sometimes harder than coping with fear and anger. This is especially true if the patient caused harm to others during the incident, failed to protect others from suffering more, or felt glad to survive at others' seeming expense.

Forms of guilt include a range from fault based on realistic self-appraisals to excessively harsh ones. This range is a kind of moral damage within the

TABLE 5–4. Steps for reconstructing meanings about a hard topic

Step	Specific actions for journal writing
1. Select a topic of concern	a. Choose a topic that tends to intrude into or "worry" your mind.
	b. Choose a topic that generates pangs of intense and confusing emotions, a medley of feelings you intuitively know you should slowly and eventually label with specific words.
	c. Choose a topic that keeps you from making effective plans for moving on with goals for your near-future life.
2. Get in the right state of mind	a. Create a calm state in which you can give yourself time to proceed slowly. Relaxation exercises, such as clenching and releasing muscles or breathing slow deep breaths, may help.
	b. Establish an intention to think clearly and openly while avoiding harsh self-criticism.
	c. Aim at thinking reasonably as well as thinking about how you are thinking.
	d. Stop and do something else if your calm disappears.
3. Consider your attitude	a. Be explicit about repetitive but dysfunctional beliefs and stances.
	b. Use dose-by-dose thinking rather than expect that you will come up with an absolute solution in just one sitting.
	c. Plan to not be too sure about your conclusions. Have an open mind.
	d. Plan to remember and return to your key ideas.
4. Clarify various perspectives on a topic	a. Give each subtopic a name so you can reconsider it later.
	b. Write down feelings and values associated with each topic.
	c. Establish sequences of events and consequences that help you conceptualize cause and effect.

TABLE 5–4. Steps for reconstructing meanings about a hard topic *(continued)*

Step	Specific actions for journal writing
5. Expand self-other roles	a. Include your intentions as a competent self and your expectations of others.
	b. Describe the intentions and expectations of others that connect with you.
	c. Include your reactions to the intentions and expectations of others.
6. Examine scenarios of what is likely and unlikely to happen	a. Describe the best (idealized) versions.
	b. Describe the worst (dreaded or catastrophized) versions.
	c. Describe more realistic (middle-ground) versions.
7. Separate rational from irrational appraisals	a. Challenge your current appraisals with alternative ones.
	b. Reconsider the attitudes you have toward your own roles and toward what the stressor events mean for your future.
	c. Consider what is preventing you from moving forward. Do not give up or give in to an easy but inappropriate choice as a quick way out.
8. Prioritize your own values	a. State your principles.
	b. Put these principles in order, from most to least important.
	c. Choose a path of gratitude, compassion, letting go, pride, and forgiveness.
9. Make realistic decisions	a. Focus on plans for the future.
	b. Imagine following these plans in various contexts. For example, if you tell your trauma or loss story to a new friend, what will you say?
	c. Practice new actions. Expect them to feel awkward at first. With repetition, they will come more easily.

patient's mind that can be confronted, clarified, and reappraised (Maguen et al. 2017).

Suppose, as in the case example of Morton, that a patient with PTSD from combat trauma develops a seemingly new repetitive intrusive thought, "I should have died like the others in my platoon." This thought may be associated with survivor guilt leading to self-punitive or even suicidal impulses or potential. If so, the therapist can clarify the warded-off feelings, reasons, and potentials. After this is accomplished and the patient is able to tolerate unpleasant feelings, the therapist can ask the patient what future action planning is now indicated. The therapist introduces the concept of taking responsibility going forward, such as through planning how to take care of and protect others in the future. Restitution, as in doing good works to help others, is an adaptive way to reduce shame or guilt.

It is helpful for the therapist to share with the patient observations about how the patient's coping capacity and trauma narratives have incrementally improved from repetitive maladaptive patterns to more adaptive stances and attitudes. The therapist also should emphasize how the patient's improved coping might extend into the future. This involves sharing observations and giving positive feedback about how the patient has improved in resilience, courage, and stamina.

The enhancement of self-confidence that results will reduce the patient's vulnerability to states of anxiety and depression and will prepare the patient to undertake the tasks of further working through unresolved and intensely emotional topics. Renarration of cause-and-effect sequences will be required in order to complete cognitive processing and emotional acceptance. This topic will be discussed further in Chapter 6.

Summary

As a therapist, remind yourself to pay attention to when a patient shifts the topic. Ask yourself why this may have occurred. Was emotional expression blunted? If so, consider sharing your observation of a possible avoidance. The patient may agree with the observation. If so, you can share hunches about what the patient may be trying to ward off and why it may have seemed safer to switch from rather than stay on a difficult topic. If this goes well, your patient may benefit if you provide some ideas about how therapy may proceed.

Therapists can provide supportive advice on enhancing coping skills. Patients can learn better ways of negotiating the world outside of therapy. Patients can also learn better ways to cope with difficult feelings in therapy as well as in the privacy of their own mind. Improving coping allows new

memories of what works in current crises. Patients learn new schemas for social action, and increased adaptive capacities allow them to review memories of loss and trauma. In and out of therapy, the patient is working to consolidate fragments of memory into a realistic story of the past, the present, and possible futures.

Memories are consolidated in present circumstance. A stressor event affects real external contexts and internal models of self in the world. After a catastrophe, whole communities may be impacted and sources of support partially lost. The patient may falter in some states of mind, lacking a coherent sense of identity and ability to think clearly. The safety of therapy allows reactivation of effective self schemas and capacities to tolerate distress.

It helps therapists working with complex issues to know that patients may learn from both direct suggestions and identification with the calm reasoning of the therapist. Dialogues between therapist and patient lead to plans for coping, and this planning can lead to tryouts of new coping strategies in social situations. As a result, current relationships may improve and the patient may experience more support and improved self-esteem.

CHAPTER 6

Renarration and Reschematization

IN THE PRECEDING CHAPTERS, WE HAVE discussed phases of therapy, including assessment and treatment planning, providing support, linking the meaning of stressor events to the current self, and improving coping skills. In these phases, patient and therapist piece together memory fragments into a communicable story of a recent trauma and loss. At this stage, patients and therapists, in dialogue, may need to renarrate the story. In this deeper phase of therapy, the patient may develop a variety of new and tentative versions of meanings and implications. The patient sees the self as an agent of the changing understanding of what happened and what may happen next (Schauer et al. 2011). Identity and attachment models of the past and earlier memories of traumas other than the current stressor events that precipitated the syndrome may be considered. Renarration of a life story promotes reschematization (Greenberg 2011; Horowitz 2011).

Renarration

Renarration rests on thinking in both words and sensory representations. Many memories are fragments of various types of sensory perception, such as visual, olfactory, and auditory. The patient learns how to translate meanings across modes of representation in the process of consolidating memories into therapy dialogues. The therapist and patient use language as the most secure communication for sharing clarity. Many aspects of trauma

memories require new word symbolizations to further connect ideas. For example, Amid, a 23-year-old man, was reviewing a memory of how his girlfriend fell off a deck while standing near him. She was severely injured.

AMID *[anguished tone]*: I heard the rail snap open. She looked scared as she fell through. I don't know….
THERAPIST: How sudden. How shocking it must have felt.
AMID: I don't know…I froze. Yes. Seeing her below, bleeding. I should have grabbed her, but I couldn't! I still feel so bad….
THERAPIST *[quiet for a moment]*: You still feel bad she was hurt, and as you think back on it perhaps you realize more fully you could not save her in that moment even though you so much wish you had.

Patients have alternative memories stored in cognitive and emotional circuitries subsuming various types of sensations (visual, auditory, gustatory, olfactory, tactile), words, and enactive (bodily movement) representations. Ideas and feelings depicted in pieces, as represented in image, word, and enactive forms, can have larger conceptual meanings translated across circuitries. Patients learn to preconsciously organize these complex memories by means of schemas. Therapists encourages reappraisal of meanings, and that dialogue leads to revised memories and new attitudes about self, others, and the nature of the world.

Reschematization

Conscious words and images can symbolize unconscious procedural knowledge and schemas. The patient unconsciously activates internal working models, or schemas, and uses these templates to organize their consciously experienced train of thoughts and feelings. The schemas themselves are not usually conscious. The therapist and patient can appraise the schemas if the implicit meanings are raised into explicit language, and they can review and revise the symbolized meanings through reflective awareness. Therapist and patient can engage in a dialogue challenging habitual concepts. Both may learn how to differentiate reality from illusory concepts. Outmoded expectations can be revised and new intentions developed.

Some of the self and relational models contained within a patient's schemas were developed in childhood and adolescent attachments. Patients may activate childhood schemas that carry early grievances and self-blaming into adult mental processes. These schemas may be outmoded and may lead to irrational beliefs about the causes of stressor and loss events. Renarration in the dialogues of therapy may help augment and modify behavior so that new learned attitudes can accord with reality. A patient may have unclear bitter feelings. Guilt over harming others and themes of envy, anger, and longing

for revenge may then need to be explicated as part of current cognitive processing and renarration.

Case Example: A Mother's Bereavement and Theme of Revenge

On the first day of a family ski trip, Ellen, 40, and her husband Max, 39, took their two children on separate runs. While Ellen and 7-year-old Amy were on the beginner's hill, Max and 10-year-old Morgan took the chair lift to the intermediate run. At the top of the mountain, Max impulsively decided that he and Morgan should come down the advanced slope. While descending at a high speed, the boy lost control, hit a tree, and died from a head injury.

Ellen's grief was overwhelming. For months, she was consumed with intense yearning for her son. She was persistently agitated, morose, and irritable. She slept poorly and had no appetite. She consulted a psychiatrist about her symptoms and was treated for major depressive disorder with antidepressant medications and supportive psychotherapy. She felt helped in some ways, but more than a year after Morgan's death, her grief remained intense and debilitating. She was reevaluated and started a more exploratory and open-ended psychotherapy with a new clinician.

As part of the therapy, Ellen began to express and reappraise her rage and revenge fantasies against Max. Ellen blamed her husband for Morgan's death, for the reckless choice he had made at the top of the ski run. "He should pay for his crime!" she repeatedly exclaimed. She realized that she begrudged Max any moment of satisfaction or pleasure. A smile on his face, a hum from his throat would ignite a flare of fury within her.

Occasionally, impulsively, she allowed herself to target Max by throwing away his mail or "forgetting" his telephone messages. This sort of angry behavior was quite unlike her. She regretted each action and felt guilty and ashamed, but she could not stop. She valued her son more than her own life and, she realized, even more than she valued Max.

Ellen loved Amy and wanted to shield her from the continued tension with Max but felt out of control. She was mortified that Amy might copy her behavior. That idea of daughter copying mother in entering uncontrolled angry states of mind activated a memory of Ellen seeing her own mother's overly hostile responses to her father during a contentious divorce. That memory motivated her to change.

In the next session, the therapist asked Ellen to use her insight and say what she thought might be her next goal with her husband. Ellen said that she had determined that better communication with Max was a greater priority than punishing him.

As the work proceeded, the therapist and Ellen reviewed their insights. Two conflicting themes were clarified:

1. Nothing will make up for the damage Max has done. It is right that he should be punished because he deserves it.
2. What is done cannot be undone. Max is my husband, and I should suppress my rage for the greater good of my marriage.

Further narratives merged these two opposing stories. Ellen said that she hated the impulsive self-centeredness of the man she married, but she loved his many good traits: his quick mind, sense of humor, love for all, and generosity.

The therapist asked Ellen to consider what she believed was going on within Max's mind. Although Ellen knew a lot intuitively, putting this frame into words was a kind of mentalization, a new perspective for her. The therapist and Ellen agreed to focus attention on a specific part of the trauma and loss narrative: what Max was doing with her now.

The therapist suggested that Ellen try to empathetically consider Max's mental state. Ellen told the therapist they had tried to watch a popular TV show, sitting side by side on the couch. During a scene of a reunion between long-lost friends, Max turned away as Ellen shed a few tears. She noticed his withdrawal and felt resentful. The therapist kept the topic open to reconsideration. She helped Ellen by asking that they imagine what Max's intentions or motives might be. Ellen found this a novel question. Slowly, she developed an idea that the happy ending had caused her to experience some grief feelings. Max picked up on those feelings and turned away because he felt guilty at causing her sorrow. Thinking about Max's state of mind helped Ellen feel more connected with the concept that they shared pain in different ways.

Ellen and the therapist went back and forth on ideas about how Max was mourning in his own way. Soon, Ellen felt more connection with Max because she knew that she and Max both mourned the loss of their son. She became able to feel compassion for his deep remorse and terrible burden of responsibility. She admitted that Max was both strong and weak, good and bad—a key verbal and self-reflective recognition that allowed her to harmonize her ambivalent feelings for him. She took pride in this difficult accomplishment. She was able to trust herself more and control her hostile impulses.

Another example illustrates how developmental topics can be clarified in interpretations about in-therapy relationship patterning.

Case Example: Resentment After an Injury

Sally, a young woman in her early 20s, had a severe compound fracture of her femur from a fall from a ladder while she was helping her father paint his house. Nerve damage complicated her recovery from the surgery to repair the bone damage because, in spite of the surgeon's efforts, the injury caused a partial paralysis. Psychiatric symptoms and Sally's pessimism about recovery of full function disrupted her plans to accept a teaching position after graduating from college. She came for therapy with a diagnosis of adjustment disorder with depressive features precipitated by her accident and its sequelae.

Reschematization involved Sally's identity within her relationship with her father. One emergent and difficult theme was Sally's hostility toward her father for not taking adequate care of her. The relevant ideas about the stressor event were that her father had given her an old rickety wooden ladder, while he used a metal one that was stable and strong. At one point

during her psychotherapy, Sally showed signs of anger at the therapist for shifting an appointment time. The therapist said: "I think you may be angry with me right now because I am not meeting your need for the same timing of appointments. Perhaps this reflects your anger with your father because you feel he took poor care of you by giving you a rickety stepladder."

Sally understood what was happening. She could counteract transference feelings safely because she also had secure knowledge of the qualities of a specific existing therapeutic alliance. The therapist's wording maintained the focus of treatment on resolving reactions to recent events but allowed reprocessing of a preexisting attitude of self as vulnerable because of being cared for insufficiently. As a result, Sally was able to gradually review her history with her father.

Schemas of Self and Relationships

For readers trained in schools using other languages for these cognitive maps of self and other relationships, a brief review of person schemas theory may be helpful. Researchers note common principles across therapies for clarifying implicit models of self and other. Childhood attachment models affect later person schemas (Bowlby 1961; Brown and Elliott 2016; Dimaggio et al. 2007; Horowitz 2005; Wallin 2007). Insecure, avoidant, dismissive, and hostile attachment relationship models function preconsciously in adulthood and affect how a person copes with stressor events.

Self-schemas help to sustain a sense of identity even in a crisis. Different self-schemas can organize different self-states, and a patient may report a range of self-states from unified to dissociated. Each self-schema is an aggregation of elements, a package of connected beliefs and procedural knowledge about the self. Each self-schema has a body habitus leading to stylistic variations in their posture and gestures when activated. Each has a role for repeated social behaviors. If a patient activates a different, dissociated self-schema, he or she may appear as if having a somewhat different set of personality traits.

With maturity in social cognition, the individual has subconsciously integrated many beliefs about self and relationships into complex combinations. The syntheses are supraordinate, a consolidated schematization that allows for identity coherence and continuity in attachments. Patients will seem more coherent at harmonious levels of personality functioning and will seem less so in lower and more disturbed levels.

The information generalized into schemas is procedural rather than declarative knowledge. It tells us how to do something but not how to think reflectively about it. The ideas and feeling may become declarative by symbolic conscious representations. Knowledge in schemas is implicit and can be made explicit in therapy dialogues that clarify patterns. For example, a

patient can learn to put a pattern into words: "Whenever I fail to protect my child from being hurt, I hear this inner voice telling me I am a total failure and should give up as a parent." The therapist can then challenge the connected concepts.

To recapitulate, individuals have a repertoire of self-schemas and role relationship models that relate self to others and that include scenarios of transactions. The expected transactions include possible actions, expressions of feelings, responses, and reactions. A configuration of desired, feared, and defensive scenarios may be part of the repertoire for significant attachments.

Adult episodes of major loss or trauma frequently activate otherwise dormant aspects of self-schematization and attachment models. In cases of complex PTSD (CPTSD), these models may have been based on childhood adversity. Traumas and unexpected losses promote dissociation, depersonalization, and derealization. Attitudes from these developmental traumas, losses, and adversities might now need revision.

Individuals may have different recurrent states of mind depending on which schemas from their repertoire organize present-state cognition, emotion, and social interaction. Traumas alter the activity of schemas. For example, a person may ordinarily feel securely attached to a companion but then, after a trauma, shift to an insecure or disorganized mode of bonding and feeling. Instead of feeling warmth, the self may expect only negative responses from the other. Anger about the trauma may be displaced; this can lead to negative transference reactions.

Current Level of Personality Functioning

After a major stressor event, a person with previously robust personality functioning may regress and exhibit disturbances in identity, relationship patterns, and level of emotional control. For individuals with lower levels of personality functioning before the specified recent stressor event, progress in deeper phases of therapy is important but will be slow. Advancement to a higher level of functioning through therapy may be more difficult for these individuals to achieve, but attainment of this higher level can result in a rich improvement in the patient's character.

Having a range of levels of personality functioning in mind is helpful in the formulation of a patient's current condition. Simpler, repetitive, and slower clarifications and interpretations may be indicated. Table 6–1 illustrates an approximation of the degree of dissociation versus coherence in a person's schemas of self and others (Horowitz 2002; Horowitz et al. 1984).

TABLE 6–1. Levels of current personality functioning

Level	Description
Harmonious	The individual is able to maintain a shared understanding of present context and shared perceptual experience.
	State transitions are smooth, appropriate, and adroit. A sense of a coherent identity is maintained across a repertoire of personal states.
	Realistic pros and cons are examined to reach rational choices of action.
	The self views others as separate people with their own intentions, expectations, and emotional reactions.
	Perspectives on relationships approximate social realities.
	Past and present views of meaningful relationships are integrated, allowing a sense of constancy.
	Emotional governance prevents out-of-control states, allowing significant relationships to be maintained.
Conflicted	The individual displays alternative states that contain varied intentions, manifesting as conflicting approach and distancing tendencies. On examination, these alternations are based on fluctuating attitudes about meaningful relationships.
	State transitions occur between positive and negative moods, and memories of each state are remembered.
	Fear of rejection may limit warm and caring attachments to others, or fear of subordination limits true cooperation.
	The person appraises self with a variety of critical judgments: some too harsh, some too lax.
Vulnerable	The individual has excessive intensity or significant flattening of affect to a degree outside cultural norms.
	Surprising shifts from vigor and boldness to states of apathy, boredom, or unpleasant restlessness may occur.
	The person seems to have an idiosyncratic perceptual experience of the world but is able to acknowledge and clarify lack of a shared perceptual experience.
	Sense of self-regard deteriorates under stress, criticism, and increased pressures to perform. To protect from feelings of inferiority or enfeeblement, grandiose supports of self-esteem may be used.

TABLE 6–1. Levels of current personality functioning *(continued)*

Level	Description
Vulnerable *(continued)*	Concern for the well-being of others may be considered less important than using others as tools for self-enhancement.
	Under-modulated rage may erupt at others who are perceived as insulting and are blamed for embarrassment.
Very disturbed	State transitions can be explosive.
	Undesirable self attributes and emotions are projected from self to other. The actions of the self may be dissociated in memory in terms of who did or felt what, and shifts in self-state may be accompanied by apparent forgetting of what happened in the alternative state of mind.
	Memories confusingly combine illusions with once-real elements.
	The individual exhibits alternative personalities, perhaps dissociating memories of what happened in a previous self-state.
Fragmented	The individual becomes chaotically distracted very easily.
	Irrational ideas tend to persist and dominate choices.
	Affect and tone vary in a labile fashion with an intensity level (high or low) that is well outside cultural norms.
	A massive chaos of selfhood can occur and, as a counter to cope with high distress, the person frequently feels as if under attack and may attack others seen as predators.
	The person may withdraw in a self-protecting coping effort that actually is self-damaging.

The goal of reschematization is to improve the current level of personality functioning. The therapist aims to help the patient 1) increase capacities for reflective awareness and emotional control, 2) modify or replace irrational beliefs about self and others, and 3) increase coherence in a sense of self.

Patients currently functioning at lower levels require more time, tact, and parsing of statements by the therapist. Patients at lower levels of personality functioning may lack current capacity to sustain a focus of attention when emotions run high. Complex, multifaceted remarks from the therapist may be misunderstood.

In CPTSD, adverse childhood patterns may need both verbal narration and renarration. Patients may become cloudy about what the therapist means when he or she provides an interpretation about past childhood de-

rivatives of current attitudes, projections, and feelings. If patients do not understand the therapist's intentions and remarks, they may experience disorientation, negative transference feelings, or perhaps even an explosive entry into an under-controlled, angry state.

Therapists should carefully share what they observed. The therapist should offer understanding tentatively, then ask the patient to repeat what he or she believed the therapist was saying. The therapist may then repeat simple statements to clarify beliefs and repeat suggestions of new alternative views of self-conceptualization (Horowitz 2016; Lindfors et al. 2014; Mullin and Hilsenroth 2014). The therapist can use gentle discussions to examine the ideas together with the patient. Repetition of clarifications of realistic representations can help the patient notice oscillations between dissociated and false binaries, as in either-or thinking such as "If I am not strong, I must be weak."

Some people have a latent attitude of self-hatred that becomes reactivated by precipitating events. Patients may have blamed themselves for adverse childhood events and subsequent tendencies toward depressed and anxious states of mind. This pretrauma trait can stem from a childhood exaggeration of the role of self in family events. This unconscious sense of fault can affect appraisals of the meanings of a traumatic event experienced as an adult. Explicit rational dialogues can put this into an adult self-reflective perspective.

Such issues as childhood schemas with a false binary of either a blameworthy self or blameworthy other are part of the difficult topics to address in cases of CPTSD. If the length of psychotherapy can be extended to address these problems, the dialogue may proceed from surface to depth. The deeper levels may not have been brought to the conceptual level of reflective self-awareness. For example, a patient who experienced loss of a parent may have retained an unconscious, "unthought" schema that he or she caused the loss. Verbalization in conversations with the therapist may be the first approach to attitudinal change. The new safely contained relationship experiences with the therapist can feel more secure than attachment relationships experienced as harshly judgmental, abandonment-prone, or exploitative. In the advanced phases of psychotherapy for treating complex cases, the therapist may at times focus on increasing coherence in previously dissociative self-schemas.

Case Example: Confronting Dissociated Self-States

Eric, a 28-year-old man, developed symptoms after being attacked and robbed at knifepoint. He reported intrusive and avoidant symptoms as well as dissociative self-experiences. As part of his social history, he reported that he had been repeatedly victimized as a child by an abusive uncle.

The therapist related Eric's beliefs within memories of adverse childhood events to his PTSD symptoms. Eric recalled out-of-body experiences during the repeated abuse episodes, seeing events as if he were on the ceiling looking down on the bed at someone else. These memories became episodic intrusive images and depersonalization experiences after the recent mugging. Eric continued to experience intrusive flashbacks of the mugging and fragmentary images of childhood assaults for 6 months, along with states of feeling himself to be unreal, "empty-hearted," and "not quite a person."

Eric reported intrusive daydreaming of a future in which he was being killed or he was killing an imagined attacker. Formulation of his self-states involved defensive reversal of roles from weak (self as a victim) to strong (imagining himself killing a perpetrator). When Eric was strong, he felt destructive, but when feeling weak, he became fearful. He tended to undo each state by shifting back and forth from one to the other.

The therapist shared with Eric his observation that Eric's reversals between strong and weak were quick and confusing for the therapist. The therapist repeatedly clarified what had been said in the recent sequence of discourse. He shared the idea that Eric could expect the oscillations between two extreme self-attributions to repeat. By paying attention, together they could identify the moment of a defensive shift and find out more about it.

With repeated clarification by the therapist, Eric learned how often he shifted back and forth in a binary of opposite self-states. He could say how and when he shifted as he categorized his self as either too strong (critical, irritable, and punitive) or too weak (timid, withdrawn, submissive, and fearful). The shared goal in therapy was to find room for attributions in between these two self categories.

Eric's binary of self as too strong or too weak was noted when he talked about work and friendships. Both Eric and the therapist learned to pay attention to shift points, moving from self-appraisal of being so strong that it led Eric to harm others and thus potentially induce guilt to an appraisal of self as so weak that Eric was frighteningly vulnerable and ashamed of his timidity. Then the therapist encouraged explicit, verbal reappraisals. The therapist suggested that Eric might come to view himself as neither super strong nor very weak but rather as competent and capable physically and mentally.

Through repetition, Eric learned to become explicit about his dissociated views. One technique used by the therapist was to explain a model framework for imagining scenarios of intentions, actions, responses, and reactions between himself and another party. The therapist suggested that they think a bit about the other person's intention and motives. Eric could then think over his own sentences, such as "I had a hunch he might want to hurt me, so I showed my weapon and concealed my fear with a strong stare, expecting him to be scared and not come closer." After many trials, Eric was able to put expectations into words. The therapist also helped Eric to use an "if, then, because" type of reasoning, guiding Eric to say out loud such sequences as "If I showed a weapon, then police might get me, because that is an illegal possession and I guess it is not really justified by what might really happen."

With lessened avoidance of emotional experiences such as feeling frightened in public, Eric learned how to think consciously about his feelings and transactional expectations. He became better able to converse reasonably. He could tolerate some tension and negotiate conflicts. He increased his ability to empathetically understand the other person's feelings even in disagreements.

Therapy that requires renarration and reschematizations takes many sessions. Even more sessions are needed if the process has to be slower and more repetitive, as with patients like Eric who are currently functioning at lower levels of self-coherence and self-reflective awareness.

General Principles of Renarration and Reschematization

Some of the principles discussed in this chapter can be generalized as shown in Figure 6–1.

Self in the Future

Some losses to self are permanent. The patient needs to change both self-schemas and future goals to regain vitality and a new equilibrium. Losses of capacities of the self need to be accepted realistically, and preconscious maps of what patient and therapist will be able to accomplish need to be reschematized. Therapy can help people with the necessary support and exploratory dialogues, as in the following case example.

Case Example: Trauma from an Amputation

Peter had severe childhood diabetes requiring insulin injections. He developed vascular problems throughout his body because his condition was resistant to treatment. At age 60, Peter was informed that one of his legs would need to be amputated because of gangrene from insufficient blood supply. After the amputation, Peter felt terrified, angry, and sad. He complained bitterly to family and friends that his illness was unfair, and they in turn felt miserable and helpless.

Psychotherapy was advised, and Peter met with a therapist. During the dialogues, Peter recognized that he was alienating others, unfairly blaming them for his illness and frustration with treatment options. He expressed an inappropriate anger toward anyone who was not infirm. He hoped psychotherapy could help him learn how to cope with his conflicting and overwhelming emotions.

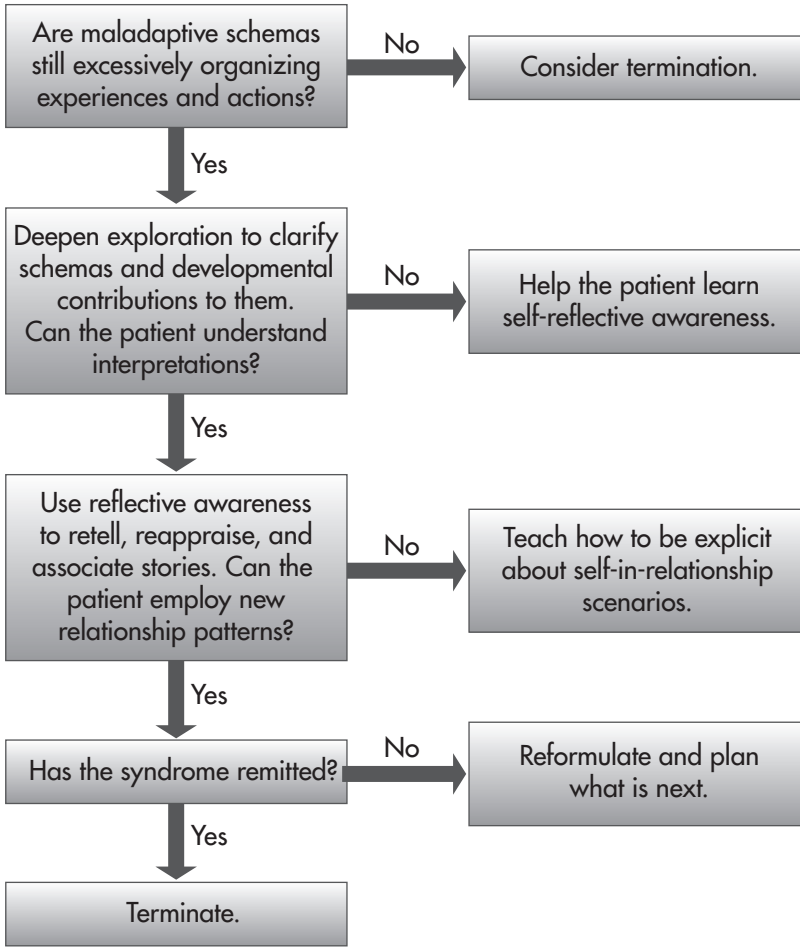

FIGURE 6–1. Decision tree for reschematization.

The therapist was eventually able to use a three scenarios method to increase insight. This was possible because Peter was able to maintain reflective awareness to compare and contrast his own differing perspectives. First, Peter would view his present fears in the context of a catastrophic future. Next, he would examine an idealistic future scenario. The third scenario was a realistic estimate between the two extremes.

In the catastrophic scenario, Peter dreaded the loss of one bodily function after another. He imagined that he would decline slowly, in anguish, totally helpless and dependent on others. In his idealized scenario, he would be cured of all ills; have a long span of good health; feel younger than his age; and be competent, vigorous, full of potential, invulnerable, and free of disability. Death, when it came, would be calm, swift, and painless.

A realistic third scenario was the next step in the therapy dialogue, but this was difficult for Peter to contemplate. Therefore, the therapist asked Peter to think more about the dreaded scenario. Then, elaborating on "a movie in my mind," Peter gained an important insight. He realized that part of his despair over the future was his primal terror of being out of control, overwhelmed, and neglected. He was envisioning himself not as a mature, competent adult but rather as a helpless and abandoned child-invalid.

As Peter and the therapist examined ensuing associated memories, it turned out the feeling of being helpless and abandoned was not new to Peter. When he was 7 years old and attending boarding school, he contracted an infectious illness. This resulted in his being transferred from the school infirmary to a hospital—a strange and frightening environment for a little boy who was left alone in isolation for long periods of time. The loneliness and desperation had been traumatic for him. The cascade of consequences of his diabetes triggered the resurfacing of these memories, which now filled Peter with a nameless terror once again.

Once Peter was able to sort out different self-concepts from the past, separate them from the present, and articulate his most cherished (and probably impossible) hopes and greatest fears, he was able to develop a realistic middle-ground scenario between catastrophic and idealized possibilities. Peter reappraised his situation and future expectations realistically and planned how to deal with them with as much wisdom as he possessed. He would face the truth about his amputation, current disability, and possible future squarely, shying away from nothing and tolerating negative feelings while staying well connected to his family and friends.

In the ensuing discussions, Peter told the therapist that he knew that many of his days to come might be unpleasant or challenging. Although there were likely to be times of relative equilibrium, there were also sure to be low periods; troughs of pain; a steady, continuing decline in his condition; and likely assaults of fear and dread with each change for the worse. He planned on coping with these negative states of mind by staying alert to possible relationships.

Peter set as his goal to value each moment of quality in living and to be as mentally prepared as he could for the onset of each low period. He could not expect to always be successful in this aim, but he set out to work toward it, and that gave him hope. He knew he would have moments of despair as his condition worsened, but he also knew that medications could ease his discomfort and eventual death. He began to make plans for how to create space for self-soothing acts and mindfulness practices for how to deal with pain and disability so that he could go on as best as possible. He used the Internet to study treatment-resistant diabetes and research new treatments, taking an active role in his own care.

In dialogue with the therapist, Peter let his imagination take him to the very end—he saw himself dying, not as a terrified little boy without inner resources but as a courageous man who could make his own decisions in each moment. He also decided on hospice care if he were about to enter an intolerable terminal state, but because this was not his current situation and might never be, he made a commitment to refrain from any suicidal plans

during his low periods, as long as there were moments of living that he still enjoyed.

These dialogues helped Peter feel more in control and less preoccupied with the anxiety of impending disaster. He worked to improve his family relationships. He now had a clearer grip on his destructive tendency to lash out when he felt pain, fear, or depression, and he was able to soften his irritability and harsh demands. Instead, he wanted to serve as a role model of courageous realism. The pride he took in his effort to live as gracefully as possible with a potentially terminal illness was able to dissolve his resentment toward others who still enjoyed robust health. He began to think about his family's future and how he wanted to be remembered. He reminded himself that how he coped would provide a role model legacy for the younger people in his extended family who witnessed his struggle and resilience. He benefited from their increased support and empathy for his suffering, as well as their respect for his courage.

By not giving up, Peter became the man he wanted to be, someone who could cope with and endure suffering. He could see that others admired him for his fortitude. He felt dignity as he experienced moments of warmth with others. The gift that he gave to himself was the ability to maintain some states of inner peacefulness even during his most difficult times. Peter redefined his current identity. This is an example of perhaps the hardest task of renarration and reschematization.

Summary

Therapists need to do more interpretive and conceptual reconstructive work in complex cases to help patients renarrate and reschematize. A patient may have irrational beliefs that were developed before the recent stressor events; these are especially hard to modify. In dialogue, the patient and the therapist may practice new ways of thinking. That process, extended to outside relationships, may alter schemas of attachment and of transactional scenarios between self and others.

Renarration is a process that encourages reschematization along realistic lines. The patient may distort appraisal and narration if meanings of the recent stressor event reactivate archaic relationship schemas. This may present a chance for reschematization. The therapist promotes these processes by serving as a role model, posing questions about self-conceptualizations, clarifying answers, and offering rational alternative beliefs. The patient may consolidate memories into ever more realistic chains of cause-and-effect understanding (Foa and McLean 2016; Horwitz 2018; Kernberg 2018a, 2018b; Rothbaum 2016). These sustained dialogues can help patients form new capacities for reflective consciousness and emotional control. Patients can also gain self-esteem and improve constancy and compassion in social connections.

CHAPTER 7
Terminating

PATIENT AND THERAPIST CAN AGREE TO

complete their work together on a selected date. Ideally, the date of the last session is set several sessions earlier. This permits working through the meanings of the separation. An agreed-on completion is active rather than passive, planned rather than unexpected. In this way, an anticipated end point is different from both recent losses and potential childhood insecurities about being abandoned.

Between the time the patient and therapist agree on a probable ending date and when the final session is actually scheduled, it is usually important to have an interval of a few sessions to underscore and review the patient's new understandings, capacities, and future plans. It is also possible that transference feelings may be transiently activated. If so, these emotions can be contained in a reaffirmed therapeutic alliance. For example, some patients may feel fearful and sad about a preconsciously conceived rejection. Other patients can feel hostile because of the activation of preconscious models from a time when they were abused or cared for insufficiently.

In clarifying such transference reactions, the therapist can indicate whether and how such attitudes may link to recent or childhood stressor events. Such actions can be considered as opportunities to work on the renarration of the autobiographical self. Equally important, the therapist can encourage the patient to discuss the meaning of the therapy experience, to share positive feelings, and to be able to express gratitude.

It may be helpful to inform the patient that he or she will continue to process stress-inducing experiences after the conclusion of therapy dialogues. Some intrusive experiences and pang-like emotional reactions, which may have previously subsided, may recur. Their reappearance

should not lead to dismay; it may be a part of normal recovery rather than a sign of relapse. When indicated, additional booster sessions may be scheduled.

It helps to inform patients that their story about the past as related to present and possible futures will continue to unfold. They may recall highlights of what they learned during therapy. They may also repeat states of distress. Usually, these states will be more tolerable if they are contained in a heightened stance of self-efficacy and autonomy. If not, patients may report fear of loss of control after therapy. That is why the availability of the therapist for booster sessions should be discussed before the last regular session.

The following case reviews phases of therapy leading to a planned termination.

Case Example: Death of a Parent and Identity Consequences

Connie, 23, had completed college successfully with a basic degree but since then had shifted often between unsatisfying temporary jobs. She recently had a break with her intimate partner. Then she experienced the unexpected death of her father. Of the surviving members of her family, Connie was the most distraught. Since her father's unexpected death, Connie felt intensely sad and experienced a loss of initiative. She faltered in her career activities and felt that her social relationships had come unglued. Her sense of identity and her sense of future direction felt more diffuse to her now than before the death. She was preoccupied with repeated intrusive thoughts such as "Who was I for my father anyway?"

Assessment and Treatment Planning

In evaluation sessions, Connie was very self-observant. She said she felt unable to stabilize her usually composed state of mind. She felt instead too often flooded with loneliness, irritability, grief, and sadness. She feared that others would see her sobbing in a messy, out-of-control manner. She assumed a defensive state of social withdrawal and career inertia in which she sat around, waiting for her roommates to organize her activities, but she was also irritable with them and frequently rejected their attempts to connect with her.

The clinician diagnosed Connie as having a bereavement type of adjustment disorder, and psychotherapy was agreed on as a preferred treatment. The shared plan was to clarify her reactions to her loss. Connie's central concern was that she could not form a consistent narrative about her past relationship with her father and how she felt after his death. In the past, she had felt adored and excited about her father's help with her high school activities. Now she felt puzzled over whether he had ever really loved her. Her father had ignored her concerns during the past 2 years, and she now experienced memories of feeling rejected by him during that time. When the therapist asked how she felt about her father now, Connie said, "I don't know." The therapist replied, "We'll be looking into that." The treatment

plan involved facilitating Connie's mourning by establishing a safe time-limited relationship without fostering undue dependency.

Initial Support

In the first two sessions, the therapist repeated Connie's story while reorganizing her narrative into a chain of events and reactions. After these sessions, Connie felt that she had made a good choice in coming for help. She could allow herself to feel states with unpleasant pangs of sadness without entering a flooded, overwhelmed, and out-of-control state.

By the fourth session, Connie experienced less intense intrusive and avoidant symptoms. She asked if she was done in therapy now that she felt more in control. She seemed to want to avoid the emotional turbulence of reviewing her relationship with her father, but the therapist advised that they continue and do this together.

Exploration of Meanings

The therapist repeatedly focused attention on the topic of the loss of Connie's father and its meaning to her. He suggested she could safely discuss this issue because doing so together could help Connie tolerate distressing feelings as they emerged during the dialogue. Talking about the topic helped Connie to conceptualize how she sometimes felt too weak without the support of her father or too revengeful toward him because she lost his support well before his death.

The therapist inferred that Connie's preoccupation with "Who was I for my father?" had an additional question of "Who am I without my father?" Connie told stories about a positive and mutually idolizing relationship with her father that she had experienced as an adolescent, which involved the sharing of intelligent and compassionate social values. As a result, in her desired future marital relationship, she saw herself as an intelligent woman prized by an equal partner or mentor.

Now, however, a less desirable self-concept was primed, and Connie tried to ward off an alternative view of herself as an abandoned child. She felt angry, as if she had been left behind by an irresponsible caretaker. She had thoughts that she caused her father's death by being angry at him for abandoning her and divorcing her mother to marry a much younger woman, which activated a view of herself as harmful. This became clearer as she described memories of how her father had criticized both her and her mother as being too emotional and dependent.

Connie also explored how she felt weak for not living up to her father's ideals and her regret that he had died before she could reestablish the same mutual and idealizing relationship of admiration and respect that she had experienced as an adolescent. This goal had been implicit until Connie's exploration of the belief that her father's death meant it could never be achieved. Through her explicit declarations, Connie realized that reestablishing this relationship had been a goal from her adolescence to the present and that she was in need of a new autobiographical narrative.

Increasing Coping Skills

Connie experienced emotions as surges of sensation and expressed them in her face and body movements as well as vocal tone. The therapist noticed

that she did not label feelings in clear speech, and he helped her formulate verbal labels for what she felt. This enhanced her communication skills, which could help her cope in close relationships. Connie learned to keep emotional topics open both in mind and in communication. This helped her both in negotiation with others and in exploring meaning in therapy.

Connie was able to use her new-found clarity for self-reflective awareness, and from there she was able to find words to talk about her feelings. She learned step-by-step decision-making to enhance self-reliance and confidence in self-as-agent. She planned what she would say about her father to friends if that topic came up. She imagined herself doing so in a well-modulated state of mind.

Renarration and Reschematization

The therapist pointed out to Connie that she sometimes reacted to him as if she expected criticism for her repeated avoidance of following up on the meanings of how she was now feeling. She acknowledged that she also frequently felt criticized by a new boyfriend. The therapist contrasted Connie's apologetic stance and expectation of shame with more realistic expectations of being treated by others as an equal partner. He suggested that she be alert to instances of self-criticism. This self-reflection might counteract her lapses in self-esteem with more appropriate appraisals.

The therapist encouraged Connie to note and verbally label moments when she felt criticized or abandoned. In renarrations, she was able to see differences between her memories of the ruptures in her relationship with her father and how she experienced transient discords with her new boyfriend. She became more able to clearly express previously confusing mixtures of sadness, humiliation, and rage.

During childhood and early adolescence, Connie had viewed her father as strong and omnipotent, her mother as weak and too emotionally volatile. In late adolescence and early adulthood, however, she had seen her father's deceits. After his death, she evoked her earlier view of his omnipotence and, through magical thinking, vaguely interpreted his death as a deliberate desertion of her. As an extension of this magical thinking, Connie also had a vague belief that her hostility toward her father's actions might have been a death wish, causing his fatal illness. The therapist clarified and challenged these beliefs. Connie's father was not omnipotent, not always right or wrong, but mortal and in part flawed. His death was not an intentional desertion, nor had it occurred because she willed it to happen.

Connie had needed this idealization of her father because she sometimes viewed herself as being too weak to survive without depending on a strong figure, and she was not able to find this strength in her mother. Connie felt that her father did not love her mother because "my mother often cried and railed at him angrily." Both Connie and her father regarded her emotional states as a sign of weakness. Now Connie was able to renarrate attitudes about both her father and her mother, seeing them as human with various positive and negative qualities. The therapist helped Connie to accept the ambivalence in her memories of her parents and to reappraise them as having traits she both valued and disliked. Connie then imagined that she

could now be both loving and angry with a companion in the future without rupturing the relationship.

Connie gradually became able to more frequently achieve a state of connected and authentic composure with the therapist. She was able to work on forming less dependent and more mutual relationships professionally and personally. She felt less threatened by her own emotionality. These changes were discussed, and a time of termination was set.

Terminating

During concluding therapy sessions, Connie reviewed how she felt about the therapist. At first, she saw him as a strong directive figure, then as one cooperating with her in her narrative efforts. Now she was actively facing some sadness at loss of a good therapy relationship and tolerating it. This process included bolstering her realistically competent beliefs about her ability to move forward in her work and social relationships.

Summary

Formulation begins during evaluation. It is revised during the phases of therapy and shared with the patient. During the final stage, a review of past, present, and future attitudes about loss can provide a context for highlighting what the patient achieved during therapy.

The stages of a prototype of therapy were summarized in Chapter 1, "Principles of Psychological Responses to Stressor Events," and expanded general processes of each stage were discussed in Chapters 2–6. Chapter 6, "Renarration and Reschematization," examined personality features that were present before a recent stressor event that affected symptom formation as well as therapeutic processes. If this deeper stage of therapy is indicated for an individual, then the patient may be expected to grow in capacities after termination. Questions regarding the how and why of these changes can be reviewed in the termination phase.

In most cases, the patient will express gratitude for the positive aspects of the relationship with the therapist. The patient may also feel anxious about the pending separation. This can be discussed supportively. Separation then can be contemplated actively and rationally rather than passively or with outdated relationship models.

CHAPTER 8
Assessing Change

SELF-REPORT RATING SCALES THAT COVER A discrete period (e.g., the past 7 days) are a helpful tool for assessing symptoms and improvement in a patient's quality of life over time. Therapists can assess progress by repeated administrations and tracking each item endorsed as occurring frequently. Clinicians treating stress response syndromes may have institutional scales that include measures of anxiety, such as the Generalized Anxiety Disorder 7-item (GAD-7) scale, and depression symptoms, such as the Patient Health Questionnaire (PHQ-9) (Spitzer et al. 1999). Various trauma checklists also provide ratings of diagnostic criteria symptoms. Useful additions for assessing most types of stress response syndromes are the Impact of Event Scale (IES; Horowitz et al. 1979), the Positive States of Mind Scale (PSOMS; Horowitz et al. 1988), and the Sense of Self-Regard Scale (Horowitz et al. 1996) (see Tables 8–1 and Tables 8–2 and 8–3 later in the chapter). I give the reader permission to duplicate and use each of them.

Impact of Event Scale

The IES (Table 8–1) has been used widely, and comparison scores for groups of subjects who have experienced various types of loss or trauma are also available (Horowitz et al. 1993b; Sundin and Horowitz 2002, 2003). The clinician should write each particular traumatic or loss event at the top of the IES, using a separate form for each event unless the intention is to combine events (e.g., the accident and subsequent emergency department visit and hospitalization). The patient then fills out all items with reference

to that particular stressor and for the time period specified, usually the past 7 days.

- The IES is made up of 15 items. Each item is rated by the subject on a scale of 0=not at all, 1=rarely, 3=sometimes, and 5=often. There are two subscales, which are scored from a patient's IES responses, intrusion and avoidance:
- Intrusion: calculated by adding items 1, 4, 5, 6, 10, 11, and 14
- Avoidance: calculated by adding items 2, 3, 7, 8, 9, 12, 13, and 15

The two subscales can be added together to calculate a total score, and the generally relevant clinical cutoff points for the total score are as follows:

- <8: Low symptom severity in the past week
- 9–19: Medium
- ≥20: High

Positive States of Mind Scale

The PSOMS (Table 8–2) is a self-report of the ability to have six types of satisfying and enlivening experiences. Low scores correlate with dysphoria (Adler et al. 1998; Horowitz et al. 1988), and signs of improvement on this scale can encourage patients in their recovery of equilibrium after the turbulence caused by stressor events.

- This scale is applicable to the 7-day period immediately preceding self-assessment. Each state that is scored by the patient as 0–2 can become a focus of attention and goal setting in therapy.
- Scores for individual items can be followed over time on repeated administrations to track in-treatment changes as well as pretherapeutic and posttherapeutic changes.

Sense of Self-Regard Scale

The Sense of Self-Regard Scale was developed to assess self-coherence as sensed by the patient over the past 7 days (Table 8–3). The scores of all five items can be added together. The result provides an approximation of the felt coherence in a subject's current sense of identity.

TABLE 8–1. Impact of Event Scale

Name: _____ Date of scale completion: _____

(Insert the traumatic event here that serves as a referent for the experiences listed below.)

Event memory: _____

Instructions: Below is a list of comments made by people about stressful life events and the context surrounding them. Read each item and decide how frequently each item was true for you *during the past 7 days* regarding the event written in just above this note. Circle the number of the response that best describes that item. Please complete each item.

	Not at all	Rarely	Sometimes	Often
1. I thought about it when I didn't mean to.	0	1	3	5
2. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	3	5
3. I tried to remove it from memory.	0	1	3	5
4. I had trouble falling asleep or staying asleep because of pictures or thoughts that came into my mind.	0	1	3	5
5. I had waves of strong feelings about it.	0	1	3	5
6. I had dreams about it.	0	1	3	5
7. I stayed away from reminders of it.	0	1	3	5
8. I felt as if it had not happened or was not real.	0	1	3	5
9. I tried not to talk about it.	0	1	3	5
10. Pictures about it popped into my mind.	0	1	3	5
11. Other things kept making me think about it.	0	1	3	5
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	3	5
13. I tried not to think about it.	0	1	3	5

TABLE 8–1. Impact of Event Scale *(continued)*

	Not at all	Rarely	Sometimes	Often
14. Any reminder brought back feelings about it.	0	1	3	5
15. My feelings about it were kind of numb.	0	1	3	5

Source. Horowitz et al. 1979.

Summary

The therapist and patient share observations of how the patient is changing in therapy. Progress is seldom linear. Some symptoms remit, some intensify. Ups and downs, new and recurring problems, and even failures of coping are often a part of an overall improving course. Rating scales that can be repeated weekly, biweekly, or monthly can help patients report how their recovery of well-being is going. Scales such as the ones presented in this chapter provide two types of information: the total score and the patient's endorsement of a specific item. The content of a specific item that indicates a worsening can become a focus for attention in the following therapy session.

TABLE 8–2. Positive States of Mind Scale

Instructions: Circle the appropriate value for each item as you experienced it during the past 7 days. Total each column at the bottom.

	Unable to experience it	Difficulty experiencing it	Limited ability to experience it	Experience it easily and/or often
Focused attention: Feeling able to work on a task you want or need to do, without many distractions from within yourself.	0	1	2	3
Productivity: Feeling of flow and satisfaction without severe frustrations, perhaps while doing something new to solve problems or to express yourself creatively.	0	1	2	3
Responsible caretaking: Feeling that you are doing what you should do to take care of yourself or others in a way that helps meet life's necessities.	0	1	2	3
Restful repose: Feeling relaxed, without distractions or excessive tension and without difficulty in resuming activity when you want to.	0	1	2	3
Sensuous pleasure: Being able to enjoy bodily senses, intellectual activity, and things you ordinarily like, such as listening to music; being outdoors; lounging in a hot bath; or being able to enjoy kissing, caressing, or intercourse.	0	1	2	3
Sharing: Being able to commune with others in an empathic, close way, perhaps with a feeling of joint purpose or values.	0	1	2	3
Score:				

Source. Horowitz et al. 1988.

TABLE 8–3. Sense of Self-Regard Scale

Instructions: For each item below, circle the number indicating your average over the past 7 days, including today.

Sense of my facial appearance	Least healthy I can really look	1	2	3	4	5	6	7	8	9	10	Most healthy I can really look
Sense of fatigue	Most tired I can really get	1	2	3	4	5	6	7	8	9	10	Least tired I can really get
Sense of a healthy body	Least healthy my body can feel	1	2	3	4	5	6	7	8	9	10	Most healthy my body can feel
Sense of a healthy mind	Least healthy my mind can feel	1	2	3	4	5	6	7	8	9	10	Most healthy my mind can feel
Sense of my identity as a whole person	Least clear sense of myself as a whole person	1	2	3	4	5	6	7	8	9	10	Most clear sense of myself as a whole person

Source. Horowitz et al. 1996.

CHAPTER 9
Conclusion

AS CLINICIANS, WHEN WE EVALUATE PATIENTS, our work consists of more than just arriving at a diagnosis. We share formulations with patients and establish a frame that is compassionate, supportive, and educational. Together with the patient, we consider social and cultural frameworks. As we begin providing therapy, we learn more about the patient's needs and reformulate as we progress through the different phases of treatment. Clinicians and patients share the reformulation process using a cycle of observation, provisional understanding, and trial of new techniques. The cycle repeats with observation of the effects of the therapist's actions.

In this book, we have focused on the phases of psychotherapy, from initial support to growth-promoting work such as developing new schemas for identity and relationships, as well as enhancing capacities for emotional self-regulation. We use a transdiagnostic approach because PTSD, acute stress disorder, and adjustment disorder share an etiology, occurring after a person experiences serious life events and subsequently develops intrusive and avoidance symptoms that involve memory and meaning.

Biological factors such as traumatic brain injury and behavioral factors such as substance use interact with cultural as well as psychosocial factors. Clinicians and treatment teams need to disentangle these factors. Therapists engaged in psychotherapy need to consider each patient's progress, cultural context, and prior developmental experience in order to understand the patient from a biopsychosocial perspective. Therapists need to explore memory and meaning in the context of the patient's current personality traits, such as those discussed in Chapter 5, "Improving Coping Skills," and Chapter 6, "Renarration and Reschematization," in order to understand how the symptoms may resolve.

Therapeutic work begins with the first sessions of evaluation. A prototypical patient might have grievances about the past, shock about the present, and dread or pessimism about the future. The patient can intuitively feel understood by a compassionate therapist during the evaluation process. Having a sense of being contained in an atmosphere of empathy may somewhat reduce the fear of loss of control as the patient reexperiences the trauma and recalls fragments of memory together with intense feelings.

Psychotherapy occurs in a sequence, with initial attention focused on surface and immediate issues and later phases of therapy dealing with deeper issues. Patients may ask an assessing clinician for a specific diagnosis and whether their symptoms will remit. Clinicians should respond with expert information that leads to realistic expectations. The patient learns that symptoms are complex.

When clinicians offer treatment, patients experience hope. Together, patient and therapist can address problems in processing memory and meanings. Supportive techniques can desensitize the patient to the fear associated with retelling a traumatic story. The therapist helps the patient understand that the recall and processing of trauma and loss stories can occur in phases, such as an initial outcry of emotions; a possible period of denial, avoidance, and/or numbing; and then a phase in which intrusive sensory images, pangs of emotions, and urgent concerns can be discussed.

Therapist and patient will frequently focus attention on ideas and feelings that emerge unbidden in the mind. The therapist listens to a patient's highly charged trains of thought and often confusing blends of emotion and establishes a calming and hopeful dialogue. The therapist also provides understanding that memories may be fragmentary and may trigger intense emotions, perhaps blended and confusing ones. The patient learns that symptoms will gradually lessen as pieces of the puzzle are articulated

Patients may be helped when therapists repeat what has been shared before. When the therapist, in a calm voice, repeats a phrase that the patient has said, the patient experiences it differently. During therapy, appraisals and reappraisals occur. When clinicians are hopeful about future progress, patients experience hope for a good outcome in the treatment process.

Intrusions may interrupt attention and disrupt social functioning at work and at home. However, intrusions may be important reminders that motivate renewed cognitive and emotional processing of events that have not yet been processed in the mind. Avoidances impede processing, but they also maintain equilibrium in the present so that patients can continue to function in their daily lives.

During the next phases of therapy, intrusive and avoidance states may recede, recur, and change. As the patient and therapist address difficult emotional topics, they may both learn to observe when a specific inhibition

of verbalization occurs. The therapist then follows a general principle of asking the patient to look at the present moment and what just happened. The clinician's aim is to focus attention on state shifts and topic curtailments within the therapeutic frame of increasing tolerance for unpleasant feeling states.

As the patient increases his or her reflective self-awareness capacities, the clinician suggests tentative interpretations about why some specific mental contents and communications can occur in the present moment. The therapeutic environment is increasingly seen as a safe place in which to experience unpleasant states. Gradually, the patient will be able to discuss dissociated experiential fragments, including associative linkages between adverse childhood experiences and the most recent trauma or loss (Horowitz 2011).

Whenever possible, therapists aim at protecting patients from retraumatization. The underlying principle is to encourage patients to share emotional expressions while they are in well-modulated, working states of mind and the emotions can be contained. Patients and therapists can work together to assess and describe the trauma and develop techniques for coping in the present time. They may then examine and try out new goals for the future. Patients share reappraisals of what the trauma or loss meant to them and how to proceed to a new life in the future. When patients have underlying personality structures that may impede progress in therapy, therapists need to proceed slowly, counteract transference feelings, and provide a path of reorganization for self systems and attachment models (Horowitz 2002, 2016).

During the course of therapy, patients may experience fewer undermodulated emotional states. They learn from new experiences within the safe model of self transacting with a trusted other in a therapeutic alliance. With transactive use of new scenarios, patients can update schemas of self and other so that their current attitudes can accord with new realities and capacities.

Because mastery of stress and loss involves both conscious and unconscious mental processing, integration of stressor memories into schemas is neither rapid nor linearly progressive. The individual may continue to experience some states of mind in which memories are intrusive or avoided. Memories may be altered from state to state. Eventually, equilibrium can be restored, and the patient can develop a new, realistic autobiography.

During the therapeutic work, the therapist needs to address pervasive schemas that interfere with relationships. For example, the therapist needs to identify antagonistic defiance at one extreme and excessive dependency at the other extreme. Some patients may persist in seeing themselves as passive victims who will never be able to assert control over their life. Other

patients may have unrealistic expectations for a complete restoration of well-being. The real consequences of trauma and loss will have to be eventually accepted and recognized as a tolerable part of life.

Clinicians will often find out more about personality traits as therapy progresses, especially if some kind of impasse has occurred. Clinicians may provide new insights into how identity itself has been partially shattered by trauma or loss, recently and/or through adverse events in childhood. As the therapist formulates the patient's sense of current identity and patterns of social relationships, he or she shares assessments about the patient's progress in establishing better emotional control. As part of this process, the therapist and patient may discuss the option of continuing to work together to enhance personality growth.

As therapists, we need to be aware that helping people with stress response syndromes never achieves perfection. The future may deliver new blows. However, this work really matters: gains are made for our patients and our field as our theories accrue. We also can experience professional satisfactions from our own growing scope of understanding.

Speaking from experience, let me also share with you that although working to promote resilience is very rewarding, too much of it can lead to compassion fatigue. Therapists need work-life balance to help them deal with traumatized individuals. As author of this book, I wish this for both you and your patients.

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Nearly 20 years after publication of the groundbreaking *Treatment of Stress Response Syndromes* comes this second, thoroughly revised and altogether timely edition. The 2020 pandemic and worldwide economic crisis are but the latest challenges to global and individual mental health and well-being. In this invaluable text, Dr. Mardi Horowitz, who is largely responsible for modern concepts of PTSD, teaches clinicians to employ a transtheoretical approach. Comprehensive and insightful, *Treatment of Stress Response Syndromes* will be useful for clinicians who are already familiar with diagnosing and treating patients but who want to advance their techniques for providing psychotherapy to this vulnerable population.

Praise for the first edition:

Mardi Horowitz "wrote the book" on stress response syndromes. Now he has written the book on their treatment. A master therapist and noted PTSD researcher, Dr. Horowitz has given us a definitive guide to the psychotherapy and management of acute and posttraumatic stress disorder that combines crystalline case description with lucid presentation of therapeutic technique.

—David Spiegel, M.D.

What separates this book from similar texts in the field are the depth and richness of Horowitz's clinical experience. His psychopharmacological suggestions are wise and an improvement over the advice of most authors, who either lack sophistication in the use of drugs or lack dynamic understanding. Horowitz's advice on countertransference is particularly helpful. His balance and emphasis are in the right places, and his writing and conceptualizations are lucid.

—George E. Vaillant, M.D.

In this volume Horowitz presents a unique integrative model for understanding and treating stress response syndromes. Drawing on empirically supported biological, behavioral, cognitive, and psychodynamic perspectives, the author outlines basic principles of individualized case formulation and treatment in a way that is both clinically sophisticated and highly readable. Chock-full of clinical examples, this book is essential reading for any student or clinician who provides psychotherapy to victims of trauma or other stressful events.

—Paul Crits-Christoph, Ph.D.

Mardi Horowitz is world famous for his decades of research on treatment of stress responses. One of his main principles in his truly individual formulations is his concept of configurational analysis. He uses process headings, such as doing evaluations, giving support, and improving coping, rather than mere diagnosis. The whole process is made vivid by many fine case examples.

—Lester Luborsky, M.D.

ISBN 978-1-61537-305-5
9 0 0 0 0
9 781615 373055

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