

# STRESS RESPONSE SYNDROMES

Fifth Edition



PTSD, Grief, Adjustment,  
and Dissociative Disorders

MARDI J. HOROWITZ

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MARDI J. HOROWITZ, MD



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For those strangers who, roused by a shared sense of humanity, help others overcome difficult events, providing compassion, restoration, and hope.



And, more personally, in loving memory of Lillian and Morris Horowitz, who taught me compassion, restoration, and hope.



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# Foreword to the First Edition

This book by Dr. Mardi Horowitz on the psychological understanding and the psychotherapeutic amelioration of specifically circumscribed psychopathological entities, the Stress Response Syndromes, is an exciting and long-needed investigation that reflects the creative interplay of psychotherapy, research, and practice. It is, after all, of the essence of the clinical, medical, and health disciplines, the so-called healing arts, of which psychotherapy partakes, that continuing advance in understanding and in practice should accrue from the effective and creative interplay of formal research, basic investigation—in theoretical structure, in experimental laboratory, or in field observation or survey—in interplay with the clinical experience and clinical reflection of the bedside, or in our instance, the consulting room. It is this creative interplay between research and practice, leading to the enhancement of *both*, which has been so underdeveloped in our “peculiar” science with its heretofore essentially one-sided development of clinical insight and understanding without the signal benefit of concomitant growth from the formal and systematic research side of any comparable insight and understanding.

Mardi Horowitz’s book is a multifaceted model, or rather a series of models, paradigmatic of a new genre, that brings psychotherapy research meaningfully into the clinical picture; that is, where each influence furthers the other. What is the nature then of these models? There is first a model of *problem setting* and *problem delineation* in the field of psychological understanding and psychological intervention. Through a sequence (1) of typical clinical *case history* in sufficient detail; (2) of equally detailed and at the same time wide-ranging field *observation* and survey drawing upon disaster and extreme circumstance, whether wartime military combat or peacetime fire or shipwreck, whether such inhumane extreme circumstances as concentration camps and nuclear holocaust or more “everyday”

circumstances of rape, severe illness, death and bereavement; and (3) of equally meticulous attention to the varieties of ingenious analogies to these stress situations, to the extent that they can be ethically re-created within the *experimental laboratory* and there be safely studied via controlled manipulation of critical dimensions; through this sequencing and drawing of common threads, this book serves as a model for the use of consulting room, of field observation, and of experimental laboratory to throw complementary and therefore incremental illumination upon the essential problem of psychotherapy, the understanding and the possibilities for intervention into the psychological dysfunctions of people.

This volume is secondly a model for the rational description of the *natural history* of a psychopathological syndrome, a description, that is, of what Dr. Horowitz calls the “general theory,” the psychological explanation of sequentially unfolding phases and the general principles of psychological management and psychotherapeutic intervention specifically and differentially appropriate to the specific developmental phase and state of the disorder. This effort brings some rational order out of what so often looks like a chaotic welter of conflicting claims and competing approaches all vying for consumer acceptance in the unregulated psychotherapy marketplace. And thirdly, really as corollary to the “general theory” that accounts for the understanding and the psychotherapeutic modification of the naturally unfolding stress response syndrome, is the model for differentiated understanding and intervention based on the differing *personality types or styles* as they differently mesh with the impositions and implications of the syndrome and the requirements and possibilities of the intervention strategies.

Robert S. Wallerstein, M.D., Professor of Psychiatry  
University of California, San Francisco

# Preface to the Fifth Edition

I kept the well supported assertions from the earlier edition and added essential new information. The most important changes involved diagnostic considerations as we head for DSM-V and ICD-11. Treatment suggestions are updated with more attention to the formulations needed for helping complex, “real world” cases. I also updated the emotional information processing theory.

In Part I we examine the core characteristics of stress response syndromes. Part II explains these general response tendencies and describes the principles of treatment for stress-induced disorders. Part III elaborates on these principles, contrasting patient types. Then Part IV presents case histories, including transcripts of sections of the psychotherapeutic process, to further illustrate how personality factors and preexisting conflicts contribute to how a person reacts to a traumatic event.

Mardi Horowitz, M.D.  
San Francisco, California



# Acknowledgments

In my introduction to the first edition, I thanked my high school chemistry teacher, Mr. Toon, for giving me the gift of wanting to study science, and UCSF professor Jurgen Ruesch for pointing the way in psychiatric research. Many other mentors and colleagues have guided me since then. In this edition I cannot list all the colleagues, teachers, patients, and students who have made vital contributions. But certainly important among these are my colleagues Renée Binder, George Bonnano, Nigel Field, Are Holen, Nancy Kaltreider, Charles Marmar, Connie Milbrath, Martha Shumway, Bryna Siegel, Charles Stinson, Robert Wallerstein, Daniel Weiss, Nancy Wilner, Eva Suintin and Hansjörg Znoj.

My own efforts at stress research would not have been possible without the support of UCSF's Langley Porter Psychiatric Institute, grants from NIMH, and the John D. and Catherine T. MacArthur Foundation. I especially want to thank William Bevan, John Conger, Murray Gell-Mann, and Jonas Salk for their vision and encouragement.

I am grateful to Margarite Salinas, Masha Ovchinikov Brown, and Jaimie Marchetti for assisting me in all ways in composing the many additions and revisions of this new edition.



Part I

# STRESS RESPONSE SYNDROMES





## CHAPTER 1

# Intrusion and Denial

## A PROTOTYPICAL CASE

Stress of a psychological nature is usually conceptualized as a psychic strain on the mind stemming from traumatic events. While the stressor life experiences may be recent, the roots of how a person will respond to this event runs deep within. A stress response syndrome combines innate personality dispositions and appraisals of new experiences. Reducing any fantasy distortions in the process of treatment can lead to a realistic trauma story. Treatment aims at assisting a person's processes of making new meanings and achieving new coping capacities.

People intuitively know when they are under extreme stress. They even say, "I was thrown off balance" or "I have not regained my bearings." Some even say "I am not myself today," after a fright, trauma, injury, severe illness, or loss.

In the aftermath of trauma, everyone has some avoidance of implications and some unbidden ideas and feelings. After a dire event, an individual may have more pangs of intense emotion and a greater sense of emotional numbing than usual. After a severe event is concluded, the mind may race on with more intrusive memories than usual and at the same time avoid representations of very important information pertaining to trauma.

Intrusive repetitions and avoidance or denial are labels for two extremes of response to stressful life events, and their meanings are our concern in this book. Because we must use abstract statements and generalizations to explore these meanings, we shall begin with a concrete example, the case of Harry. His unbidden images of a dead woman's body illustrate the intrusive repetition of a horrible sight, and his temporary inability to acknowledge how moved he was by his involvement with her death illustrates a period of denial. Harry is a fictional character whose case is discussed throughout the book. His history is a composite of characteristics found in studies of real individuals. The events of his

life are held constant while his character style is molded in various ways in order to contrast the response of different personality styles to the same circumstance.

Harry was a 40-year-old truck dispatcher who had worked his way up in a small trucking company. One night he took an assignment for a truck pick-up and delivery job by himself because he was shorthanded. The load consisted of steel pipes, which were carried in an old truck, and although the truck had armor between the load bed and the driver's side of the forward compartment, it did not fully protect the passenger's side.

Late at night Harry passed an attractive woman hitchhiking alone on a lonely stretch of highway. He impulsively decided to break the company's rule, which stated not to have passengers of any sort, and picked her up, reasoning that if he did not she might otherwise be in danger.

A short time later a car veered across the divider line and entered his lane, threatening a head-on collision. Harry pulled across the shoulder of the road into a clear area but then crashed into a pile of gravel. A pipe shifted, came through the cab of the truck on the passenger's side, and impaled the woman. Harry crashed into the steering wheel and windshield and briefly became unconscious. When he regained consciousness, he was met with the grisly sight of his dead passenger.

The highway patrol found no identification on the woman, the other car had driven away, and Harry was taken by ambulance to a hospital emergency room. No fractures were found, his lacerations were sutured, and he remained overnight for observation. His wife, who stayed with him, found him anxious and dazed, talking of the events in a fragmentary and incoherent way.

The next day Harry left the hospital against his wife's wishes and his doctor's recommendation to rest, and returned to work. From then on, for several days, he continued his regular work as if nothing had happened. Harry met with his superiors and with legal advisers and was reprimanded for breaking the rule about having a passenger, but was also reassured that otherwise the accident was not his fault and that he would not be held responsible. It was no secret that other truck drivers also often broke the no-passenger rule.

During this phase of relative denial and numbing of emotional responses, Harry thought about the accident from time to time, but was surprised to find how little emotional effect it seemed to have on him. He was responsible and conscientious in his work, but his wife reported that he thrashed around in his sleep, ground his teeth, and seemed more tense and irritable than usual.

Four weeks after the accident he had a nightmare about mangled bodies and he awoke with an anxiety attack. For the next several days he had recurrent, intense, and intrusive images of the woman's dead body. These images, together with his ruminations about her, were accompanied by increasingly severe anxiety attacks. Harry even developed a phobia of driving to and from work, and his

regular habits of weekend drinking increased to a nightly use of increasing quantities of alcohol. He lost his temper over minor frustrations and had difficulty concentrating at work, even while watching television. Harry tried unsuccessfully to dispel his feelings of responsibility for the accident and worried about his complaints of insomnia, irritability, and increased alcohol consumption. Finally his doctor referred him for psychiatric treatment.

This phase of the trauma-related disorder illustrates intrusive repetition in waking and dreaming states, as well as in thought and emotion. Initially, Harry was reluctant to talk about the accident in his psychiatric evaluation. But this resistance subsided relatively quickly, and he reported recurrent intrusive images of the woman's body.

## Background

Harry's family lived in a mid-size central California city. His father worked as a hardware store manager and had a middle-class income. His mother married his father after graduating from high school and had been a housewife and mother since then. Harry had two older sisters and one younger sister.

Harry's father, a strict and moralistic man, had a constricted outlook on life. He had been out of work during the 1930s Great Depression and remained preoccupied with trying to save money. When this was not possible, he became irritated or worried. Besides his work and family, Harry's father valued his men's club activities and his trout fishing. Harry's father also took him on occasional fishing trips, but remained fairly emotionally remote. As we shall see, Harry internalized his father's moralistic standards of behavior, which contributed to his guilty feelings after the accident.

Harry's mother struggled to provide a good home for her children, making sure that the house was clean, the meals were on time, and the laundry was done. She sometimes cried and belittled herself when she was unable to complete these tasks. Harry felt that his father did not appreciate his mother and that his father did not help her enough. While his father sat in a chair during the evening, his mother continued working, with Harry sometimes helping. Harry's mother favored him and generally was lenient about what he did.

One of Harry's older sisters resented his favored position with their mother and periodically teased and tormented him. But the other two sisters shared their mother's feeling that he was the special one. Harry felt especially close to his younger sister but was not closely attached to the others.

Harry was one of the more intelligent and gifted children in his high school class, and some of his teachers encouraged him to go to college. But he fell in love with a girl in his class, they began dating, and in their senior year of high

school, she became pregnant. They decided they should get married and raise the child together. Harry found a job working for a local store, which led to his entering the truck-driving field. Harry's wife was a homemaker and did not work outside the home. Periodic promotions followed until he reached the position of chief dispatcher a few years before the accident. He worked hard, valued the esteem of the other men, but felt bored and limited. His resulting desire for something more contributed to an increasingly impulsive attitude, such as his readiness to break the rules and pick up the hitchhiking woman.

Harry and his wife had three children, two boys and a girl. Although Harry rarely had time, the children demanded that he spend time with them on weekends. He was attentive to his children and consciously wanted to be a better husband than his father had been. His resentment of his wife occasionally surfaced, however, for he felt unfulfilled in the marriage. He believed that if he had not had to marry her, he could have gone to college, developed his potential, and found more interesting and remunerative work.

For several years, Harry had served in the military and his wife and family were able to accompany him to a stateside base. He remembered this as one of the happier periods of his life because of the variety of experiences and the camaraderie he was exposed to with the other men. He had felt occasionally depressed since then.

When he was feeling morose, instead of coming home for dinner, Harry would go to a local bar with some of the men from work. He generally returned home three or four hours later, moderately intoxicated. His wife reacted with coldness, tears, or an angry attack. He counteracted by either feeling upset, guilty, apologetic, or angry in return and would criticize his wife's faults and shortcomings. Once he hit her during such an altercation; she threatened to leave him and because of this the physical abuse was never repeated. After the accident he feared that his wife would react to his picking up the woman with similar coldness, accusation, and anger.

Following such outbursts, Harry tended to carry a grudge against his wife for several weeks. But to his surprise, she would recover from these attacks the same day. Her main grievance was that she felt unappreciated for all her devotion as his wife and the mother of his children. Although their sex life was intermittently active, she accused him of being less interested in her, and herself of being less interesting. Even though Harry did not tell her, he agreed. He had been sexually interested in women at work, but this had not gone beyond flirtations and kissing at office parties. But his sexual fantasies had been activated by seeing the woman alone on the highway.

Harry's main leisure activities were picnicking and camping with his family and trout fishing with his father. The two had developed a kind of distant but affectionate relationship around this activity. In addition, Harry liked to read. He

tended to select recent novels and had also purchased a set from a “great books” series that he was determined to read from beginning to end.

## Diagnosis, Formulation, and Treatment

Harry received a diagnosis of Post Traumatic Stress Disorder based on the severity of the event he had experienced and his symptoms. His symptoms included intense and disruptive night terrors, unbidden daytime images, anxiety attacks, phobic avoidance of driving vehicles, obsessive rumination, excessive alcohol use, insomnia, and irritability. He had states of mind with reduction in emotional regulation. That is, he had states of expressing under-modulated anger, worry, and remorse. Certain topics seemed unresolved in his mind, and they were topics of worry. These included:

- Degree of responsibility for accident
- Worry about his future
- Worry about his marriage

As he thought about these topics, he sometimes saw himself as a harmful aggressor, leading to his passenger being hurt, and sometimes as a victim with superiors at work being excessively critical accusers. He also saw himself as needy, without sufficient current emotional support.

Therapy was aimed to work on these problems. The focus would be on the accident, its consequences and antecedents, and the meanings of these experiences to his sense of competence and future possibilities. He was seen in individual integrative psychotherapy (integrating psychodynamic and cognitive techniques).

During his psychotherapy, Harry worked through several complexes of ideas and feelings linked associatively to the accident and his intrusive images. The emergent conflicting themes (see Table 1.1) included guilt over causing the woman’s death, guilt over sexual ideas about her that he had fantasized before the accident, guilt that he felt glad to be alive when she had died, and fear and anger that he had been involved in an accident and her death. There was also a magical belief that the woman had “caused” the accident by her hitchhiking, and his associated anger toward her that then fed back into his various guilt feelings.

The feelings of guilt and anger Harry experienced were activated not only by the accident, but also by his psychological state prior to it. Relationship difficulties and lack of sexual interest in his wife had led to fantasies about other women and activities that resulted in themes of guilt. Such guilt was connected with these feelings after the accident, just as his anger with his wife was related

**Table 1.1 Themes Activated by the Accident**

<b>CURRENT CONCEPTS</b>	<i>Incongruent with</i> →	<b>ENDURING SCHEMAS OR BELIEFS</b>	→	<b>EMOTION</b>
A. Self as "aggressor"				
1. Relief that she and not he was the victim.		Social morality		Guilt
2. Aggressive ideas about the woman.		Social morality		Guilt
3. Sexual ideas about the woman		Social morality		Guilt
B. Self as "victim"				
		Invulnerable self		Fear
1. Damage to her body could have happened to him.		Invulnerable self		Fear
2. He broke rules.		Responsibility to the company		Fear (of accusations) and
3. She instigated the situation by hitchhiking.		He is innocent of any badness; the fault is outside		shame Anger

to the theme of his anger with the hitchhiker. Thus, the accident led to a period of stress that combined predisposition with stress responses.

Harry's symptoms gradually diminished. At first he was able to sleep better, and gradually he felt less anxious, tense, and irritable. He reduced his alcohol intake to an occasional social drink. Later, the image symptoms stopped, and his relationships returned to about the same level as before the accident, except that he felt closer to his wife, whom he credited with helping him through a difficult period.

## CHAPTER 2

# Clinical Observations and Syndromes

Clinical observation rests largely on self-reports from people who may not have a clear language for describing certain mental experiences such as flashbacks. Knowing how to describe symptoms, the clinician can ask questions that amplify the patient's spontaneous reports and augment observations of non-verbal communications. In addition, we aim at understanding how and why symptoms have developed. Such an understanding helps us plan how to attenuate these symptoms and restore the patient's self-confidence and functioning.

## Background and Current Context

Stress response syndromes, which describe the altered experiencing and impaired social functioning, have been noted in literature that goes back many hundreds of years. The arguments of what is normal and transient, versus abnormal, complicated, and prolonged that were present in the past literature are fresh and alive in current debates about establishing diagnostic criteria and frameworks. Reasons for such debate include not only theoretical and intellectual differences but also encompass economic and legal issues.

If a stress-induced syndrome represents suffering and some disability, then whoever caused the life event might be in part responsible for costs of care, emotional damages, or support for those whose ability to earn a living is impaired. Personal injury litigation may occur. Institutions may be challenged to pay for care, and make up for emotional suffering, and related disability. Economic issues can cloud scientific reasoning and data interpretation, even the data one can collect in research investigations. War combat provides such an example, with the rate of Post Traumatic Stress Disorder being high in veterans. The govern-



ment care of them is rather costly, which creates an incentive to establish strict diagnostic criteria and establish inexpensive treatment limitations.

Another reason for the debate about diagnostic categories relates to the fact that criteria for disorders are based mainly on patient-reported psychological symptoms, such as intrusive mental images repeating traumatic perceptions. This makes diagnostic tools rely largely on subjective experience and difficult to verify self-report. So far, there are no clear biological markers, such as X-ray for bone fractures, to assess PTSD.

Post-traumatic conditions concern not only the clinical problem of diagnosis and etiological formulation but also the legal problem of compensation when the traumatic events were seen as the potential responsibility of others. The advent of the development of railroad systems in the industrial era led to a clearer observation of post-traumatic disorders (Trimble, 1981). The lawsuits, as a result of accidents, led to many legal arguments among experts on both the plaintiffs' and the defendants' sides. In the latter part of the nineteenth and into the twentieth century, these arguments concerned the degree to which a patient's distress and functional impairment was related to (1) aims to get compensation; (2) somatic reactions precipitated by trauma; (3) physical disability and (4) psychological symptoms and behavioral signs induced by psychic trauma.

Using the early methods of psychoanalysis, Breuer and Freud (1895) explored hysterical symptoms in terms of associated memories and fantasies and hypothesized that earlier psychological traumas provided the contents that were reenacted symbolically or indirectly in the symptoms of hysteria. These traumatic events often involved a situation in which the dependent child or adolescent was sexually abused. The pressure for expression, of reactions to childhood abuse, together with defensive distortions of expression, was seen as the cause of symptoms such as interpersonal pattern disturbances that emerged much later in adult life. This is still seen as an aspect of what will be discussed later as the controversial syndrome of Complex PTSD.

Breuer and Freud noted that psychological traumas could precipitate symptoms such as recurrent visual hallucinations, emotional outbursts, paralyzes, compulsive movements, and other sensory or motor disturbances. They also discovered that there was frequently a latent period between the occurrence of a stressful event and the onset of symptoms. Once symptoms formed, however, there was a remarkable tendency toward recurrence or persistence long after the termination of the precipitating event. In addition, there was often a bland denial of the meaning of symptoms, which was called *la belle indifférence*.

Later, Freud made many theoretical revisions about the hypothetical traumatic basis of some intrusive hysterical symptoms. He was at first dismayed to find that memories of childhood seduction and abuse were not always true memories but occasionally fantasy elaborations of childhood situations (Jones,

1953). Thus, the traumatic event did not always represent an external stress alone. It also involved internal components and might produce a range from resilience to symptom formation to personality disturbances (Freud, 1920).

Through the elaborations and corrections of the first psychoanalytic theory, the concept of trauma became generalized. The generalization of trauma as an explanatory concept necessitated the description of its many variations. Also, early treatment techniques emphasized abreaction (emotional recall of traumatic memories) and catharsis (extensive and intense expression of the emotional reactions). An array of terms resulted, including multiple strains, cumulative bad-object crises, abandonment reactions, and retrospective traumas (Fairbairn, 1954; Freud, 1937; Furst, 1967; Glover, 1929; Greenacre, 1952; Sachs, 1967; Sears, 1936; Stern, 1961; Prior, 2006; Summers, 1999).

Despite this diffusion of terminology and theory, clinicians agreed on several key findings. One of these discoveries was the phenomenon that after a traumatic event there is a compulsive tendency to repeat some aspect of the experience (Schur, 1966). This involuntary repetition includes the recurrence of thoughts and especially images about the stress event, of feelings related to the original experience, and of behavioral reenactments of parts of the experience itself. Repetitions in thought may take many forms, including nightmares, hallucinations, pseudohallucinations, recurrent unbidden images, illusions, and recurrent obsessive ideas.

As discussed in Chapter 1, the case of Harry is an example of some common post-traumatic symptoms. His intrusive and repetitive images of the dead body and his recurrent emotional alarms exemplify the distress that may be prolonged. His emotional repetitions occurred often with or without clear conscious awareness of their conceptual associations.

Involuntary repetitions of aspects of the trauma story as conscious representations are not necessarily static replicas of the original experience. A series of successive revisions in content and form is frequently noted in clinical studies of telling the story of a trauma. The change in content and reduced intrusiveness may indicate that there has been a progressive mastery of the experience. But unfortunately this does not always happen, and in some people these intrusive repetitions persist and disrupt a sense of self control and/or they impair the person's abilities for social functioning.

The involuntary repetition of stress-relevant contents may be a sharp contrast with its ostensible opposite: the massive ideational denial of the event and general emotional numbness. This phenomenon was described by Menninger (1945), who called this the most normal and the most prevalent of defenses *hy-persuppression*. Avoiding thoughts about the stress event or its implications may alternate with intrusive repetitions in a variety of phasic relationships. Denial and numbness may occur over a given time span of hours or days, alternating

with phases of ideational intrusion and emotional pangs. There also may be intrusive repetitions of one aspect of a stress event, with simultaneous denial and numbing of another implication of the event (intrusion of fearful themes, for example, with Harry's inhibitions of the experience of guilty themes).

To summarize, early studies indicated that major stress events tend to be followed by involuntary repetition or intrusion in thought, emotion, and behavior. Such responses tend to occur in phases and to alternate with periods of relatively successful avoidance of repetitions, as indicated by ideational denial and emotional numbness. In addition, the bodily reactions called hyperarousal of fear-circuitry and alarm psychology form a historically recognized set of symptoms. "Soldier's Heart," for example, was a diagnosis explaining sudden states of rapid pulse rates in American Civil War veterans in the 1860s and 1870s.

As an overview, some historical observations of post-trauma symptoms are summarized under the intrusive, avoidant, and hyperarousal states in Table 2.1. The symptoms are organized by various sectors of mental processes, ranging from perceptions to action-planning.

Now I would like to expand on a delineation of some of the most frequent trauma-related symptoms. During *intrusive* states, mental images in any sensory modality (visual, auditory, kinesthetic) may form (Horowitz, 1970, 1983, 1998; Brett & Ostroff, 1985). In a hallucinatory experience, the person has sensations that he or she interprets as real but have no external basis. In a *pseudohallucination*, the person sees the vivid subjective images as false signals of external reality but nonetheless responds emotionally as if they were real. These *unbidden images* include sensing the presence of others who may have died during the traumatic event. These images may be the source of paranormal phenomena, such as believing that one is seeing or hearing the voices of the deceased's ghosts.

The unbidden images tend to occur most frequently when the person relaxes, lies down to sleep, or closes her eyes to rest. Vivid sensory images occurring during periods of rest or relaxation constitute a *hypnagogic* phenomenon. A similar occurrence when awakening is called a *hypnopompic* phenomenon. These frightening experiences may lead to *anticipatory anxiety* about their recurrence to *secondary anxiety* if the subject interprets the phenomenon as a sign of losing control or "going crazy." In treatment, patients can immediately be reassured that such phenomena and other unbidden perceptual experiences are not serious portents of psychosis but are common in those who have experienced traumatic events. Reassurance is especially useful if denial states have created a latency period before the onset of an intrusive phase of response. In such instances, intrusive experiences come as a major surprise to a person who believes that she has already "mastered" the stressful life event.

Responses to trauma also affect attention and perception. The daze and selective inattention of the avoidant or denial states contrast with the excessive

**Table 2.1 Common Symptoms and Signs During Intrusive, Avoidant, and Hyperarousal States**

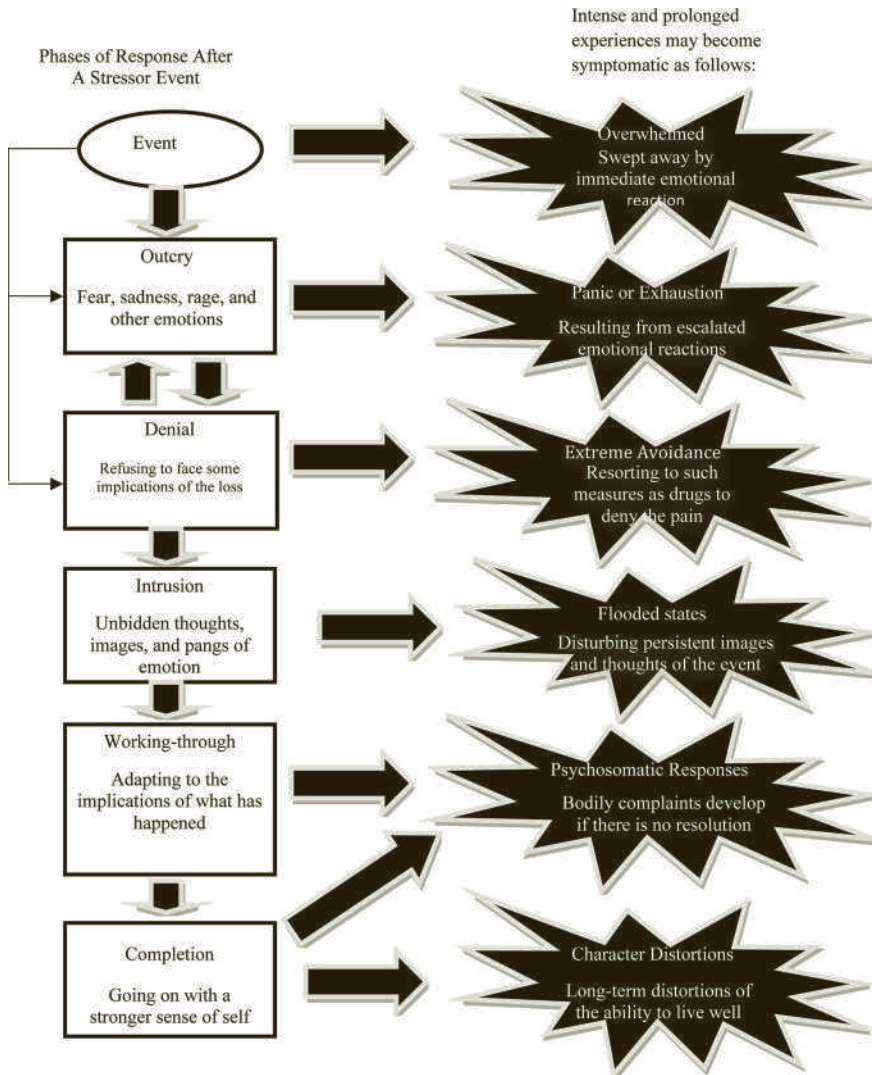
<i>Sector of Observation</i>	<i>Avoidant States</i>	<i>Intrusive States</i>	<i>Hyperarousal States</i>
Perception and Attention	Dazed Selective inattention Inability to appreciate significance of stimuli	Sleep and dream disturbances, flashbacks	Hypervigilance, startle reactions
Consciousness of ideas and feelings related to the event	Amnesia (complete or partial) Non-contemplation of topics that ought to be considered because of implications of the stressor event	Intrusive-repetitive thoughts, emotions, and behaviors Feeling disorganized when discussing event-related themes	Feeling time-pressured; racing thoughts
Information Processing	Disavowal of meanings of current stimuli in some way associated with the event Loss of realistic sense of appropriate connection with the ongoing world Constriction of range of thought Inflexibility of purpose Major use of fantasies to counteract real conditions	Overgeneralization of stimuli so that they seem related to the event Preoccupation with event-related themes with inability to concentrate on other topics	Bias towards information with negative emotional connotations
Emotional attributes	Numbness	Emotional pangs related to the event or to reminders	Gastrointestinal irritations, muscle pain, cardiac palpitations
Action patterns	Frantic over-activity, non-event-related withdrawal Failure to decide how to respond to consequences of event	Compulsive repetition of actions associated with the event (e.g., search for lost persons or situations)	Frantic event related overactivity

alertness and startle reactions of the intrusive states. Numbing experiences may include staring blankly into space, and even avoiding the faces of others who can provide emotional support. There may also be a narrowing of focus and a failure to react appropriately to new stimuli, with a sometimes stubborn adherence to tasks and stimuli considered important before the new and drastic changes in the life situation occurred. As well, there may be an accompanying inner sense of clouding of perception, with a feeling that the world has become gray, less colorful than before. This clouding of consciousness may include a diminished awareness of bodily sensations, even a feeling of being “dead in life” (Lifton, 1967).

This brings us to two other important post-trauma symptoms: (1) the sense of emotional blunting, even depersonalization or derealization that may be present during an avoidant or denial phase and (2) its opposite, explosive pangs of strong emotion or even dissociative identity experiences that may characterize an intrusive phase. Numbness as a symptom is not simply an absence of emotions; it is a sense of being “benumbed.” The individual may actually feel surrounded by a layer of cotton or insulation. This emotional blunting may alter patterns of interaction with support systems, affecting family life, friendship, and work relationships.

Symptoms may tend to co-occur during different states as shown in Table 2.1. A general phasic tendency may be noted in the responses of some people. Those phases are shown in Figure 2.1. Relatively less disturbed response tendencies are to the left, and more disturbed response tendencies are shown on the right. This phasic tendency is reinforced by empirical findings when studied in groups but has many individual and situational variations (Horowitz et al. 1980a; Zilberg et al. 1982).

The presence or intensity of a symptom can be assessed using a rating scale. The Impact of Event Scale (IES) (Horowitz et al. 1979) measures symptoms by self-rating. The Stress Response Rating Scale (SRRS) (Horowitz et al. 1980; Weiss et al. 1984) assesses symptoms using clinicians’ reports based on structural interviews. Numerous subsequent scales based on diagnostic category criteria are now also available. My colleagues and I conducted research in the 1970s and 1980s. One important study summarized the comparative frequencies and intensities of the various intrusive and denial experiences in 66 cases. These data are reported in Tables 2.2 and 2.3. Both the self-report and the clinician’s rating scale yielded separate scores for intrusive and avoidance or denial experiences. A meta-analysis conducted in 2003 reviewed 66 studies on trauma, with different trauma types, which have used the IES in different countries. Intrusion and denial symptoms were present and their quality was similar to what we described earlier. Two types of traumatic events, combat and sexual abuse, emerged as the strongest predictors of symptom severity.



**Figure 2.1 Phases of Response after a Stressor Event.**

Intrusion and denial symptoms decreased over time, and the demographic variables did not influence the symptoms. This experiment confirmed our earlier findings and further validated the constructs of the IES (Sundin & Horowitz, 2003).

In another study, we studied the rates of intrusive and avoidant symptoms in two different trauma groups. We compared the mean scores of 38 patients

who were victims of violence and 43 patients who suffered the death of a close relative or a close friend. There were no significant differences in scores on intrusion or avoidance in these groups, thus agreeing with the assertions made in this book that these are general tendencies regardless of the type of trauma. But there were a few differences on specific items:

The group exposed to violence reported more efforts to forget and cognitively avoid the event. Seemingly paradoxical, but in keeping with the dual; deflections to both more denial and more intrusive experiences, the violence group reported having more symptoms of hypervigilance, startle reactions, and more impairing bad dreams. The group who had experienced deaths often reported that they felt as if the event had not been real, or at least not completely real, (this is perhaps related to a problem in mourning which is slowly, and unconsciously, as well as consciously, coming to realize the finality of the death of a loved one [Horowitz, 2011]). The data for these findings are presented in Tables 2.4 and 2.5.

**Table 2.2 Impact of Events Scale: Experiences Reported by Sixty-six Subjects with Stress Response Syndromes (Horowitz, Wilner, Kaltreider, et al., 1980)**

	% <sup>1</sup>	Group Mean <sup>2</sup>	SD
<i>Intrusion Items</i>			
I had waves of strong feelings about it.	88	3.8	1.9
Things I saw or heard suddenly reminded me of it.	85	3.7	1.9
I thought about it when I didn't mean to.	76	3.3	2.2
Images related to it popped into my mind.	76	3.2	2.2
Any reminder brought back emotions related to it.	76	3.0	2.1
I have difficulty falling asleep because of images or thoughts related to the event.	64	2.6	2.4
I had bad dreams related to the event.	44	1.7	2.2
<i>Avoidance Items</i>			
I knew that a lot of unresolved feelings were still there, but I kept them under wraps.	71	3.0	2.2
I avoided letting myself get emotional when I thought about it or was reminded of it.	70	2.8	2.1
I wished to banish it from my store of memories.	65	2.8	2.3
I made an effort to avoid talking about it.	61	2.2	2.0
I felt unrealistic about it, as if it hadn't happened or as if it wasn't real.	58	2.2	2.3
I stayed away from things or situations that might remind me of it	53	2.2	2.3
My emotions related to it were kind of numb.	59	2.1	2.1
I didn't let myself have thoughts related to it.	50	1.8	2.2

<sup>1</sup> Percent positive endorsement.

<sup>2</sup> On a scale of intensity where 5 is severe; 3 is moderate; 1 is mild; 0 not at all (occurring within the past 7 days.)

**Table 2.3 Stress Response Scale: Signs and Symptoms Reported by Clinicians for Sixty-six Subjects with Stress Response Syndromes (Horowitz, Wilner, Kaltreider, et al., 1980)**

	% <sup>1</sup>	Group Mean <sup>2</sup>	SD
<i>Intrusion Items</i>			
Pangs of emotion	95	3.1	1.3
Rumination or preoccupation	90	2.9	1.4
Fear of losing bodily control or hyperactivity in any bodily system	82	2.6	1.5
Intrusive ideas (in word form)	77	2.3	1.5
Difficulty in dispelling ideas	74	2.1	1.6
Hypervigilance	69	1.6	1.4
Bad dreams	54	1.6	1.7
Intrusive thoughts or images when trying to sleep	51	1.6	1.8
Reenactments	57	1.5	1.5
Intrusive images	51	1.4	1.6
Startle reactions	34	0.6	1.0
Illusions	26	0.6	1.1
Hallucinations, pseudohallucinations	8	0.2	0.8
<i>Denial Items</i>			
Numbness	69	1.8	1.5
Avoidance of associational connections	69	1.7	1.4
Reduced level of feeling responses to outer stimuli	67	1.7	1.5
Rigidly role adherent or stereotyped	62	1.5	1.5
Loss of reality appropriateness of thought by switching attitudes	64	1.4	1.2
Unrealistic narrowing of attention, vagueness, or disavowal of stimuli	52	1.2	1.3
Inattention, daze	48	1.2	1.5
Inflexibility or constriction of thought	46	1.0	1.2
Loss of trains of thought	44	0.9	1.2
Loss of reality appropriateness of thought by sliding meanings	41	0.8	1.2
Memory failure	34	0.8	1.2
Loss of reality appropriateness of thought by use of disavowal	25	0.6	1.2
Loss of reality appropriateness of thought by use of fantasy	15	0.3	0.8

<sup>1</sup> Percent positive endorsement<sup>2</sup> On a scale of intensity ranging from 5 (major) to 0 (not present) within the past seven days.



The scales are worded exactly as given to patients and clinicians. The stress response rating scale has been expanded to 40 signs and symptoms. The additions go beyond intrusive items to include denial items and general stress reactivity. Table 2.6 lists the additional items.

## Common Themes

Human beings are as similar as they are different. However, there seems to be certain fairly universal conflicts between wishes and realities after accidental

**Table 2.4 Impact of Event Scale: Self-Report**

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you *during the past seven days*. If they did not occur during that time, please mark the “not at all” column.

	MEAN ENDORSEMENT	
	VIOLENCE GROUP (n = 38)	D DEATH GROUP (n = 43)
1. I thought about it when I didn’t mean to.	3.39	3.64
2. I avoided letting myself get upset when I thought about it or was reminded of it.	3.32	2.88
3. I tried to remove it from memory.	3.50	1.95 <sup>a</sup>
4. I had trouble falling asleep or staying asleep.	3.00	2.67
5. I had waves of strong feelings about it.	3.95	3.60
6. I had dreams about it.	1.87	1.09 <sup>b</sup>
7. I stayed away from reminders of it.	2.66	2.12
8. I felt as if it hadn’t happened or it wasn’t real.	1.18	2.05 <sup>a</sup>
9. I tried not to talk about it.	2.59	2.33
10. Pictures about it popped into my mind.	3.35	3.39
11. Other things kept making me think about it.	3.29	3.53
12. I was aware that I still had a lot of feelings about it, but I didn’t deal with them.	3.16	3.52
13. I tried not to think about it.	3.34	2.40 <sup>c</sup>
14. Any reminder brought back feelings about it.	3.78	3.77
15. My feelings about it were kind of numb.	2.26	2.53

Intrusion subset = 1, 4, 5, 6, 10, 11, 14; avoidance subset = 2, 3, 7, 8, 9, 12, 13, 15. Mean scores on each item are based on a 5-point scale, where 0 = not experienced, 1 = rarely experienced, 3 = sometimes experienced, and 5 = often experienced during the last week.

<sup>a</sup> Value significantly different from value in violence group.

<sup>b</sup> Value marginally significantly different from value in violence group.

**Table 2.5 Stress Response Rating Scale: Clinicians' Ratings**

Directions: Please judge the degree to which the following signs and symptoms describe the patient *within the last seven days only*. Do not spend too much time deciding about any one item. Base your judgments on either the history as reported, or your own observations. Check the appropriate line for each item. If you have absolutely no information for a particular item, and the not-present response might inaccurately describe the subject's condition, then use the no-information response, but use it sparingly. Scores are based on degree of presence with 0 = not present, 1 = minor, 3 = moderate, 5 = major.

SYMPTOM	MEAN ENDORSEMENT	
	VIOLENCE GROUP (n = 38)	DEATH GROUP (n = 41)
1. <i>Hypervigilance</i> : Excessively alert, overly scanning the surrounding environment, overly aroused in perceptual searching, tensely expectant.	2.38	0.56 <sup>a</sup>
2. <i>Startle reactions</i> : Flinching after noises, unusual orienting reactions, blanching or otherwise reacting to stimuli that usually do not warrant such responses.	1.09	0.42 <sup>a</sup>
3. <i>Illusions or misperceptions</i> : A misappraisal of a person, object, or scene as something or someone else (e.g., a bush is seen for a moment as a person; a person is misrecognized as someone else).	0.57	0.52
4. <i>Intrusive thoughts or images when trying to sleep</i> : Unwelcome and unbidden mental contents that may be difficult to dispel; include trains of thought that begin volitionally but develop an out-of-control quality.	2.22	1.43
5. <i>Bad dreams</i> : Any dreams experienced as unpleasant, not just the classical nightmare with anxious awakenings.	2.11	1.13 <sup>a</sup>
6. <i>Hallucinations, pseudohallucinations</i> : An emotional reaction to imagined stimuli, experienced as if it were real, regardless of the person's belief in its reality. "Felt presences" of others as well as sensations of smell, taste, touch, movement, sound, and vision are included, along with out-of-body experiences.	0.29	0.75
7. <i>Intrusive images while awake</i> : Unbidden sensations which occur in a non-volitional manner either in visual or other sensory systems. Awareness of these images is unwanted and occurs suddenly.	2.06	2.31
8. <i>Intrusive thoughts or feelings while awake</i> : Unwilled entries of simple ideas or trains of thought and feeling taking unwilled directions.	2.08	2.68
9. <i>Reenactments</i> : Any behavior that repeats any aspects of the serious life event, from minor tic-like movements and gestures to acting out in major movements and sequences, including retelling the event. Repeated enactments of personal responses to the life event, whether or not they actually occurred at the time of the event.	0.94	0.77

10. <i>Rumination or preoccupation</i> : Continuous conscious awareness about the event and associations to the event that go beyond ordinary thinking through. The key characteristic is a sense of uncontrolled repetition.	2.77	2.90
11. <i>Difficulty in dispelling thoughts and feelings</i> : Once a thought or feeling has come to mind, even if it was deliberate, awareness of it cannot be stopped.	2.2	2.68
12. <i>Pangs of emotion</i> : A wave of feeling that increases and then decreases rather than remaining constant.	2.89	3.08

<sup>a</sup> Value in a death group significantly different from value in violence group.

**Table 2.6 Other Symptoms of Stress for Clinician Rating on the Stress Response Rating Scale**

13. *Fears or sensations of losing bodily control*: Sensations of urinating, vomiting, or defecating without will, fear of suffocating, fear of being unable to control voluntary behavior as well as somatic responses such as sweating, diarrhea, and tachycardia.
14. *Inattention, daze*: Staring off into space, failure to determine the significance of stimuli, flinches of response to stimuli.
15. *Memory failure*: Inability to recall expectable details, sequences of event, or specific events.
16. *Loss of train of thought*: Temporary or micro-momentary lapses in continuation of a communication, or report of inability to concentrate on a train of thought.
17. *Numbness*: Sense of not having feelings, or being "unfeeling." (Note: Either patient report or your inference is acceptable here.)
18. *Sense of unreality*: Experiences of depersonalization, de-realization, or altered sense of time and place.
19. *Withdrawal*: Feelings or actions indicating social isolation, or experiences of being isolated and detached.
20. *Misdirection of feelings*: Displacement of positive or negative feelings.
21. *Excessive use of alcohol or drugs*: Avoidance of implications of the event by increased usage. Alcohol: excessive usage. Drugs: abuse of prescription agents, as well as abuse of other drugs, legal and illegal.
22. *Inhibition of thinking*: Attempts to block thinking about the event. Success or awareness of the attempt is not a consideration.
23. *Unrealistic distortion of meanings*: Effects of the event on day-to-day living are inaccurately appraised.
24. *Excessive sleeping*: Avoidance of implications of the event by increased sleeping as well as by simply staying in bed.
25. *Avoidance of reminders*: Staying away from certain places, foods, or activities; avoiding photographs or other mementos.

26. *Seeking of distracting stimulation or activity*: Avoidance of the implications of the event by seeking excessive exposure to external stimuli or activities such as television, loud music, fast driving, sexual activity, voracious reading, or other diversions.
  27. *Hyperactivity*: Fidgeting, markedly increased pace of activity, inability to slow down or stop sequences of actions; periods of frenzied activity.
  28. *Altered pace of actions*: Psychomotor retardation; clear slowing, either continuous or episodic, of thought or behavior.
  29. *Tremors or tics*: Tremors or tics, including around the eyes and mouth. (*Note*: Basis of tremor or tic as neurological or characterological is irrelevant.)
  30. *Clumsiness or carelessness*: Dropping objects, bumping into furniture, actions that are more than awkward.
  31. *Autonomic hyperarousal*: Sweating, palpitations, frequent urination, altered skin color, altered pupil size, or other autonomic signs.
  32. *Troubled sleep*: Inability to fall and stay asleep; bad feelings about or during sleep.
  33. *Restlessness or agitation*: Report of inner sensations of agitation or action and behavior which is restless or agitated.
  34. *Excited states*: Thought and action are dominated by excessively high rate of arousal, information processing, and expression. May include excessively high levels of sexuality, creativity, productivity, exercise.
  35. *Self-hatred*: Uncontrollable suicidal preoccupation or gestures, self-loathing, or hostility toward a part of the body.
  36. *Rage at others*: Uncontrollable hostility and anger, even if the target is unclear.
  37. *Panic or disintegration*: Periods of high pressure, confusion, chaos, anxiety, and purposelessness.
  38. *Sadness*: Uncontrollable sadness or grief; floods of despair, longing, pining, or hopelessness.
  39. *Guilt or shame*: Out-of-control experience of remorse, sense of wrongdoing, or exposure of personal evil or defectiveness.
  40. *Irritability or touchiness*: Relations with peers, children, or strangers that can either be inwardly irritating or outwardly abrupt, hostile, and bristling.
- 

injuries, assaults, illnesses, and losses. Clinical studies reveal at least nine themes as common problems during the process of working through stressful life events. Such thematic contents may occur as intrusive ideas, deliberately contemplated ideas, or warded-off ideas. Any event is appraised and assimilated in relation to the past history and the current cognitive and emotional set of the person who experiences it, and therefore it produces idiosyncratic responses.

## FEAR OF REPETITION

Many of the same signs and symptoms that characterize a phobic disorder may be found in a post-traumatic stress disorder. The fear of repetition leads people to develop a phobic anxiety with any stimulus that can be associated to the previous traumatic event and to engage in a variety of marked withdrawal procedures. A person who has had an accident on the street may develop a phobic reaction not only to a specific street corner, but also to any street corner, or traffic and may even withdraw into his or her home and be labeled as agoraphobic.

Sometimes a peripheral stimulus present during the traumatic event, such as the fragrance of flowers that was noticed at the scene of a previous attack in the park, may trigger a sudden fear response when the fragrance is smelled again. This may lead to a panic attack, with full-blown symptoms of pounding heart, weak knees, and choking sensations. At other times, there is no sudden acceleration of alarm responses but rather, a constant sense of foreboding, impending doom, and a nameless dread constituting chronic anxiety. Sometimes the specific fear of repetition is relatively unconscious; only the dread seeps into conscious awareness. Then the anxiety is not associated with the memory of the stressful life event or the concern that it might be repeated.

## SHAME AND RAGE OVER VULNERABILITY

The expectation of personal omnipotence or total control is unrealistic but is nonetheless a universal hope and sometimes a deeply felt personal belief. Both the failure to prevent a stress event such as an accident and the weakness that may follow an event such as an illness are regarded as a loss of control, and conflict with the wish for power and mastery. People who have had a heart attack or back injury, for example, may apologize profusely because they cannot carry out garbage cans, or they may unwisely carry them out to avoid a sense of shame for either shirking their duty or feeling useless. After a fire has burned down the family house, parents may feel deflated in the eyes of their children because their life is now uncomfortable, with smaller quarters and economic difficulties. Magical thinking often extends such irrational attitudes so that the inability to master a stressful event is regarded as equivalent to a regression to infantile helplessness.

## RAGE AT THE SOURCE

Rage is a natural response to the frustration of trauma. One important theme after stress events is anger with any symbolic figure that can be construed as re-

sponsible, however irrational this may seem. A patient may become angry with a doctor who tells him the bad news that a diagnostic study has revealed a serious and unexpected illness. A mother who cuts her finger while slicing meat may feel an impulse to say to a nearby child, "See what you made me do?" Asking why it happened, and "why me?" after a stress event, is usually associated with the need to find out who is to blame and who should be punished.

Rage frequently will conflict with a sense of social morality. For instance, a person may feel rage toward a friend who has fallen ill; this rage conflicts with the recognition that the illness is not the friend's fault and that he needs help, not blame.

A less obvious, but often important instance of rage at the source is the theme of resentment toward a person who has died. At an unconscious level, the deceased may be regarded not as a passive agent who has died but, rather, as an active agent who has deliberately abandoned the survivor. Thoughts directed toward the deceased are expressed as "How could you have left me now?" Knowing consciously and intellectually that the death was not deliberate may not prevent such an emotional and transient response. These themes may be based in part on unconscious views from childhood that parental figures will always be there, are omnipotent, and so can prevent bad things from happening to them if they really wanted to.

## **RAGE AT THOSE EXEMPTED**

If one has suffered a loss, perhaps the death of a loved one, it is possible to feel angry with those others, no matter how sympathetic they may be, whose loved ones remain alive. Such responses can range from envy to hatred and destructive wishes, even though such ideas seem irrational, undesirable, and unthinkable to the person who experiences them.

## **FEAR OF LOSS OF CONTROL OF AGGRESSIVE IMPULSES**

There is another conflict between the destructive fantasies mentioned above and the wish to remain in control and that is the fear that one will impulsively act out one's fantasies in an out-of-control manner. For example, a soldier traumatized by repeated combat experiences often fears, upon his return to civilian life, that he will even physically attack people who slightly provoke him.

## **GUILT OR SHAME OVER AGGRESSIVE IMPULSES**

The rage alluded to above often extends to destructive fantasies directed toward anyone symbolically connected to the stressful event. When violence is a part of

the event, this itself seems to stimulate generalized aggression. The aroused hostility conflicts with a sense of conscience and leads to feelings of guilt or shame. For example, there may be severe bodily damage to others killed in an accident, in which both social convention and natural revulsion dictate looking away from maimed bodies or covering them up. Staring at dead bodies seems, to the person who does it, to be an unwarranted aggression. The memory of such episodes of compulsive looking can lead to anxiety or guilt if the person feels that he was morbidly curious and thus fails to recognize the presence of an intrinsic need to gain information about a potential threat.

### **GUILT OR SHAME OVER SURVIVING**

When others have been injured or killed, it is a relief to realize that one has been spared. Once again, at a level of magical thinking there is a common irrational belief that destiny chooses an allotment of victims, as in the placation of primitive gods through human sacrifice. If one has eluded the Fates, it may seem to have been unfairly at the expense of other victims. The wish to be a survivor conflicts with moral attitudes toward sharing social pain, leading to self-castigation for being selfish.

### **SADNESS OVER LOSSES**

Any painful stress event contains an element of loss that conflicts with the universal wish for life permanence, safety, and satisfaction. The loss may be another person, an external resource, or an aspect of the self. Naturally, some losses are both symbolic and real. A person who has been laid off from work, not for personal reasons, but because a plant has closed, may suffer a loss of self-esteem because he or she is not working. In terms of symbolic losses, a person may lose a previously taken-for-granted sense of safety in the world following an attack. Similarly, following trauma survivors may experience a loss of a sense of agency and trust in one's ability to act effectively.

The frequency of these stress-related themes can be determined for stressed populations by defining their ideational and emotional components and independently rating their occurrence in clinical material (Krupnick & Horowitz, 1981). Such studies indicate these themes' presence in many kinds of traumatic life events.

As mentioned earlier, these themes provide the ideational and emotional contents that are commonly avoided in periods of denial or are intrusive in periods of compulsive repetition. Any one of these themes merges the current

stress event with earlier conflicts over previous stress events. Guilt over hostile impulses is too common in everyone's past history to be a theme unique to a current trauma. Rather, the current event will be emotionally associated to previous memories and fantasies of guilt over excessive hostility. Such blending of themes leads to a diagnostic dilemma requiring determination of how much of the problem is due to the recent life event, however stressful, and how much is due to earlier developments.

## Evolution of Diagnostic Categories

As the field of psychology evolved over time, the official diagnostic description of trauma in the *DSM* has progressed as well. The manifestation of trauma symptoms and its interaction with individual differences has proved to be so difficult to describe that before *DSM-III* there was not really an adequate diagnostic category for Traumatic Neuroses in the formal nomenclature. Syndromes occurring after stressful life events demonstrate the interaction of elements from earlier unresolved conflicts with response tendencies related to the recent experience (Greenacre, 1952; Murphy, 1961; Solomon et al. 1971; Windholz, 1945). Given that all psychological manifestations are determined by multiple causes, the question of diagnosis becomes one of the relative weights of possible etiological factors. The main problem is the existence, nature, and etiological importance of general stress response tendencies, as contrasted with idiosyncratic or person-specific variations in response to stress.

In the official (1952) American psychiatric nomenclature (*DSM-I*) and in the 1968 revision (*DSM-II*), neuroses that followed major external stress events were classified according to their presenting symptoms, as were other types of neuroses, such as anxiety neurosis, obsessive compulsive neurosis, or hysterical neurosis. In *DSM-I*, symptomatic responses to very stressful experiences could also be classified as Gross Stress Reactions, but this category was later deleted in the *DSM-II* of 1968. The appropriate categorization became Transient Situational Disturbances, with subheadings of adjustment reaction of adult, adolescent, or childhood life.

Despite such vague official diagnostic definitions in the psychiatric literature, courtrooms, and case conferences, the diagnosis of traumatic neurosis was used frequently, and most agreed on what the term meant (Keiser, 1969). For example, in Hinsie and Campbell's *Psychiatric Dictionary* (1960), traumatic neurosis was defined as having the following features:

- (1) fixation on the trauma with amnesia for the traumatic situation which may be total or partial; (2) typical dream life (dreams of



annihilation, aggression dreams where the patient is the aggressor but is defeated, frustration or Sisyphus dreams, and occupational dreams in which it is the means of livelihood rather than the body ego which is annihilated); (3) contraction of the general level of functioning, with constant fear of the environment, disorganized behavior, lowered efficiency, lack of coordinated goal activities, and profoundly altered functioning in the autonomic motor and sensory nervous system; (4) general irritability; and (5) a proclivity to explosive aggressive reactions. (pg. 497)

These kinds of clinical summations and the first edition of this work (Horowitz 1976) led to the inclusion of the diagnosis of Post Traumatic Stress Disorder in the American Psychiatric Association's *DSM-III*. The diagnostic criteria, as later revised for *DSM-IV*, are summarized in Table 2.7. *DSM-V* is in progress, without much change envisioned for PTSD.

PTSD is the keystone in the arch of diagnostic categories to be considered as a stress response syndrome. For near-to-trauma-event times, a related diagnosis of acute stress disorder was agreed to by the committee that argues down to a compromise set of descriptive symptomatic criteria. The criteria for Acute Stress Disorder in *DSM-IV* are included for comparison purposes. The most frequently cited diagnosis in the set of categories applicable to stress response syndromes is PTSD. In the future revision of *DSM-IV*, I anticipate from my current committee work that it will be part of Stress Response Syndromes instead of Anxiety Disorders along with Acute Stress Disorder, Adjustment Disorder, Brief Reactive Psychosis, Complicated Grief Disorder, and Dissociative Post-Stress Disorder (Spiegel et al. 2011).

Intrusive thoughts and feelings are not unique to Post Traumatic Stress Disorder. They are a sign of strain to psychological systems and may occur in a variety of disorders. Some diagnostic issues are illustrated in the following case vignette.

## CASE EXAMPLE

Following his graduation from college, James, a 24-year-old African American, middle-class man from California, lived with his mother while working sporadically at jobs that he disliked. He occasionally dated but had never lived with a woman or with other roommates. He and his mother occasionally had heated arguments about domestic issues such as who would keep the apartment clean, and on occasion they had even been warned by the landlord that other tenants had complained about the noise.

One evening, after such an argument, his mother had crushing chest pains and shortness of breath. The young man called their family physician but

**Table 2.7 Post Traumatic and Acute Stress Disorders**

<i>Post Traumatic Stress Disorder</i>	<i>Acute Stress Disorder</i>
<p>A. The person has been exposed to a traumatic event in which both of the following were present:</p> <ol style="list-style-type: none"> <li>1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.</li> <li>2. The person's response involved intense fear, helplessness, or horror. <i>Note:</i> In children, this may be expressed instead by disorganized or agitated behavior.</li> </ol> <p>B. The traumatic event is persistently re-experienced in one (or more) of the following ways:</p> <ol style="list-style-type: none"> <li>1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. <i>Note:</i> In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.</li> <li>2. Recurrent distressing dreams of the event. <i>Note:</i> In children, there may be frightening dreams without recognizable content.</li> <li>3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). <i>Note:</i> In young children, trauma-specific reenactment may occur.</li> <li>4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.</li> <li>5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.</li> </ol>	<p>A. The person has been exposed to a traumatic event in which both of the following were present:</p> <ol style="list-style-type: none"> <li>1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.</li> <li>2. The person's response involved intense fear, helplessness, or horror.</li> </ol> <p>B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:</p> <ol style="list-style-type: none"> <li>1. A subjective sense of numbing, detachment, or absence of emotional responsiveness</li> <li>2. A reduction in awareness of his or her surroundings (e.g., "being in a daze")</li> <li>3. Derealization</li> <li>4. Depersonalization</li> <li>5. Dissociative amnesia (i.e., inability to recall an important aspect of the trauma)</li> </ol>

**Table 2.7 Post Traumatic and Acute Stress Disorders**

<i>Post Traumatic Stress Disorder</i>	<i>Acute Stress Disorder</i>
<p>C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:</p> <ol style="list-style-type: none"> <li>1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.</li> <li>2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.</li> <li>3. Inability to recall an important aspect of the trauma.</li> <li>4. Markedly diminished interest or participation in significant activities.</li> <li>5. Feeling of detachment or estrangement from others.</li> <li>6. Restricted range of affect (e.g., unable to have loving feelings).</li> <li>7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).</li> </ol> <p>D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:</p> <ol style="list-style-type: none"> <li>1. Difficulty falling or staying asleep</li> <li>2. Irritability or outbursts of anger</li> <li>3. Difficulty concentrating</li> <li>4. Hypervigilance</li> <li>5. Exaggerated startle response</li> </ol> <p>E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.</p> <p>F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p>	<p>C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event</p> <p>D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).</p> <p>E. Marked symptoms of anxiety of increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).</p> <p>F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.</p>

**Table 2.7 Post Traumatic and Acute Stress Disorders**

<i>Post Traumatic Stress Disorder</i>	<i>Acute Stress Disorder</i>
	G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
	H. The disturbance is not due to direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
Specify if: <i>Acute</i> : if duration of symptoms is less than 3 months. <i>Chronic</i> : if duration of symptoms is 3 months or more. <i>With Delayed Onset</i> : if onset of symptoms 6 months after the stressor	

reached an answering service. After some frustration, he was advised to call an ambulance to take his mother to the nearest emergency room. He became increasingly frantic when she lost consciousness and the ambulance had not yet arrived. He therefore took her to an emergency room in his own car and stayed at her side as she was wheeled to the intensive care unit. Shortly after intravenous treatment was started, monitors indicated a cessation of heartbeat. The woman was defibrillated and an airway passed into her trachea. Her son refused to leave and was pushed aside by the resuscitation team. Several urgent medical orders were given and then rescinded, and the young man wondered whether his mother was receiving adequate care.

Despite the resumption of heartbeat with defibrillation, there was again a cardiac arrest, and after a time his mother was pronounced dead. The young man wept, received some support from the emergency room staff, and then returned alone to his apartment.

For the next several days he remained at home by himself, felt sad, and occasionally cried. He then resumed his job and apparently worked well for two months but then began to function less well and was laid off. Within a few weeks he consulted a community mental health center because of depression. After the initial interview, a diagnosis of major depressive disorder was made because he had difficulty sleeping, had lost weight, had no appetite, had a loss of sexual interest, felt morose, and brooded most of the time.

After a few interviews it became apparent that his depressive symptoms seemed to be clearly related to the event of his mother's death. He reported that he had difficulty sleeping because of intrusive and repetitive images of his mother's head being yanked back while a laryngoscope was being forced, as he saw it, down her throat. He was enraged at the emergency room staff, who he felt had provided incompetent care. He blamed himself for not taking his mother more quickly to a better emergency room, without the telephone delay or waiting for an ambulance. In continued psychotherapy, he worked on the conflicted relationship with his mother, in which his ambivalence toward her before her death was also a prominent feature.

He remained angry about the care of his mother in the emergency room, sought legal advice, and brought a suit against the hospital. Records of her treatment at the hospital emergency room were subpoenaed, and the defense counsel for the hospital obtained documents about the young man's treatment at the community mental health center, including the process notes of the therapeutic interviews.

In the ensuing trial for medical malpractice and damages of emotional distress the relationship between the patient and his mother, the competency of her care in the emergency room, and the patient's reaction thereafter became issues. The following is an analysis of each of these points.

It was clear that the young man had had a somewhat turbulent relationship with his mother, with feelings of ambivalence toward her, as she had toward him, in the period before her death. This ambivalent attitude may have complicated his mourning process. While he had never received a formal psychiatric diagnosis or treatment for a depressive disorder before his mother's death, he had sought previous psychiatric consultations and had made some incomplete starts on psychotherapy in college. His emotional pain following his mother's death was partly due to the traumatic perceptions, partly due to pre-event characteristics in his personality, and to the ambivalence and guilt in his relationship with his mother.

In the process notes, the therapist at the community health center had recorded an interpretation made to this young man in which she had said that his anger with the hospital emergency room staff was an attempt to displace his anger with himself. This anger with himself was due to guilt over his argument with his mother and his own sense of having failed her. The therapist encouraged him to review more realistically the events leading to the death and to feel an appropriate level of remorse but not an exaggerated guilt. Even though this interpretation may have been accurate, it only indicates that there were complex themes involved in the development of this man's stress response syndrome with its phasic components of intrusion and denial.

The competency of medical care as an issue in the suit included both the degree of damage to the mother's chances of survival and the degree of damage done to the young man as he witnessed the trauma of the treatments, as well as

his mother's death. In reviewing the mother's treatment in the emergency room, it was established that there had been some procedural errors and omissions but that these had been rapidly corrected and were not deemed to have caused her death. There was some impression of violence in the treatment, as in the passage of the laryngoscope, but the impact of this on the young man was partly due to his refusal to follow the staff's instructions to leave the room. In this case, the actions witnessed contributed to his syndrome but not to his mother's death. Although the perceptions led to memories intrusively recalled, it was felt that the inappropriate actions by the hospital staff were not significant in causing his reaction.

If this case had turned out differently, if the hospital had been found in some way responsible for precipitating some of the young man's psychological responses, an expert opinion might then have tackled the diagnostic problems. There might have been a debate among experts on post-traumatic stress disorders, about whether this patient warranted that diagnosis. After all, his initial diagnosis in the community mental health center was that of a depressive disorder, not a post-traumatic disorder or an adjustment disorder. His experience could also be seen as a complicated grief syndrome once the connection to the death of his mother was established, as most people do have to sustain at some time the death of one or both parents.

The arguments for this individual's being diagnosed as having Post Traumatic Stress Disorder are that (1) the initial diagnosis of major depressive disorder was not based on the full information, (2) the death of the young man's mother was associated with visual traumas that had been shocking to him, and (3) his symptoms of repetitive and intrusive recollection of the emergency room scene were prominent. His reaction did involve pre-event conflicts, invariably the case to some degree, but the context of the event was of sufficient severity to warrant the diagnosis.

From this case, we find that premorbid personality is involved even with reactions to shocking, unusual, and disastrous experiences. It is especially pertinent to how a person works through these experiences and when the person emerges from a period of symptomatology. Life events that seem commonplace, such as the death of a parent, are not necessarily simple bereavements but may have traumatic features for the individual. Finally, diagnoses are not mutually exclusive; a person may satisfy several diagnoses according to the *DSM-IV*'s criteria and clinical criteria.

## Adjustment Disorders

Adjustment disorders are defined in *DSM-IV* as maladaptive reactions to identifiable psychosocial pressures. The identifiable psychosocial pressures that may

precipitate adjustment disorders include such changed life circumstances as divorce, difficulties with child rearing, illness or disability, financial difficulties, a new form of work, graduation, moving, retirement, and cultural upheaval. Adjustment Disorders are likely to be included under the frame of Stress Response Syndromes in *DSM-V*. For this to be the correct diagnosis, signs and symptoms should emerge within three months of the onset of the change in life circumstances. The signs and symptoms include a wide variety of disturbances in interpersonal and work functions as well as maladaptive extremes of anxiety, depression, rage, shame, and guilt.

Others and I have recommended criteria for Complicated Grief Disorder, as a separate category of the future *DSM-V*. However, if Complicated Grief Disorder does not become a separate entity in *DSM-V*, it will probably be included as a type of Adjustment Disorder.

The *DSM-IV* lists subcategories for adjustment disorders, organized by the patient's predominant complaint about her subjective experience. Among the subtypes are depressed or anxious mood, other out-of-control emotional states (i.e., rage, shame), disturbance of social conduct, work or academic ambition, and withdrawal from others. This is an open-ended diagnostic entity, with subtypes classified by surface phenomena.

## Complicated Grief Disorder

Complicated bereavement induced disorder has been described in our scientific literature with greater clarity in recent years. Many people react to bereavement in a resilient manner, often having a sense of equilibrium restored within six months. But for others, bereavement leads to a period of turbulent distress lasting up to two or more years (Osterweiss et al. 1984). At some time during the year following a death, a person may episodically experience signs and symptoms that would constitute a major depressive disorder were they not transient and clearly connected to grief. For these reactions, professional treatment may be indicated.

Medical disorders may be part of the bereavement reactions. Clinicians should take a careful history for increased alcohol consumption, being alert for cirrhosis of the liver, organic brain syndrome, and accident proneness. They should also ask about suicidal impulses, increased cigarette smoking and its cardiorespiratory consequences, and the use of sedatives or tranquilizers with their potential for habituation, paradoxical wakefulness, and other side effects.

Some circumstances are likely to increase the severity or duration of grief reactions, including a preexisting high dependency on the deceased, preexisting

frustration or anxiety in relating to the deceased, unexpected or torturous deaths, a sense of alienation or antagonism to others, a history of multiple earlier or simultaneous losses that have not been integrated, and real or fantasized responsibility for the suffering or death itself. When several of these factors are present, a complicated bereavement reaction may result.

Recent research, based on reliable clinician-observer ratings and utilizing latent class model analyses and signal detection statistical analyses, have indicated the validity of a diagnosis of complicated grief disorder that may be comorbid with depressive disorders but that may also be found in people who do not also meet diagnostic criteria of Major Depressive Disorder (Horowitz et al. 1997; Prigerson et al. 1977, 1998; Prigerson, Horowitz et al. 2009). Subjects selected by an algorithm for the set of symptoms did not significantly overlap with diagnoses of Major Depressive Disorder, which are often applied in disturbances due to excessive, distorted, or prolonged grief. The most sensitive symptoms specific to this disorder, over a year after the loss event, include intrusive symptoms, pangs of severe emotion, and distressingly strong yearnings, all related to the lost relationship. They also include great feelings of emptiness, social isolation, disturbed sleep, and losses of interest in career, caretaking, and recreational or creative activities to a maladaptive degree. Criteria for a new diagnostic category, Complicated Grief Disorder, from this research are found in Table 2.8 (Prigerson, Horowitz et al. 2009).

**Table 2.8 Criteria for Complicated Grief Disorder**

<i>Event</i>	Bereavement at least a year ago.
<i>Signs and Symptoms Criteria</i>	Any <i>three</i> of the following seven symptoms, experienced during the recent month, and for at least a month, with a severity that interferes with daily functioning.
<i>Intrusive Symptoms</i>	<ol style="list-style-type: none"> <li>1. Unbidden memories or intrusive fantasies related to the lost relationship</li> <li>2. Strong spells or pangs of severe emotion related to the lost relationship</li> <li>3. Distressingly strong yearnings or wishes that the lost one was there.</li> </ol>
<i>Signs of Avoidance and Failure-to-Adapt</i>	<ol style="list-style-type: none"> <li>4. Feelings of being far too much alone or personally empty</li> <li>5. Excessively distancing ones self from people, places or activities that remind the subject of the deceased</li> <li>6. Unusual interference with sleep</li> <li>7. Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree.</li> </ol>



## Subtypes of PTSD

The provisional diagnosis of Complex PTSD, Disorders of Extreme Stress Not Otherwise Specified, and Dissociative Stress Disorder have gained attention from researchers in recent years. An argument exists that the *DSM-IV* description of PTSD does not always capture the complexity of patient presentations seen by clinicians in real-world settings. A need arose to form more accurate conceptualizations of trauma-related psychopathology. These considerations are, at the time of this writing, influencing the next diagnostic nomenclatures *DSM-V* and *ICD-11*.

The diagnostic criteria presented in the first edition of this book were used in creating criteria for the first inclusion of PTSD in *DSM-III*. Our clinical research team developed these criteria by case studies of patients who met our specific investigative criteria (Horowitz et al. 1976, 1980, 1984). These cases included individuals who were selected for clinical research studies because they experienced a single non-continuous trauma a year or so before our first evaluation interviews. We avoided choosing subjects who had cascades of serious events and people with major psychiatric problems such as suicidality, self-cutting, or eating disorders. The treatments were time limited to twelve individual sessions for purposes of uniformity. The therapeutic technique was brief psychodynamic psychotherapy. We studied simple forms of PTSD and not cases that could be called compound or complex. We tended to exclude participants with major symptoms from the most frequent co-morbidities of PTSD such as Major Depressive Disorder, Panic Disorder, and Substance Abuse Disorders. Another aspect of complexity concerns personality disturbances, especially in adults exposed to recent severe events who also had childhood traumas, as well as a cascade of adult stressors. We can discuss these issues as Compound PTSD.

### COMPOUND PTSD

If the patient has Compound PTSD, the other diagnoses are made when planning treatment. Moderate to severe Traumatic Brain Injury and Substance Abuse Disorder may be amongst the most important considerations early in treatment. Cognitive retraining or detoxification from addiction to substances of abuse may become a top priority. One aspect of Compound PTSD can include comorbid Traumatic Brain Injury (TBI). In making both differential and comprehensive diagnoses, it is important to consider the possibility of concussion in acute physical traumas or even severe malnutrition. Very mild concussions may leave no immediate apparent neurologic signs but may have residual long-term effects on mood and concentration (Trimble, 1981). Malnutrition during

extended stressful periods may also lead to organic brain syndromes. Speaking of organic problems, clinicians note that people with post-traumatic stress disorders commonly cope in ways that may lead to other disorders, such as turning to an excessive use of tobacco, alcohol, narcotics, sedatives, or food. If they present a mixed syndrome combining organic and psychological factors, one should make a diagnosis of each disorder concurrent with the diagnosis of post-traumatic stress disorder.

## COMPLEX PTSD

Complex PTSD, Disorders of Extreme Stress Not Otherwise Specified (DESNOS), or Dissociative Stress Disorders have been discussed by several researchers (Brier & Rickards, 2007; Brier, 2000, 2004; Herman, 1992; Myers et al. 2002; van der Kolk et al. 2005; Pearlman & Courtois, 2005; Spiegel, 2000) Complex PTSD involves the disturbances in self-organization in people with unresolved prior traumas and may manifest in a variety of symptoms, including substance abuse, depression, anxiety, and occasional explosive and irrational but transitory and episodic mind states.

Repeated childhood trauma is often implicated in development of complex PTSD. Childhood abuse affects the development of person schematizations, and perhaps most importantly, the organization of self-concepts. Cohesion of self may be in jeopardy. The person may seem to compartmentalize and segregate different self-concepts. The resulting lack of self harmonization and deficits in self organization may be symptoms that some have called self-capacity problems.

If these impairments happen in childhood and the person does not advance towards greater self-coherence by adulthood, then these self-configuration qualities function as predispositions to stress response syndromes (Drager and Langeland, 1999). In other words, the combination of infant and childhood trauma and adult stressor events can increase the likelihood of PTSD symptoms in adulthood. In addition to PTSD, intentional childhood abuse can predispose children to develop psychotic symptoms (Arenault et al. 2011). Certain types of adult stressors, short of the "A" criteria of severe terror or fright events, can also increase the likelihood of PTSD symptoms. I refer especially to relationship ruptures or betrayals (Brier and Rickards, 2007; Brier, 2000, 2004; Herman, 1992; Myers et al. 2002; van der Kolk et al. 2005; Pearlman and Courtois, 2005).

Complex PTSD may co-exist with Compound PTSD, and both contain signs and symptoms of Simple PTSD. What appears to be Simple PTSD at evaluation may seem to be Complex PTSD during treatment. Some symptoms and observable signs may suggest Complex PTSD. If observed during evalua-

tion, one can plan for a longer and perhaps a multifaceted treatment plan (as with Compound PTSD).

Symptoms can be grouped from simpler to more complex formations. These are listed in Table 2.9, from Simple or Primary, to Secondary and Tertiary. Adding many Tertiary symptoms to a list of current problems suggests Complex PTSD.

Complex PTSD involves relatively more of the hard-to-resolve tertiary cluster symptoms, and also a more complex prior trauma or multi-trauma story.

**Table 2.9 Complex PTSD Symptom Formation**

<i>Primary Cluster of Symptoms</i>	<ul style="list-style-type: none"> <li>• Perceptual reminders trigger startle, fear, and hyperarousal adrenergic systems (e.g., racing pulse, gastric constriction, and sweating)</li> <li>• Mind/brain systems of alarm reactivity are now over-sensitive to any kind of new stimuli, leading to inappropriate fight/flight responses</li> <li>• Sleep interruptions from waking up and feeling fearful and panicky, but without experiencing a specific nightmare</li> <li>• Fatigue and exhaustion from over-arousal and sleep loss</li> <li>• Inattention and error-proneness due to inadequate sleep</li> </ul>
<i>Secondary Cluster of Symptoms</i>	<ul style="list-style-type: none"> <li>• Recurrent and intrusive distressing recollections involving perceptual derivatives of the traumatic stressor</li> <li>• Recurrent nightmares of trauma-related themes</li> <li>• Irrational feelings as if the traumatic event is now imminent</li> <li>• Obstacles to having thoughts, feelings, or conversations about the event; efforts to avoid activities, places, or people that arouse recollections of the event</li> <li>• Inability to recall important aspects of the traumatic story</li> <li>• Markedly diminished interest or participation in usual activities</li> <li>• Difficulty concentrating beyond simple effects of fatigue</li> <li>• Persistent states of feeling emotional numbness (may progress to an alteration in the perception or experience of the external world so that it seems strange or unreal)</li> </ul>
<i>Tertiary Cluster of Symptoms</i>	<ul style="list-style-type: none"> <li>• Unresolved themes of guilt, revenge, shame, or misattribution of blame</li> <li>• Feeling of detachment or estrangement from others</li> <li>• Identity degradation (progressing towards lapses of self-coherence)</li> <li>• Fear of intimacy</li> <li>• Sense of foreshortened future and impending punishment or interrogation</li> <li>• Helplessness and irrational over-dependency</li> <li>• Disassociative states of memory variation (trauma story reported inconsistently) in different states of mind</li> </ul>

Complex PTSD is related to assessment of the level of personality disturbance and possible diagnoses of personality disorders. Such issues of identity coherence or discord, and relational rationality or irrationality are important but difficult to assess during an initial evaluation.

During early contacts, personality factors are seldom clear because the trauma itself may cause identity regressions and interpersonal disorganization.

Signs are those problematic expressions of trauma-related pathology that are observable to others. Some signs suggest the presence of Complex PTSD or Simple PTSD plus comorbid disturbance in personality. When I consider the initial diagnosis, I ask myself a series of questions to help me observe such signs. These questions are:

- Does the patient express sudden shifts in self-image and views of relationship characteristics?
- Do the patient's statements sometimes convey confusion between what has been thought and what action he/she has taken?
- Does the patient report radically impulsive decisions?
- Does the patient distort life stories and recent memories by excessively and remarkably removing his or her sense of responsibility?
- Does the patient become disorganized or out of control when angry or frustrated?
- Does the patient grossly misread communications and intentions?

If the clinician responds with "Yes" to three or more of these questions, that may suggest a Complex or Compound form of PTSD with comorbid personality disorders. There is a spectrum and some of the observations made in answering these questions may also indicate dissociative processes. More study of such symptoms is one of the modern frontiers for further research on stress response syndromes.

As mentioned, disturbance in personality can be a regression due to the trauma reaction or a personality configuration that was present before the event. In individuals with signs of personality disturbances present before the recent trauma, the clinician should plan to proceed slowly. Attention to building a stable therapeutic alliance over time is indicated and thus, time restrictions on the length of treatment are contraindicated.

I do not think that a diagnosis of Complex PTSD should be based solely on a history of early or multiple prior traumas. Many people have histories of abuse or have suffered severe losses without experiencing adult personality disturbances. Thus, it is important to assess current functioning by observing the nature (explosive or smooth) of shifts in states of mind, as well as of the patient's ability to sort out realistic and unrealistic concepts about self and others.

Patients who have more vulnerability to loss of identity coherence often use reality-distorting projections to stabilize a sense of self-efficacy. As these projections or dissociations of self-other conceptualizations occur or fail to protect them, such patients may under pressures exhibit explosive shifts in their states of mind. Such patients who are more disturbed may not differentiate well between internal versus external loci of action, or between reality and fantasy. Therapy may need to include acquisition of new skills for self-awareness and reflecting on the intentions of others which may mean longer treatment. Therapeutic techniques to treat Complex PTSD will include more reprocessing of memories and learning new, corrective, relationship skills. The result aimed for is to develop more stability in a sense of authentic identity and a continuous sense of good attachment (Ford et al. 2005).

## Brief Psychotic Disorder with Marked Stressors

Another diagnosis related to traumatic events is that of brief psychoses. These conditions have a sudden onset following exposure to extremely stressful events. They may last for a few hours or for as long as two weeks. The clinical picture includes emotional turmoil and the presence of at least one gross psychotic symptom such as expressed delusions. This is what primarily differentiates a brief reactive psychosis from a complex form of PTSD or Adjustment Disorder.

To be diagnosed as having a brief psychosis, the patient should have experienced a recent traumatic life event that lies outside the range of usual human experiences. Observations suggest that brief stress-induced psychoses are much less common than are post-traumatic stress disorders. Also, there is not a clean line of separation between highly disturbed beliefs and the kind of irrational misappraisals that can occur with the projections in severe stress-induced dissociations.

## Conclusions

Stress response syndromes include multiple diagnoses that share some causative and symptomatic features. The criteria for diagnoses discussed in this chapter are the product of consensus as achieved in the arguments within committees of expert clinicians. In evaluating an individual, inquiry into symptoms and problems extends beyond the types of distress that have been chosen as agreed-upon criteria for a diagnosis.

The symptoms for the disorders reviewed all relate to external stressor events. These events can usually be verified as actual experiences that are beyond the average occurrences for that individual and, often, for the population at

large. An important addition to this factuality of an external event is the internal perpetuation of the events in symptomatic or problematic memories. Thus, nightmares of a past accident, intrusive fearful recollection of combat scenes, and alteration of a sense of identity with concepts related to the helplessness felt in a disaster speak to the partial, but highly important etiological role of the specific stressor events that preceded symptom formation. The traumatic events combine with pre-existing dispositions, current social circumstances, and post-event appraisals of the trauma events to produce the signs and symptoms of stress response syndromes.



## CHAPTER 3

# Field Studies on the Impact of Life Events

*With Nancy Wilner*

Studies of the non-clinical population help us to determine the generality of trauma-related symptomatology. Epidemiology studies done on house-to-house surveys of selected samples estimate the frequency of PTSD in the United States as 7-10% of the population in one year, with a 50-60% chance of a lifetime occurrences (Kessler et al. 2000). Researchers also examine populations that experienced the same type of life stressor. War and natural disasters are common examples of stressors studied in such field studies.

## War

Terror, injury, death, maimed bodies, and the loss of comrades are the tragically common experiences of war. In World War I the presence of daze, fear, trembling, nightmares, and inability to function were sometimes attributed to brain damage or even cowardice. Both attributions were often wrong. The biological cause was postulated to be a result of cerebral concussions and the ruptures of small blood vessels caused by exploding shells, hence the use of the term *shell shock*. This organic focus led to a concentration on expectable symptoms such as those memory disturbances known to characterize acute and chronic brain syndromes.

Multiple observations eventually revealed that physical traumas were not invariable antecedents of combat reactions. Anyone repeatedly exposed to death threats, even vicariously, and to terrible events might respond with prolonged symptoms.

During World War II, the study of combat reactions by Grinker and Spiegel (1945) led to a summary of the nineteen most common symptoms. These syndromes from extreme stress and repeated exposure to combat persisted long



after the soldiers were removed from combat. These symptoms are shown by rank order of frequency in Table 3.1. The most common terms used in labeling the syndrome were *operational fatigue* and *combat neurosis*.

Similarly, a large number of studies were conducted on the stress response syndromes in military personnel deployed to Korea and Vietnam (Blake et al. 2000) where the term was *combat fatigue*. For recent military conflicts in Iraq and Afghanistan the term is Posttraumatic Stress Disorder (Sareen et al. 2007; RAND, Tanielian et al. 2008; Seal et al. 2009).

The symptoms shown in Table 3.1 are similar to those found in other studies of military combat. After World War II, Lidz (1946 a, b), Fairbairn (1952), and Brill and Beebe (1955) each described nightmares as especially significant signs of combat neuroses. The work by Haley (1974) on reports of atrocities described Vietnam veterans who were depressed, anxious, sad, angry, and despairing. He saw their delayed reactions as including denial and leading toward intrusions, which also took the form of sleep disturbances and nightmares.

**Table 3.1 Most Common Signs and Symptoms of Operational Fatigue (Traumatic Neurosis in WWII) as Found by Grinker and Spiegel (1945) and ranked by frequency of occurrence.**

Frequency of Occurrence	Signs and Symptoms
1	Restlessness
2	Irritability or aggression
3	Fatigue on arising, lethargy
4	Difficulty falling asleep
5	Anxiety, subjective
6	Frequent fatigue
7	Startle reactions
8	Feeling of tension
9	Depression
10	Personality change and memory loss
11	Tremor
12	Difficulty concentrating, confusion
13	Alcoholism
14	Preoccupation with combat
15	Decreased appetite
16	Nightmares
17	Psychosomatic symptoms (e.g., vomiting, diarrhea)
18	Irrational fears (phobias)
19	Suspiciousness

The research by Sareen and colleagues (2009) surveyed rates of psychopathology and the use of mental health services in 8000 active duty military personnel, mostly males between 24–40 years old. The findings showed a positive association for combat and peacekeeping activity with mental health problems, subjective distress, and help-seeking. Among mental health concerns, participants endorsed depression, alcohol dependence, and social phobia most commonly.

Witnessing atrocities was a factor most likely to cause mental health problems.

A large study of returning Iraq and Afghanistan combat-exposed veterans found not only the commonly recognized PTSD symptoms, but also a host of related psychosocial concerns. Veterans in these studies struggled with depression, substance abuse, family and vocational problems, as well as difficulties controlling anger.

Among the risk factors for the development of a stress response syndrome and other mental health issues were young age, lower rank, the degree of combat exposure, and the number of deployments. Female veterans were more at risk for depressive symptoms, while the males were most likely to develop substance abuse problems. (Thomas, J. L., Wilk, J. E., Reviere, L. A., McGurk, D, Castro, C. A., & Hoge, C. W. (2010); Seal et al. (2009). Earlier similar findings had been compiled by De Fazio (1975), Figley (1978, 1979), Figley and Leventman (1982), and Kolb (1982, 1983, 1984).

Wilson and Krauss (1982) made a systematic study of Vietnam veterans with and without post-traumatic stress disorder (see also Hendin and Haas, 1984, and Wilson, 1980). Their results indicate that the best predictor of PTSD in Vietnam veterans is the degree of involvement in combat, felt stress during combat, exposure to injury and death, and psychological isolation upon returning home from the war (see also van der Kolk et al. 1984). Along the same lines, Dohrenwend and colleagues (2006) identified a graded relationship between mental problems and the amount of combat exposure. Furthermore, peacekeeping operations in high-atrocity war zones have been linked with suicidal tendencies and high distress in exposed individuals.

In a multiple regression analysis of the best predictors of seven post-traumatic symptoms such as intrusive imagery, depression, and problems of anger and rage, Wilson and Krauss (1982) found that the best predictive exponential variables for subsequent intrusive imagery were exposure to scenes of injury and/or death and psychological isolation upon coming home. The protective role of social support, which is in essence the opposite of isolation, has also been noted by Charuvastra & Cloitre (2008) in their analysis of multiple trauma-exposed populations. Psychological isolation, but not injury and death, was the best predictive variable for the other six symptoms of post-traumatic stress disorder.

The expression “everyone has his breaking point” evolved from experience with reactions to combat. It suggests that every person, when exposed to enough

stress, may develop an acute stress response syndrome. People with certain latent neurotic conflicts or predispositions to certain stress triggers and alarm reactions may respond to lower levels of external stress (Hendin and Haas, 1984; Hendin et al. 1983). People with a higher stress tolerance will not “break down” until the level of stress is higher. Research on complex trauma, which also indicated that the risk of developing PTSD is greater in those exposed to prior traumatic events (van der Kolk, B.A., Roth, S., Pelcovitz, D., Sunday, S. & Spinazzola, J., 2005).

## CONCENTRATION CAMP SURVIVORS

Additional evidence regarding the duration of stress responses and the frequency of occurrence of stress symptoms arose from the most deplorable circumstances imaginable. Studies of Nazi concentration camp survivors indicated that profound and protracted stress may have chronic or permanent effects no matter what the predisposition of the pre-stress personality. This evidence was found in the decades of studying the survivors after they were rescued or had escaped from the camps (Eaton et al. 1982). Study after study (Krystal, 1968; Krystal and Niederland, 1971) confirmed the occurrence of stress response syndromes, persisting for decades, in major proportions in those populations who survived protracted concentration camp experiences.

As just one example, 99% of the 226 Norwegian survivors of a Nazi concentration camp in World War II had some related disturbing symptoms when intensively surveyed years after their return to normal life. Of the total population studied, 87% had cognitive disturbances such as poor memory and inability to concentrate, 85% had persistent nervousness and irritability, 60% had sleep disturbances, and 52% had nightmares (Eitinger, 1969). It should be noted that the hideousness of these concentration camps also meant severe malnutrition and physical maltreatment that could have caused traumatic brain injury. Also, in combat, helmets protect the skull but being in close explosion proximity can produce traumatic brain injury that may escape immediate diagnostic notice.

In addition to such general stress response symptoms as recurrent intrusive memories, concentration camp survivors may have special symptoms and signs because of the protracted duration of their stress and the intensity of their dehumanization by the Nazis. Such signs as depersonalization, emotional blunting, the bleaching away of childhood memories, survivor guilt, and other altered schemas of self and object relationships may distinguish the survivor syndrome of the self and other relationships and may lead to the categorization of some concentration camp victims as Complex PTSD and Post Traumatic Character Disturbances (Furst, 1967; Krystal, 1968; Lifton, 1967; Ostwald and Bittner, 1968).

The effects of being a victim of a concentration camp can lead to changes in personality and thus, to changes of interpersonal patterns, including those of parenting. The result is that the effects of the concentration camp may be shown to the children of the victims and perhaps to succeeding generations (Yehuda et al. 2003; Krystal, 1985). These generations of families thus become carriers of conscious and unconscious values, myths, fantasies, and beliefs, as well as actual interpersonal styles that may have been forcibly changed by the violent life experiences of one generation (Danieli, 1982).

In conclusion, even though the influence of pre-stress personality configurations is powerful, findings from large groups of people indicate that stress response syndromes are not limited to any subgroup of the exposed populations. There is no doubt that some general stress response tendencies can be found. Past and contemporary studies on PTSD reveal a similar symptomatic picture in a significant minority of those exposed to trauma.

## The Concept of Phases of Stress Response

War and concentration camps produce extraordinary strain, but even so, there seems to be phases of responses in which denial or intrusive symptoms and signs may predominate.

Shatan (1973), in a study of Vietnam veterans 24 months after combat, noted the presence of hyper-arousal and intrusive symptoms in the form of insomnia, nightmares, and restlessness that may not have surfaced during combat and demobilization, when denial and numbing may have predominated. Shatan observed that the delay in the manifestation of these symptoms caused the government physicians to assume that the Vietnam War produced fewer psychiatric casualties than may actually have been the case. Similar findings were also observed by Horowitz and Solomon (1975, 1978)

Thomas et al. (2010) described the differences between soldiers under great prolonged combat stress during World War II and those in Vietnam. As in the Shatan study, soldiers in combat in World War II went initially into a period of denial and numbing, but they did, nonetheless, remain at the front. The stress mounted, and when it exceeded the person's ability to maintain denial, then experiences characteristic of intrusive and repetitive painful feelings emerged.

In Vietnam, because of repeated rotation to relative safety, Horowitz and Solomon presumed it was possible for many soldiers to enter and remain in the denial phase. Other elements, such as the availability of drugs, the lack of group fidelity, and the opposition to the war, contributed to a state of alienation characterized by depersonalization and isolation.

Upon return to the United States, there would be a period of relief and well-being, with the denial and numbing continuing for a while. Ultimately, with the relaxation of defensive and coping operations, the person might then enter the painful phase of intrusive recollection (Egendorf et al. 1981).

For whatever combination of reasons, during the combat period of the Vietnam War, there was a general impression that levels of traumatic disorder were lower than they were during World War II. A period of controversy followed the combat period as to the prominence of Post Traumatic Stress Disorder in veterans, succeeded by a growing recognition of widespread problems in the Vietnam veterans. Today, PTSD in military populations is widely accepted among clinicians and researchers.

Wars are often fought by combat troops in late adolescence or very early adulthood at a time when identity is not completely consolidated. The traumatic experiences of the war become incorporated into self-schemas and concepts of the relationship of self to the world, thereby influencing an important developmental phase of identity formation. Identity may become reflected in the group cohesiveness essential to effective military units. This identity transformation situation combines with predisposition before the war. War experiences affect self-judgments during this important developmental phase. Then, the warrior identity must change after being discharged from the military. A civilian's identity based on family and career must be formed if the self-esteem is to be maintained effectively. During transitions in such phases of life problems in self-definition, self-coherence, and self-articulation may occur.

Excessive adherence to official diagnostic labels may inhibit individualized case formulations along these lines. Character development occurs throughout adult life, and massive trauma or prolonged strain affects this process. Prolonged denial or intrusion phases become, in some, new features of personality.

## **TERRORIST ATTACKS AND NUCLEAR HOLOCAUST**

Terrorist attacks, which have gained much political attention since the attacks on the United States of September 11, 2001, and are one of the most significant sources of mass trauma in the last several years. A study by Laugharne, Janca, and Widiger (2007) reviewed findings on the mental health effects following the demolition of the World Trade Center in New York City, on September 11, 2001 (the 9-11 attacks). This study cited rates of PTSD ranging from 2% to 11% among New York and Washington DC residents who were directly and indirectly exposed to the attacks. A Washington study of Pentagon employees revealed PTSD in 14% of participants two years after attacks (Schlenger et al. 2002). Those directly exposed have persistent PTSD rates of 20–30%, and

these findings were cross-culturally consistent. The authors concluded that higher rates of PTSD are present immediately after attacks but stabilize after a few months. Survivors with PTSD after 9-11 were compared to those who had survived other terrorist attacks. These showed the following PTSD rates among survivors: 31% for the Oklahoma City bombing with little reduction at follow up, 25–31% in the Paris 1995 bombings at 2.6-year follow-up. Shalev et al. (2006) reported that the rate of PTSD was 21–26% for Israeli residents directly and indirectly exposed to the Intifada hostilities. However, only one third of those with symptoms in Shalev et al. study reported functional impairment or great degree of distress.

The Laugharne et al. (2007) 9-11 study identified high-risk populations for developing PTSD. This study examined responses in flight attendants on the hijacked planes and individuals with pre-existing PTSD (veterans). Rates of PTSD among flight attendants were 18–19% (Lating et al. 2004), and these findings are consistent with other studies on PTSD risks. Other risk factors for PTSD were high levels of media coverage, gender, socioeconomic status, and social support. People watching a great deal of media coverage of the 9-11 attacks had higher PTSD rates. Among 9-11 survivors and witnesses, Hispanic women living in New York had the highest rates of PTSD when demographic variables were considered.

Past studies on the atomic bombing of Japan during World War II details a symptomatic picture of survivors. Based on interviews with seventy-five survivors, which was made seventeen years after the United States dropped an atomic bomb on Hiroshima, Japan, Lifton (1967) described the experience as a “permanent encounter with death,” consisting of four phrases, as with veterans described earlier. The first was an overwhelming immersion in death, a “death in life” feeling similar to that of the concentration camp victims. This phase was dominated by elements of extreme helplessness in the face of threatened annihilation and surmounted by an extremely widespread and effective defense mechanism that Lifton called “psychic closing off,” a cessation of feeling within a very short period of time. The dissociative process was described as closing oneself off from death, the controlling fantasy being “If I feel nothing, then death is not taking place.” It is thus related to a state of apathy, and is distinguished by its global quality, a screen of protection of the self against the impact of death in the midst of death and dying. This response to an overall exposure to death merges with longer-term feelings of depression and despair, mingled with feelings of shame and guilt. The guilty fantasy “I am responsible for his death; I killed him” is interwoven with the shameful fantasy “I should have saved him or helped him.”

The second phase of the Hiroshima encounter with death is called the “invisible contamination,” in which symptoms of radiation sickness appeared at

unpredictable intervals of weeks or months after the bomb had been dropped. There was a fear of epidemic contamination, a sense of individual powerlessness in the face of an invisible agent, and a denial of illness when the symptoms did appear.

The third phase, which occurred many years after radiation effects, was an undecurrent of imagery of an endless chain of potentially lethal impairments which, if not evident that year or five years later, would appear in the next generation.

The fourth phase was that of a lifelong identification with death and dying, which Lifton explained as the survivors' means of maintaining life. Because of the burden of guilt they carry for having survived, the survivors' obeisance before the dead is their best means for justifying and maintaining their own existence and is a continued preoccupation.

Lifton also described the survivors' residual problems, especially those of psychological imagery, which manifest themselves in various ways. Among them he noted a profound impairment of the sense of invulnerability; a sense of being among the "elite" who have mastered death and a sense of vulnerability to it at any time. Many victims carried with them, seventeen years later, intrusive images of the horror of that day and the days immediately after, and talked of still seeing pictures in their minds of people walking slowly in the streets, their skin peeling off.

As far as treatment issues for nuclear holocaust survivors, a profoundly ambivalent pattern emerged of both seeking help and resenting it. Working through this event, Lifton felt, was a reformulation, a way of establishing an inner ideology as a means of dealing with overwhelming feelings, creating a new reality within, which the victims could understand and master their experiences and their feelings of shame and existential guilt. Faced with this form of guilt, with difficulty in establishing trust in the human order, the survivors of concentration camps, of the atomic bombing, and of the Vietnam War need a new identity, a sense of connection with people, and meaning and significance for their life in order to come to terms with the past catastrophes and the world in which they continue to live.

## Natural Disasters

The signs and symptoms characterizing both the denial and the intrusion phases of stress response syndromes have been noted in modern studies of disaster (Green, 1982; Mills, Edmondson, & Park, 2007). These symptoms are found more frequently and prominently in those people exposed to a disaster who have had the greatest levels of shock, injury, or loss (Green et al. 1987). Treatment by psychotherapy helps reduce these symptoms (Lindy, 1987). Pre-trauma

culture and the social environment—whether supportive or neglectful, benign or hostile—also influence the course of recovery from stress response syndromes (Boehnlein et al. 1985, Green et al. 1985).

For example, hurricane Katrina in New Orleans in 2005 is a recent large-scale disaster that produced a lot of damage and trauma. A total of 132 people in Red Cross shelters were surveyed weeks after the hurricane by Mills and colleagues (2007). Mills found that 62% of participants met criteria for Acute Stress Disorder. Participants were exposed to a wide range of traumatic experiences ranging from seeing dead bodies to missing a loved one for at least one day, to losing someone they knew. Individuals studied were mostly lower income, African American individuals of whom 67% had a pre-existing mental health diagnosis. It is notable that evacuees waited several days for rescue, which increased their exposure to psychological trauma, and African American evacuees waited at least a day longer than Caucasian evacuees.

In an earlier example, the skywalk of a prominent hotel in Kansas City fell, crushing, injuring, and threatening hundreds below in a crowded social gathering. Wilkinson (1983) studied the 102 survivors during the five months following the disaster. Of these, 88% had a significant degree of intrusive episodes of thought and feeling. Repeated recollections of the disaster were reported as symptoms in 83% of the 52 men and in 94% of the 50 women studied. Recurrent feelings, usually of anxiety and depression, were found in 54% of the sample, again, more of these states were found in women (60%). Difficulty concentrating was found in 44% of the sample. The victims and observers of the falling skywalk suffered more often from such symptoms as intrusion and hyperstartled responses than did those who served as rescuers. Themes of survivor guilt were prominent in the bereaved, and many needed to talk over and over again about what happened. Post-traumatic symptoms may also be found in secondary disaster victims, those who had to recover and sort the human remains (Jones, 1985).

Similar findings were noted in several studies of the survivors of the Buffalo Creek Disaster in West Virginia (1976). The Buffalo Creek Disaster occurred when a large dammed body of water was suddenly released, forming a gigantic wave that tore through Logan County, West Virginia, killing 125 people and rendering the entire population of 5,000 homeless.

Erickson (1976) described these survivors in some of the same terms used by Lifton to describe the survivors of Hiroshima, Japan. Some were demoralized, disoriented in terms of life plans, and apathetic. In a separate study of some of the same people, Titchner and Kapp (1976) found post-traumatic neurotic symptoms in 80% of the group interviewed, with a prominence of unresolved grief, survivor shame and guilt, and feelings of impotent rage and hopelessness even two years after the traumatic event.



People have variations in character and culture, so it is hard to predict how many members of a given population will develop what type of stress response syndrome after a disaster. Some indication is offered, however, by epidemiological studies that sample a large population of people who have, and have not, been exposed to a given event.

Robins and colleagues (1985) studied a group of 43 people exposed to flood, tornado, or toxic contaminations and compared their responses to the responses of similar but unexposed 325 people. Over half of the exposed people had three or more symptoms of Post Traumatic Stress Disorder, although only 2 of the 43 warranted a diagnosis as circumscribed in *DSM-III*. This contrasted with 10 people, about 3%, of the sample of unexposed people, one of whom warranted the diagnosis of Post Traumatic Stress Disorder. Of the exposed group, 8% warranted the diagnosis of phobic disorder, compared with 4% of the unexposed group. In addition, 27% of the exposed group reported their health to be only fair to poor, contrasted with 8% of the non-exposed group. The more directly exposed the people in such samples, as already mentioned, tend to exhibit greater morbidity (Smith et al. 1985). The best predictors of post-trauma symptoms were the degree of exposure and the number of symptoms the individual subject experienced before the event. Gender differences were not noted.

A similar study, Shore and colleagues (1985), found that people involved in the Mount St. Helens volcanic eruption disaster in 1980 had significant elevations in the frequency of three psychiatric disorders when compared with an epidemiologically similar group. These disorders were Post Traumatic Stress Disorders, Generalized Anxiety Disorders, and single episodes of Major Depressive Disorder. In this sample females showed higher incidences of the conditions than did males, and morbidity increased between year one and year three after the disaster. Women between the ages of 36 and 50 seemed the most susceptible to experience these disorders.

## Children

Children, with their rapidly developing mind and psyche, may have some of the same, or different, characteristics of responses to a traumatic event. An example is Terr's (1981, 1983) reports on the responses of the survivors of the Chowchilla kidnapping in California in 1976. This study was about 23 to 25 of the 26 children who, in 1976, were kidnapped from their school bus. Three kidnappers drove them for about eleven hours in two vans with blackened windows and then buried them alive in a truck-trailer under the ground in a covered hole. The children and their bus driver remained there for sixteen hours, uncertain of

their fate, until two of the kidnapped boys dug a tunnel out to summon help. Terr was able to follow the childrens' ensuing trauma and reported their status four years later.

Every one of the 25 Chowchilla victims suffered from persistent fears, although after four years, 19 reported spontaneous resolutions of some of these fears. Eighteen of the 25 youngsters, mostly between 10 and 15 years of age, suppressed any thoughts about the kidnapping. Although the children had visual memories of the events, they were like daydreams and not accompanied by signs of acute distress or a sense of intrusiveness (except when they occurred as nightmares or hallucinations). Misperceptions and perceptual overgeneralizations led to startled reactions.

Unexpected, sudden reminders could evoke sensory memories and precipitate extreme anxiety in some of these children. Although five children had terrifying dreams in the first year after the kidnapping, 12 described these nightmares in later follow-up interviews, after more than two years had passed. Sometime during the four years post-kidnapping, 18 of the children had played out repetitively some theme clearly related to the traumatic events. Some of the children denied the post-traumatic symptoms, but Terr felt that every child she studied suffered from a post-traumatic stress response syndrome. However, the reaction observed in previously studied traumatized adults such as numbing, amnesias, and intrusive and dysphoric flashbacks were not prominent in Chowchilla children.

## Bereavement

Much of the earlier literature on unduly prolonged, complicated, or pathological bereavement was summarized by Parkes (1964), later expanded through his own studies (1970, 1972; Parkes and Weiss, 1983); literature has also been reviewed by Raphael (1983), Osterweiss and colleagues (1984), and Bonanno et al. (2003). Bowlby (1961, 1969, 1980) has also reviewed the material and developed a highly influential attachment theory. Latter studies came from Shear, Frank, Houck, and Reynolds (2005), as well as from Zhang and colleagues (2006). In this section, symptoms of complicated bereavement in different types of losses are reviewed in earlier and latter studies.

Parkes referred to the now-classic paper by Lindemann (1944) on the varieties of reactions to bereavement found in a mixed group of psychiatric and non-psychiatric patients. Parkes noted that Lindemann did not show the relative frequency of the various syndromes that he described, nor did he indicate how long after bereavement his interviews took place. Lindemann defined acute grief as a definitive syndrome with psychological and somatic symptomatology, which may appear immediately after a crisis or may be delayed until later. He

described it as uniform, in that it is expressed by waves of anxiety and panic that are defended against by denial of the event and by avoidance (i.e., of visits from others, of mentioning the deceased, or of expressions of sympathy by others). He explained the use of denial as motivated by fear of loss of control and emphasized the importance of the possibility of under reaction, as well as overreaction.

Parkes conducted an experiment on widows' reaction to their husbands' impending deaths. He (1970) interviewed 22 London widows at three-month periods for thirteen months after their bereavement. These widows were felt to be showing typical grief reactions: of the 22, only 6 felt that they had fully accepted the news when they were told that their husbands would die; 8 of the women frankly disbelieved the news. As a result of these interviews, Parkes was able to find phases of reaction.

## DENIAL-NUMBING

The initial, immediate reaction is described by Parkes as a state of numbness, often preceded by an expression of great distress. Although this sense of numbness was a relatively transient phenomenon, some form of denial of the full reality of what had happened often persisted. One year later, 13 widows said there were still times when they had difficulty believing in the reality of their husbands' deaths. Bowlby, also (Bowlby and Parkes, 1970), had revised his classification of the phases of mourning to introduce numbness as the initial phase. This is reflected, in Parkes's study, in affective reports of one group that showed little or no affect in the first week, not much in the second, but by the third month they showed moderate-to-severe disturbance.

A second group showed a steady increase in affect over a period of time, and a third group, which showed moderate or severe affect in the first week, tended to remain disturbed during the first two months but improved thereafter. Each widow seemed to have her own way of mitigating her feelings. These included a blocking out and/or denial of affect, partial disbelief, an inhibition of painful thoughts and evocation of pleasant ones, and an avoidance of reminders.

## INTRUSIVE REPETITIONS

Parkes noted the distressing symptom of misidentification illusions (seeing the deceased in a stranger) and pseudohallucinations (Marris, 1958). For example, one woman felt initially stunned and angry after the death of her husband. For the next few days she kept busy, and then, five days later, she said that something invaded her; a presence almost "pushed [her] out of bed." It was her husband,

and the experience was "terribly overwhelming." During this period, on the whole, the widows' feelings were seldom admitted fully to consciousness, and their minds were often distracted from the loss, but there were periodic breakthroughs. Parkes pointed out that hallucinations and illusions occurred and noted that they have always occupied a prominent place in folklore, especially in the form of ghosts and in the concept of being haunted.

In 1972, Parkes distinguished seven phases of mourning: (1) initial denial and avoidance of loss; (2) alarm reactions such as anxiety, restlessness, and physiological complaints; (3) searching, an irrational urge to find the lost person; (4) anger and guilt; (5) feelings of internal loss; (6) adoption of traits or mannerisms of the deceased; and (7) acceptance and resolution, including appropriate changes in identity.

Grayson (1970) found a similarity between the grief reactions to the loss of real objects and the loss of intangibles, particularly missed experiences and relinquished hopes. The process of diminishing the force of these wishes requires the same working through to completion as does the mourning process (Lewis, 1961, Rees, 1970). Grayson found tension release and catharsis to be valuable discharges of affect without which eventually withdrawing attachment from the deceased loved one would take longer and be less complete. He emphasized the need for people to break through the phase of denial in order to face the painful reality of the missed experience.

Gorer (1965) also agreed with the theory of phases, having studied 35 bereaved people who sought psychiatric help because they suffered from prolonged grief, delayed reaction, vivid nightmares, or an absence of grief that signified that all was not well. Gorer described the most characteristic feature of grief not as prolonged depression but as acute and episodic pangs or episodes of severe anxiety and psychological pain that begin within a few hours or days after bereavement that would reach a peak of severity within two weeks. At first they are frequent and spontaneous, but as time passes, they become less frequent and occur only when something brings the loss to mind.

Glick and colleagues (1975) found that widows in the first year after their husbands' deaths usually could not enter into a new relationship without concomitant feelings of disloyalty toward the dead spouse. This indicated a gender difference, as the widowers in their study did not feel that a new relationship would conflict with the memory of commitment and fidelity to the deceased wife. Instead, widowers often established a new quasi-marital relationship within a few months of their wife's death and expected sympathy from the new companion for their continued grieving for their dead wife.

In addition to gender differences, there are cultural differences in response to bereavement that may be related to different views of the meaning of death, different patterns of attachment, different rituals and responses to loss, and other

factors (Cowles, 1996; Eisenbruch, 1984, Windholz et al. 1985). Nonetheless, tendencies toward intrusive experiences, including hallucinatory experiences of the deceased, and toward denial experiences, including denial of the fact of death itself, are found in some individuals cross-culturally. Across cultures, intense grief and mourning responses are expected to last up to a year after the death, often with a ritual at that time to mark a return to social availability (Rosenblatt et al. 1976).

## DEATH OF A CHILD

Finally, Horowitz and colleagues (1977) reviewed a life events questionnaire to survey the distress experienced by groups of individuals after a variety of events. The most devastating type of loss was usually considered to be the death of a child. As just one example of many studies, marital discord and divorce were reported in 50 to 70% of families whose child died from cancer (Kaplan et al. 1976; Strauss, 1975).

## DEATH OF A PARENT

As the worst loss appeared to be the loss of a child, in contrast, the loss of a parent is often anticipated. Selecting a specific type of bereavement, such as the death of a parent, makes it possible to compare the experiences and responses of people who do or do not seek help in dealing with the trauma. Even though parental deaths are often culturally expected and anticipated, they nonetheless have a significant impact on the survivor, as both the loss and the past meaning of the relationship are reconsidered, with concomitant reflection on self-concepts.

In a series of papers, our own research group reported on the quantitative and clinical studies of field subjects who experienced a parental death and went through two-, six-, and 13-month evaluation sessions of their responses, and of patients who sought brief psychotherapy because of depressive and anxious symptoms precipitated by the death of a parent (Horowitz, Krupnick et al. 1981; Horowitz, Marmar, Krupnick et al. 1984; Horowitz, Marmar, Weiss et al. 1984; Horowitz, Weiss et al. 1984; Horowitz, Wiber et al. 1980b; Kaltreider et al. 1984; Kaltreider and Mendelson, 1985).

In the initial evaluations, intrusion levels were high on the self-report in 33% of the field subjects and at medium levels in 39%. High levels were defined clinically as the level of signs and symptoms that merited concern, that diagnostic, evaluative, or treatment procedures were clearly warranted, and that the person was more likely to be in a problem or pathological category. Medium levels were

defined when symptoms gave a global indication of a condition that warranted further diagnostic, evaluative, or treatment procedures, even though the severity was not marked. Though the patient sample had higher levels of distress, as shown in Table 3.2, there was a subpopulation among the field subjects that was also high in distress, as shown in Table 3.3. Table 3.4 shows the same data 13 months after the death of the parent.

Participants who felt in some way responsible for, guilty over, or ashamed of the events leading up to, during, and following the parental death had more prolonged symptoms. The loss of the mother produced more prolonged symptoms over time than did the death of the father. The more the people experienced other negative life events, the more they tended to have persisting symptoms related to the themes of the parental death. Those people judged to have more developed self-organizational capacities had the sharpest rate of decline in symptoms over time.

## PERSONAL ILLNESS, DYING, AND THE THREAT OF DEATH

In her study of 400 dying patients in a Chicago hospital, Elizabeth Kubler-Ross (1969) pioneered investigations into the psychological effects of the process of dying. After first having difficulty in getting these individuals to talk to her, she

**Table 3.2 Differences between Groups at First Evaluation after Death of a Parent**

PRIMARY DISTRESS VARIABLES <sup>a</sup>	MEAN (SD)		<i>t</i>	<i>P</i>	<i>w</i> <sup>2b</sup>
	PATIENTS (N = 31)	FIELD SUBJECTS (N = 36)			
Intrusion (IES)	21.52 (7.99)	13.83 (9.05)	3.66	.001	.16
Avoidance (IES)	20.74 (9.64)	9.69 (9.66)	4.67	.000	.24
Depression (SCL-90)	1.75 (1.00)	0.81 (0.78)	4.30	.000	.21
Anxiety (SCL-90)	1.22 (0.84)	0.69 (0.78)	2.62	.011	.08
Total symptoms (SCL-90)	1.12 (0.63)	0.57 (0.59)	3.68	.000	.16
Clinician rating					
Intrusion (SRRS)	18.53 (11.05)	8.36 (10.72)	3.79	.000	.17
Total neurotic signs and symptoms (BPRS)	16.48 (4.68)	10.64 (6.83)	4.13	.000	.19

<sup>a</sup> Impact of Event Scale (IES); SCL-90: the symptom Checklist 90; SRRS: Stress Response Rating Scale; and BPRS: Brief Psychiatric Rating Scale.

<sup>b</sup> This is an index of the proportion of variance accounted for by group variance.

Source: Horowitz, M. J., Krupnick, J., Kaltreider, N., et al. Initial psychological response to parental death. *Archives of General Psychiatry* 38:316-323, 1981.

**Table 3.3 Percentages of Persons at Three Levels of Distress on Initial Evaluation after the Death of a Parent**

PRIMARY DISTRESS VARIABLES <sup>a</sup>	PATIENTS (N=31)			FIELD SUBJECTS (N = 36)			$\chi^2$	<i>P</i>
	LOW	MEDIUM	HIGH	LOW	MEDIUM	HIGH		
<i>Self-rating</i>								
Intrusion (IES)	3	36	61	28	39	33	8.98	.011
Avoidance (IES)	10	32	58	61	17	22	19.02	.001
Depression (SCL-90)	7	32	61	46	31	23	15.23	.001
Anxiety (SCL-90)	23	26	51	65	6	29	13.32	.001
Total symptoms (SCL-90)	23	23	54	66	17	17	13.68	.001
<i>Clinician rating</i>								
Intrusion (SRRS)	17	40	43	67	19	14	16.91	.001
Total neurotic signs and symptoms (BPRS)	3	52	45	42	47	11	17.56	.001

<sup>a</sup> IES is Impact of Event Scale; SCL-90: the symptom Checklist 90; SRRS: Stress Response Rating Scale; and BPRS: Brief Psychiatric Rating Scale

Source: Horowitz, M. J., Krupnick, J., Kaltreider, N., et al. Initial psychological response to parental death. *Archives of General Psychiatry* 38:316-323, 1981.

**Table 3.4 Percentage of Distress of Persons at Three Levels of Distress at 13 Months**

	PATIENTS			FIELD SUBJECTS <sup>1</sup>				
PRIMARY DISTRESS VARIABLES <sup>a</sup>	LOW	MEDIUM	HIGH	LOW	MEDIUM	HIGH	$\chi^2$	<i>P</i>
<i>Self rating</i>								
Intrusion (IES)	57	33	10	69	19	12	1.72	NS
Avoidance (IES)	73	17	10	75	19	6	.31	NS
Depression (SCL-90)	55	26	19	66	22	12	.87	NS
Anxiety (SCL-90)	68	19	13	85	6	9	2.88	NS
Total symptoms (SCL-90)	77	13	10	81	13	6	.26	NS
<i>Clinician rating</i>								
Intrusion (SRRS)	53	37	10	90	7	3	10.04	.007
Total neurotic signs and symptoms (BPRS)	43	47	10	47	53	0	3.17	NS

<sup>a</sup> IES is Impact of Event Scale; SCL-90: the symptom Checklist 90; SRRS: Stress Response Rating Scale; and BPRS: Brief Psychiatric Rating Scale.

<sup>b</sup> Numbers vary from 23 to 30.

Source: Horowitz, M. J., Horowitz, M. J., Krupnick, J., Kaltreider, N., et al. Initial psychological response to parental death. *Archives of General Psychiatry* 38:316-323, 1981.

discovered that the denial of impending death existed not only in the patients, but also in the doctors and nurses. The medical staff coped with the difficulty of confronting the impending death of a patient by the defensive maneuvers of selective withdrawal and inaccessibility. Thus when the dying patient needed human contact the most, it was less available because of avoidance behavior. According to Kubler-Ross's report, patients go through five stages (described below) between their awareness of serious illness and their death:

1. *Shock and denial* upon being diagnosed with a serious illness. A few individuals maintain this defense until the very end. Aldrich (1974) mentioned the impact of ambivalence or difficulty accepting death on anticipatory grief. The dying person grieves in anticipation of the loss of her loved ones and resents being the one to die. The dying person finds it difficult to cope with this ambivalence, which increases the likelihood of denial. Aldrich noted that denial will prevail until the patient's disengagement and withdrawal have progressed to a point from which he or she can face death and loss with relative equanimity.
2. *Anger*, which is often directed toward family, nurses and doctors, and those who epitomize health, healthy functioning, and life itself, and remind them of what they are attempting to deny. The patients are, in effect, asking "why me?" and, by expressing their rage or anger, may receive some comfort.
3. *Bargaining for time*, for example, to live long enough to see a son graduate from college or a grandchild born. The patient is now saying, "Yes me, *but . . .*"
4. *Depression*, which may be of two kinds: one is a reactive depression manifested by simultaneous crying and talking about the loss that lies ahead; the other is a quiet depression in which there is crying but no speaking of the imminent death. Encouraging the grieving and mourning over the impending loss allows for the emergence of anticipatory grief and leads the patient into the last phase.
5. *Acceptance*, a period when the patient separates from those people that he or she will leave behind. The unfinished business has been finished.

## Rape

Rape, or attempted rape, is an extremely traumatic and often life-threatening event. It is an unexpected and sudden event which takes a long period of time to heal from (Veronen and Kilpatrick, 1983). Its victims also indicate a phasic response to this kind of episode.

In a study of "rape trauma syndrome," during a one-year period, Burgess and Holmstrom (1974) followed 146 women who were seen at the emergency



ward of Boston City Hospital. Their results were essentially similar to those of an earlier study of 13 women by Sutherland and Scherl (1970) in which they noted phasic responses. The rape trauma syndrome is described as “an acute phase and a long-term reorganization process that occurs as a result of forcible rape or attempted forcible rape” (p. 508). These behavioral, somatic, and psychological responses are an acute stress reaction to a life-threatening situation. In the acute phase, there may be a wide range of emotions, characterized by disorganization of the victim’s lifestyle. Shock and disbelief are often expressed, and two emotional styles emerge in equal amounts. One is the expressed style, in which feelings of fear, anger, and anxiety are shown by crying, smiling, restlessness, and tension. The other is the controlled style, in which feelings are masked or hidden by the victim appearing calm.

In the second phase, which was found to begin about two or three weeks after the attack, motor activity changes, and nightmares and phobias are especially evident. Dreams and nightmares are very disturbing and are of two types, one in which the victim is being attacked, wishes to do something, but awakens before acting. In the second type of dream, also of an attack, which occurs after a longer period of time, the victim masters the situation and fights off the assailant. There were some instances in which the victim woke up crying, though she had been unable to cry during daytime hours. Fears connected with the setting in which the rape occurred (outdoors, indoors, being alone), fear and avoidance of sexual experiences, fears of crowds, and fears of being followed are common aspects of phobic responses.

In a later publication on crisis intervention with victims of rape, Sutherland-Fox and Scherl (1975) described a third phase in which the patient feels depressed and wants to talk. It is during this phase that two central issues must be worked through: 1) the victim’s feelings about herself and 2) her feelings about the assailant. Some go through a period of guilt and self-punishment as a first step toward integrating the experience. Initial feelings of anger or denial—suppressed or rationalized during the second phase—now reappear for resolution. The third phase is relatively brief, and if, after several weeks, the experience has not been integrated and taken its appropriate place in the past, Sutherland-Fox and Scherl suggest that further help be sought.

A “silent rape reaction” was also observed. A number of women in the sample stated that they had been raped or molested at earlier periods of their lives and that the current rape reawakened their reaction to the earlier experience. It became clear that because they had not talked about and worked through the effects of the previous rape, the syndrome had continued to develop and remained unresolved. Emphasis was placed on the victim’s need for support and comfort, for a working through from the acute phase to reorganization to completion, and a return to normal functioning as quickly as possible.

In a monograph sponsored by the American Psychiatric Association Committee on Women, Hilberman (1976) described four clinical phases of response to such a crisis: (1) an anticipatory or threat phase in which there is a need to protect the illusion of invulnerability; (2) an impact phase that includes anxiety, numbness, disorganization of thought, and loss of control; (3) a recoil phase in which the individual becomes more aware of adaptive or maladaptive responses to the stress and can experience either increased self-confidence or damage to self-esteem, depending on her perception of her behavior during the stress; and (4) a post-traumatic phase in which a successful response includes assimilation of the experience and spontaneous recovery, whereas a maladaptive response may result in a permanently impaired self-concept with evidence of continuing anger, guilt, nightmares, and impaired capacity to function.

Burgess and Holstrom (1976) elaborated on the fourth phase in explaining the victim's coping strategy before and during the assault as an issue to be confronted after the assault. For example, they asserted that there might have been intense guilt for the woman who submitted to rape in response to physical threats, whereas the victim who was beaten to insensibility and then raped may have suffered differently. Rape, of course, is used here as an extreme example of many other types of assault such as mugging, battery, burglary, and bullying. Any of these episodes of violence, threat, or fright can lead to stress response syndromes.

## Medical Illness

Medical procedures, illnesses and disabilities can also cause psychological stress and, in some people, may lead to stress response syndromes. Kaltreider and colleagues (1979) found that a portion of a sample of women who had a hysterectomy manifested a subsequent stress response syndrome. Similar problems may occur after an abortion. Often a new pregnancy diminishes the stress reaction but new symptoms of stress may not occur after the birth of a healthy baby (Bourne and Lewis, 1984). During the period between a perinatal death and a subsequently healthy pregnancy, the person may be relatively unwilling to look at all the implications of the perinatal death.

Life-threatening illnesses such as myocardial infarctions are even more likely to be associated with early denial and later intrusive thinking as well as anxious and depressed states. The early denial may even ameliorate certain problems, as it can reduce emotional arousal at a time of cardiac irritability, when arrhythmias, with fatal consequences, may occur (Biodeau and Hackett, 1971; Hackett and Cassem, 1970). Broncoscopy, burn treatment, spinal cord malfunction, renal dialysis, stroke, chronic pain, and other illnesses all may provide a major stressor with profound psychological, as well as physical consequences (Krueger, 1984).

Even the news of being at risk for premature death may set in motion a stress response syndrome. Interventions to inform people of risk factors are now more and more common; perhaps the most common is telling people that they are at risk for premature heart disease because of high cholesterol, patterns of heavy cigarette smoking, or elevated blood pressure. In a large study of men so informed, intrusive thinking was found at higher levels in those given repeated reminders than in an informed group with fewer systematic reminders of the causes for early death from heart attacks. Elevated levels of intrusive thinking were found at yearly intervals, including the time period of three years after the news of risk. At the third year, 7% of a group of nearly 1,500 men reported they were more than “quite a lot upset” by this news (Horowitz, Simon et al. 1983). An additional 11% were at “moderate” to “quite a lot upset” about this news, meaning that 18% of men were substantially upset for a period of three or more years after receiving such news. Having intrusive thoughts and being constantly upset about the news is not the same, however, as having a diagnosable stress response syndrome, as indicated in the previous chapter.

### MENTAL ILLNESS AS A STRESS EVENT

Other mental disorders also may create a cascading series of stressful events, while at the same time impairing the coping capacity. The individual who has a psychotic reaction, is hospitalized and treated, and then is to be discharged may also be regarded as having a stress response syndrome involving the memories (and fantasies) along this pathway of experience. If manic behavior occurred at work, there may be memories of the episodes that lead to a dreadful anticipation of social scorn on returning to the workplace. If violent or bizarre behavior threatened loved ones during a paranoid reaction, the person who has now recovered to rational levels of interpersonal functioning may still have intrusive thoughts about the illness episodes. Witnessed struggles with staff or demented episodes of other patients in the hospital may also have been stressful events, during a period of relative “copelessness.” The kind of brief psychotherapy to work through stressful life events, which will be discussed later, should also be considered as part of the overall approach to patients who have had such psychotic disorders or relevant non-psychotic medical and psychiatric disorders.

## Conclusions

Phases of stress response found in clinical studies of individuals who seek evaluation and treatment are also found in populations that sustain similar stress events

and are then evaluated as part of field study research. Intrusive thinking and denial characterize these phases. The generality of intrusive thinking as a stress response tendency led to the type of experiments to be described in the next chapter, as a further examination of the generality of this type of response in the experimental laboratory where many variables may be systematically controlled.



## CHAPTER 4

# Experimental Findings

*With Stephanie Becker and Nancy Wilner*

When perceived information is tagged as important to self it has a tendency to be stored in the memory. When quality of this information is tagged as possibly highly important it can lead to repeated representation in conscious thought. This general tendency, observed after a variety of stressors, leads to a hypothesis that can be tested in the laboratory by use of stimuli such as films. The hypothesis is that more psychological stress will be followed by more intrusive experiences that recapitulate aspects of the external stimuli that created tension in the mind.

Experimental studies are advantageous for several reasons: the degree of generality across different kinds of events and people can be examined under controlled circumstances, and the precise operational definitions necessary for experimental work may sharpen theoretical reflection on how and why intrusive thoughts and unbidden images return in spite of efforts to deploy attention elsewhere.

All experiments summarized here used volunteer participants who reported their conscious experiences before and after viewing a variety of mild stress-inducing films. The findings indicated that intrusive and repetitive thought tended to follow this kind of stress for a short time and that both exciting and depressing films produced effects equivalent to those elicited by a film that depicted bodily injury. This data will be summarized in this chapter.

## Experimental Background

Films are well-studied and replicable laboratory stimuli for providing visual stress events (Goldstein et al. 1965; Lazarus, 1966; Lazarus and Opton, 1966;

Nomikos et al. 1968; Hennessey, 2004). Intrusive and repetitive thought can be defined and then quantified using self-report and content analysis procedures. The hypothesis tested states that after a visually perceived stressful event elicited by film, subjects from a variety of population groups, given a variety of instructions, will report more intrusive thoughts of repetitions of film contents, and more visual images than after a less stressful contrast film.

This hypothesis was first tested in a pilot study, and when significant positive results were found, a series of replications with additional controls were conducted. The series varied the subject populations, the instructions and demand set was given to the subjects, as well as the contents and order of the stress films. An outline of sequence and references is found in Figure 4.1.

## DESIGN

In a prototypic experiment, groups of subjects saw a stress film and a neutral contrast film in counterbalanced order. Before and after each film, measurements were taken to obtain baseline, postneutral film (referred to as neutral), and after the stress-inducing film (referred to as stress) scores on selected variables.

## SUBJECTS

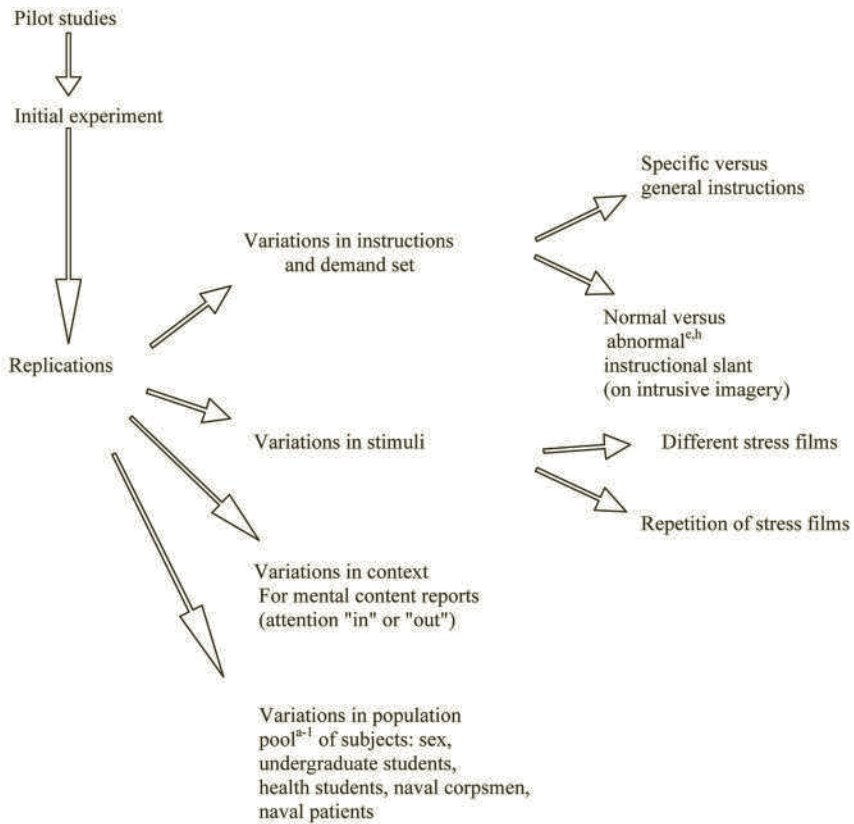
The volunteers in the different experiments were college students and enlisted men in military service.

## FILM STIMULI

The stress films were (1) *Subincision*, which depicts circumcision as part of a puberty rite; (2) *It Didn't Have to Happen*, a film showing woodshop accidents; and (3) *Highway Safety*, an auto accident film used in drivers' education. The neutral contrast film used was *The Runner*, a pretty film which shows a man running through the countryside making friends and acquaintances along the way. All films were silent and edited to run from six to nine minutes.

## SIGNAL DETECTION TASK AND MENTAL CONTENT REPORTS

The periods for reporting mental contents were interspersed between segments of a signal detection task. Although boring, this task demanded continuous atten-



#### References for details of particular experiments

- |  |   |
|--|---|
| a. Horowitz (1969)                     | g. Horowitz, Becker, Moskowitz & Rashid 1972) |
| b. Horowitz (1970)                     |   |
| c. Horowitz & Becker (1971a)           | h. Becker, Horowitz & Campbell (1973)         |
| d. Horowitz & Becker (1971b)           | i. Horowitz & Becker (1973)                   |
| e. Horowitz & Becker (1971c)           | j. Horowitz & Wilner (1976)                   |
| f. Horowitz, Becker & Moskowitz (1971) | k. Wilner & Horowitz (1975)                   |

**Figure 4.1 The Sequential Organization of the Series of Experiments.**

tion. Subjects heard a series of sounds and judged whether each particular tone was higher, lower, or the same as the preceding tone. At the end of each segment, during a two-minute break, subjects wrote a report of their mental contents, defined as any thoughts, feelings, visual images, other images, observations, "flashes," memories, or anything else that occurred in the mind during the tone task.



## SELF-RATINGS OF AFFECT

The affect ratings consisted of 11 moods that the subjects rated, on a 9-point scale, to indicate their feelings at different specific points in the experiment. The negative affect words were anger, contempt, disgust, fear, nervousness, pain, sadness, and surprise, and the positive affect words were happiness, interest, and pleasantness.

## QUANTIFICATION OF DATA ON CONSCIOUS EXPERIENCE

The raw data from the mental contents reports were content-analyzed by judges for intrusive thoughts and film references. The Spearman-ranked difference correlations for the two or three judges used in the separate experiments ranged from 0.85 to 0.94 for intrusions and 0.91 to 0.99 for film references.

Briefly, an *intrusive thought* was defined as any thought that implies nonvolitional entry into awareness, requires suppressive effort or is hard to dispel, occurs persistently, and is experienced as something to be avoided. A *film reference* was defined as any thought that refers directly to the film, film setting, or film experience, and it includes anticipations of seeing the film.

## INSTRUCTIONAL DEMAND

The different experiments varied according to the demand sets incorporated into instructions to subjects. The main instructional variances, as indicated in Figure 4.1, suggested to some subjects that the intrusive images were a pathological process, leading to hallucinations. To other subjects we suggested that such images were normal or even creative processes aimed at mastering a stress event.

## DATA ANALYSIS

Computer implementation of the Finn Multivariate Analysis of Variance for a non-orthogonal design enabled the cross-experimental data analysis reported here (Finn, 1972). The analysis was divided into stages, because not every variable was scored for every experiment and not every design included baseline, neutral, and stress conditions. The main variables, scored for every experiment, were subjected to an analysis of variance for 133 subjects who had data in all three conditions. Included as potential sources of variance for this analysis were

the subject groups: the demand set incorporated in the instructions; the order in which films were viewed; the baseline, neutral, and stress conditions; interaction effects; and variances among and within subjects.

## Results

The hypothesis that intrusive and repetitive thoughts would occur most frequently in the stress condition was confirmed. A study of the effects of films with stressful content by Holmes, Brewin, and Hennessy (2004) led to a similar result.

### INTRUSIONS AND FILM REFERENCES

At the  $p < .05$  cutoff level, only the change in conditions (stress versus neutral films) exerted a significant effect on both intrusions ( $MS = 57.5$ ,  $df = 2$ ,  $F = 20.70$ ,  $p < .001$ ) and film references ( $MS = 146.5$ ,  $df = 2$ ,  $F = 49.1$ ,  $p < .001$ ). Population differences (health sciences students, college students, military personnel), film order (stress or neutral first), sex of subjects, and instructional demand (general, specific, abnormal, normal slants) did not exert a significant influence. Intrusions and film references correlated positively in the stress condition ( $r = .51$ ,  $p < .001$ ,  $n = 133$ ).

The adjusted means in Table 4.2 indicates the deflections of a content analysis item from a norm of zero, with zero computed as the expected level based on word length alone. Positive scores indicate the number of intrusions per subject above expectation, and negative scores indicate lower than expectable levels. The significant condition effect for intrusions is accounted for by the stress film. Baseline film references are, of course, especially low because no film had yet been seen and only occasional anticipatory remarks had been made. The neutral and stress condition film reference levels are significantly different. Overall, 77 percent of the participants were scored by two or three judges as having at least one episode of intrusions in the stress condition.

### INTRUSIONS CORRELATED WITH DEGREE OF THE STRESS REPORTED

In the stress condition, people who rated themselves higher on negative emotions also reported higher levels of intrusions. The adjusted intrusion scores, in 133 participants who made the same affect report measure during the stress condition, correlated significantly and positively with a composite of negative

**Table 4.1 Analysis of Variance Data for Intrusion and Film References Considering All Factors and Conditions for 133 Subjects**

<i>Sources of Variance</i>	<i>MS</i>	<i>df</i>	<i>F</i>	<i>p</i>
<i>Intrusions</i>				
<i>Among Subjects</i>				
Population of Sample	7.46	2	1.01	<.37
Instructional Demand	16.16	3	2.18	<.09
Sex	16.84	1	2.27	<.13
Order of Films	1.14	1	.15	<.70
Among-subjects Error	7.42	117		
<i>Within Subjects</i>				
Condition	57.51	2	20.69	<.001
Cond. X Pop.	6.39	2	2.30	<.10
Cond. X Instruc.	1.67	3	.60	<.50
Cond. X Sex	3.13	1	1.13	<.30
Cond. X Order	1.05	1	.38	<.50
Within-subjects Error	2.78	234		
<i>Film References</i>				
<i>Among Subjects</i>				
Instruct	32.75	2	2.11	<.13
Sex	1.16	3	.07	<.97
Order	1.73	1	.11	<.74
Among-subjects Error	4.52	1	.29	<.59
<i>Within Subjects</i>				
Condition (s)	15.51	117		
Pop. X Cond. (s)	146.51	2	49.08	<.001
Instruc. X Cond. (s)	14.04	2	2.57	<.10
Sex X Cond. (s)	6.93	3	1.27	<.20
Order X Cond. (s)	5.72	1	1.05	<.30
Within Subjects	12.01	1	2.20	<.20
	5.47	234		

affects ( $r = .27$ ,  $p < .001$ ) and significantly and negatively with a composite of positive affects ( $r = -.16$ ,  $p < .05$ ). The highest correlation with specific individual affects was with pain ( $r = .38$ ,  $p < .001$ ) and surprise ( $r = .35$ ,  $p < .001$ ). With large numbers of subjects, some low levels of correlation (e.g.,  $r = -.16$ ) may reach statistical levels of significance but indicate only a small size of effect.

A group of 77 participants also rated themselves after the stress film on a 1-100 scale for emotional and physical stress. Both scales correlated significantly

**Table 4.2 Combined Means on Intrusions and Film References as Adjusted According to Report Length**

	INTRUSIONS				FILM REFERENCES		
<i>Factor</i>	<i>N</i>	<i>Base</i>	<i>Neutral</i>	<i>Stress</i>	<i>Base</i>	<i>Neutral</i>	<i>Stress</i>
<i>Population</i>							
Military Inpts.	23	-.44	-.16	.41	-1.69	-.88	-.08
Civil. Students	82	-.83	-.40	1.38	-2.14	-.23	1.51
Health Students	28	-.50	-.11	.39	-1.53	.08	1.61
<i>Gender</i>							
Male	99	-.66	-.33	.55	-1.81	-.13	.98
Female	34	-.80	-.20	2.33	-2.29	-.69	2.05
<i>Instructional Demand</i>							
Normal	24	-.72	-.30	1.73	-2.26	-.53	2.44
Abnormal	25	-.63	.02	1.79	-1.96	-.25	1.65
Specific	16	-.49	.01	.93	-1.70	.07	.86
<i>General</i>							
Order	68	-.76	-.49	.49	-1.86	-.28	.78
Stress 1st	51	-.67	-.20	.57	-1.82	.16	.86
Neutral 1st	82	-.71	-.36	1.27	-2.00	-.55	1.50
Overall	133	-.69	-.30	1.00	-1.23	-.29	1.23

and positively with intrusion levels. For emotional stress, the correlation was  $r = .39$ ,  $p < .01$ , and for physical stress,  $r = .34$ ,  $p < .01$ .

## Mixed Affect Experiment

The previous series of experiments indicated that the tendency toward intrusive thought is general in that it occurs even after the mild to moderate stress of seeing a silent film and is thus not restricted to traumatization or overwhelming stress. However, the theme of each stress film used was one of bodily-injury, a topic usually evoking fear.

Though fear is highly relevant to the concept of stress and trauma, it is a specific and limited emotion. If intrusive repetitiousness is a general response tendency, it can be expected after the arousal of other types of tension-evoking emotion associated with other sets of information.

To test this hypothesis, four stimulus conditions were used to evoke fearful, sad, aroused and comparatively neutral states. To maintain coherence with

the previous series of studies, equivalent designs and measures were used. It was predicted that the three affect arousal states all would lead to intrusive and repetitive thought, and that these responses would be significantly greater than those resulting from the comparatively neutral stimulus.

## Methods

### DESIGN

The subjects were drawn from the same population pool. They were ranked for emotional responsivity according to pretest data on their usual responses to horror, pornographic, and tragic films. Following their ranked order, they were evenly assigned to view films depicting either the separation of a small child from his parents, nude erotic interactions, bodily injury, or the neutral film used in the previous experiments. After collecting the data, as described earlier, the subjects were informed of an investigator's interest in qualities of thought and were taught how to rate themselves retrospectively for frequency and intensity of intrusive and repetitive thought. The data were analyzed according to the particular film stimulus. There were eight film showings, two at each of four experimental sessions. The order of films was rotated. For example one of the four films was shown as the first film during one session and as the second film during another session.

### FILMS

All of the films were silent and edited to run between six and nine minutes. The woodshop film provided the bodily-injury stimuli, the runner film was, of course, the neutral stimuli. For a separation theme, *John*, a documentary (Robertson and Robertson, 1969), was edited to depict an 18-month-old boy whose mother had just died. His father places him in a foundling home and makes occasional brief visits. The film portrayed John's initial gregariousness; his subsequent angry, crying, and searching behavior; and finally, his lethargy, despair, and withdrawal. There were poignant close-ups of his facial expressions, some as he is rejected by his father, but no shocking scenes such as in the other negative affect film. The basic theme to viewers of this film was the threat of abandonment by an attachment figure.

The erotic film depicted a loving heterosexual couple enjoying foreplay and intercourse. The film held no hints of perversion. The erotic arousal in this group film setting is supplemented by activation of voyeuristic-exhibitionistic themes, which increases tension and was regarded as stressful.

## SUBJECTS

The participants were 75 health science students.

## DATA ANALYSIS

The direct means for each subject, derived by averaging the scores given by three judges, were used to analyze the mental content data, as the word length of reports was noted to be consistent among the subject subgroups. Analyses of variance were used to determine the possible significance of film order, and gender of subject effects. T-tests were used to examine the significance of differences among particular cells of data.

# Results

## FILM EFFECTS

As predicted by the main hypothesis, intrusions and film references were high after the erotic, separation, and bodily-injury films. As apposed to after the neutral film the intrusions and film references were low. This variation in films contributed the main effect, according to an analysis of variance (see Tables 4.3 and 4.4).

The bodily-injury film, least evocative of intrusions of the three stress films, differed significantly from the neutral film ( $t = 3.5$ ,  $df = 78$ ,  $p < .001$ ). The greatest differences among the three stress films was between the separation film (more intrusions) and the bodily-injury film (fewer intrusions), but this difference was not significant. The stress films did not differ significantly for film references. The lowest film reference scores after a stress film were also those after the bodily-injury film. This level was significantly higher than that noted after the neutral film ( $t = 2.47$ ,  $df = 78$ ,  $p < .02$ ). People with high levels of intrusions had higher levels of film references after the separation film ( $r = .61$ ,  $p < .01$ ), the bodily-injury film ( $r = .49$ ,  $p < .01$ ), and the neutral film ( $r = .36$ ,  $p < .05$ ) but not after the erotic film ( $r = .16$ ,  $p = \text{NS}$ ) (see Table 4.5).

## AFFECTS

The data on affects conform to what one would expect from the different themes of the films. In analyses of variance, the film effects dominated and were highly

**Table 4.3 Intrusions: Analysis of Variance and Means by Gender and Film**

<i>Source of Variance</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P</i>	
Order (1st or 2nd)	1	6.01	2.24	.14	
Sex	1	8.93	3.33	.07	
Film (Content)	3	18.31	6.82	.0003	
Sex X Film	3	3.91	1.46	.23	
Film X Order	3	4.39	1.63	.18	
Between S's Error	134	2.68			
COMBINED MEANS					
	<i>Erotic</i>	<i>Neutral</i>	<i>Separation</i>	<i>Injury</i>	
Males	1.68	.62	1.42	1.58	1.27
Females	1.98	.68	2.98	1.74	1.83
	1.81	.64	2.23	1.65	
NUMBER OF PARTICIPANTS					
	<i>Erotic</i>	<i>Neutral</i>	<i>Separation</i>	<i>Injury</i>	
Males	22	27	15	20	84
Females	17	17	16	16	66
TOTAL	39	44	31	36	150

**Table 4.4 Film References: Analysis of Variance and Means by Order and Film**

<i>Source of Variance</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P</i>	
Order (1st or 2nd)	1	49.54	2.74	.10	
Sex	1	25.02	1.39	.24	
Film (Content)	3	81.99	4.54	.0046	
Sex X Film	3	14.03	.78	.51	
Film X Order	3	44.02	2.44	.07	
Between S's Error	134	18.06			
COMBINED MEANS					
	<i>Erotic</i>	<i>Neutral</i>	<i>Separation</i>	<i>Injury</i>	
Order 1	3.94	3.16	5.32	3.12	3.80
Order 2	5.92	1.50	6.28	6.24	5.00

significant for every affect ( $p$  values < .0001). Pleasantness, interest, and happiness were greatest after the erotic film. Sadness and anger were greatest after the separation film, and contempt was rated equally high for the bodily-injury and the separation films. Fear, nervousness, physical sensations, pain, and disgust were greatest after the bodily-injury film.

Correlations of selected individual affects with levels of intrusions after the separation film were positive between intrusions and sadness, greater than that of

**Table 4.5 Correlation of Content Analysis and Self-Report Variables**

CONTENT ANALYSIS VARIABLES	SELF-REPORT VARIABLES					
	<i>Frequency of Non-deliberate Film Repetitions</i>			<i>Intensity of Non-deliberate Film Repetitions</i>		
INTRUSIONS	<i>Erotic</i>	Separation	Injury	<i>Erotic</i>	Separation	Injury
Erotic	.32 <sup>a</sup>			.42 <sup>b</sup>		
Separation		.62c			.49 <sup>b</sup>	
Bodily Injury			.71c			.68c
FILM REFERENCES	<i>Erotic</i>	Separation	Injury	Erotic	Separation	Injury
Erotic	.25			.15		
Separation		.60c			.47 <sup>b</sup>	
Bodily Injury			.54c			.36a

<sup>a</sup>  $p < .05$   
<sup>b</sup>  $p < .01$   
<sup>c</sup>  $p < .001$

**Table 4.6 Frequency and Intensity of Film Repetitions by Self-Report: Group Means on a 1 (Low) to 9 (High) Scale**

<i>Film Type</i>	<i>Erotic</i>	<i>Neutral</i>	<i>Separation</i>	<i>Bodily Injury</i>
Frequency of Repetition	4.23	2.06	3.77	3.75
Intensity of Repetition	4.38	2.11	4.06	4.03

any other affect. Intrusions after the bodily-injury film correlated positively but not significantly with reports of nervousness and physical sensations during the film. Intrusions after the erotic film also correlated positively and significantly with physical sensations, happiness, and nervousness.

## SELF-REPORT OF INTRUSIONS AND REPETITIONS

The self-ratings of involuntary film repetitions during the signal detection task, and the intensity of these repetitions, were significantly affected by the kind of film seen before the task ( $F = 4.15$ ,  $df = 110$ ,  $p < .008$  for repetitions,  $F = 4.87$ ,  $df = 110$ ,  $p < .003$  for intensity). This difference was due to the mild effects of the neutral film, as opposed to the films evocative of strong emotions, as shown in Table 4.6.



## Conclusion

The tendency toward intrusive and repetitive thought after stressful events, as observed in clinical and field studies, was also observed in experiments. Both the field and experimental studies supplemented the clinical understanding by showing that the tendency is a general one, found across divergent populations. The experimental studies also revealed another aspect of the generality of this pattern. Intrusive and repetitive thoughts usually occurred after stress that varied in the type of emotional tension that was aroused and in the intensity of that emotion ranging from mild, to moderate, to severe. The more stress, the higher the rates of reports of intrusive conscious experiences.

Part II

# GENERAL THEORY OF SYMPTOM FORMATION



## CHAPTER 5

# Explanation of Symptom Formation

Traumatic stress exerts its far-reaching effects on many levels of human functioning, including thoughts, emotions, bodily responses, memory, and unconscious beliefs. Modern theories of stress response stem from psychodynamic and cognitive neuroscience theories. This chapter presents an integrative theory.

## Phenomena to Be Explained

The findings from the clinical, field, and experimental studies can be summed up as a list of psychological observations to be explained by our theory.

1. Although people vary in resiliency there is a general tendency to develop more symptoms as stressors multiply or intensify.
2. General response tendencies may appear after a variety of stressful events differing in quantity and quality.
3. In some people, deflections from usual conscious experiences and social functioning capacities persist long after termination of the external stressor.
4. In some people, symptoms begin only after an interval of apparent restoration of calm.
5. One of the main symptom observations is: intrusive repetition of the stressor event, related perceptions and associations in thought, emotion, visceral hyperactivity and/or behavior.
6. A set of related but antithetical responses, including: conceptual denial or disavowal, emotional numbness, and behavioral blunting is also frequently noted.
7. The seemingly paradoxical stress response tendencies of intrusion and avoidance are inclined to occur in temporal phases.

## General Phasic Tendencies

Phases may overlap, and people may vary in their entry into, and emergence from a given phase, as well as in the sequence and termination of phases. In abstracting a general stress response tendency from a wide range of variation in individuals and kinds of stress events, the stages approximate the following:

1. Phase of initial realization that a stress event has occurred, often with a sharply accelerated expression of reactive emotion.
2. Phase of denial, numbness, avoidance and/or inhibitions
3. Mixed phase of denial and intrusive repetition in thought, emotion, and/or behavior.
4. Further ideational and emotional processing, working through, and acceptance leading towards equilibrium and reduced intrusions, avoidances, and hyper arousals.

## Early Explanations of Symptom Formation

Freud (1920) hypothesized that traumas occur when excessive stimuli overwhelm the mind. The person's intense fear overloads the mind, subsequently leading to easily triggered anxiety attacks. To moderate overwhelming affect, the individual might utilize unconscious processes that could involve both inhibitions and facilitations of representation. Modern fear-circuitry sensitization hypotheses concur with such early concepts.

Freud conceptualized a feedback loop. Suppose that there is a continuous perceptual sampling of an ongoing external stress event and that the degree of processing of this information can be regulated. The degree of emotional modulation, in turn, depends on the magnitude of aroused emotions such as fear.

As the information input from a trauma memory increases, negative emotions such as anxiety also increase. These emotions signal that the news of threat does not match up well with existing security operations to protect the self and others. Such emotions can motivate a person to focus more attention on the implications of the trauma memory and how to cope with these implications.

The intense, incipient emotions encourage an increase in defensive inhibitions, and these reduce information processing. This down-regulation of emotional arousals may result in affective numbness and behavioral blunting.

If anxiety decreases as a result of these controls, the emotional motive for modulation also decreases. With less modulation there is then more information

processing and so the anxiety or other emotional arousal increases again. The result can be an adaptive oscillation leading towards a dose-by-dose assimilation of bad news.

## Emotional Information Processing Theories

After experiencing a severe stressor event, a typical adult person will have a triangulation of three motives for thinking, feeling, communicating, and acting: He or she will aim 1) to understand stimuli and plan responses, 2) to restore personal safety and to feel and share positive social emotions, and 3) to regulate emotional arousal so as to stabilize a sense of self-competency within states of mind.

Lazarus and Folkman (1984) emphasized the importance of the apex of that triangle of motives: cognitive appraisal and reappraisal in planning the best ways of coping with threat. They considered emotions as responses to cognitive operations, as did Beck (1976) in forming a theory of techniques for cognitive behavioral treatments.

In this cognitive control of emotion theory, a person views environmental cues as threatening or nonthreatening through primary and secondary appraisals and reappraisals. The degree of threat appraised and reappraised leads to variations in consciously felt and socially reported emotions such as fear, anger, depression, euphoria, and elation. Tomkins (1978) and Ekman (2003) viewed such emotions as ways of increasing motivation to respond to threats.

Lazarus explained that secondary appraisals compare the threat with the coping resources of society and the capacities of the self-system. Several reappraisals of threat would occur cognitively to see whether it exceeds the coping capacity. The discrepancy between the degree of threat and the available coping capacity thus accounts for the emotion activated. An initial emotional response such as fear or anger may be reduced when a benign reappraisal of threat is made through processing.

Janis, another early investigator of psychological response to stress (Janis, 1958, 1962, 1967, 1969; Janis and Leventhal, 1968; Janis and Mann, 1977) agreed with Lazarus on the importance of cognitive processing but placed greater transactive emphasis on emotions as motives.

Janis studied distinctive motivational properties of what he called “reflective fear.” The word *reflective* indicates that both threat and information from cognitive processing affect the magnitude of this kind of emotional response to danger. When aroused, reflective fear can lead to three modes of adjustment of the stress state. Janis called these adjustments 1) increased vigilance, 2) exaggerated reassurance as a kind of denial, or 3) fusions into a compromise of vigilance to threat and the blanketing effects of reassurance

The perceived need for increased vigilance increases external alertness and also amplifies cognitive processing of possibly relevant internal associative information. The result can be adaptive coping but increased vigilance can also lead to the exaggeration and misinterpretation of cues and unwarranted increases in reflective fear, even to alarming and unnecessary startle reactions. Needs for soothing may motivate thought processes or actions like the proverbial ostrich that puts its head in the sand to “hide” from predators.

These soothing operations can satisfy the second part of the triangle of motives, which includes aims at positive social emotions. However, excessive reassurance and security of attachment needs can lead to “blanket reassurance,” which is a maladaptive level of unrealistic complacency. In extreme forms the reassurance needs lead to states that contain elements of denial, numbness, depersonalization, or derealization.

The difference in Janis’s emphasis on emotions as motives and Lazarus’s emphasis on emotions as responses to cognition can easily be resolved. That is, emotions, thoughts, and controls all interact in terms of multiple types of memory and parallel processing systems. Emotions are responses to thought processes, and are represented and examined by cognitive processes. The contemporary model is transactive; that is, pathways include forward and feedback connectivity. In parallel processes, various controls regulate intensity of excitations, leading sometimes to overcontrol and sometimes to undermodulation, as well as to working states in which the information can be processed optimally.

## States of Mind and Person Schemas Theory of Trauma Story Processing

An emotion such as fear signals a mismatch between actualities such as a firestorm, and expectations of being as usual in a safe setting. The mismatch and feeling state at a lower level of brain processing activates higher-level appraisals and planning for action. Levels of emotion signal the type of mismatch and may themselves act as conscious recognitions of bodily sensations, such as “butterflies in the stomach” or “weak knees.” These sensations may increase associations to memories related to similar bodily-sensory states (Horowitz, 1976, 1988, 1998; Van der Kolk, 1994).

Memories of emotional experience are, by the nature of the evolved mind of human beings, projected into the future as desired pleasures or, in stress response syndromes, fearful dreaded anticipations. Review of these memories can lead to a gradual increase in the understanding of the meanings of a major life event until the memories become part of a personal life narrative.

To recapitulate, in states approaching extreme emotional arousal, inhibitory controls may be activated. One result constricts the associational width of ideational processing. The reason for this heightened control lies in part in motives to avoid accelerating disruptions from hyperarousal and so avoid entry into panic states. Ehlers and Clark (2000) also theorized that a negative cognitive appraisal of the self, others, world, and trauma sequelae leads to a maladaptive feedback loop of avoidance that drives PTSD symptoms. Negative appraisal often involves seeing oneself as damaged, weak, out of control, or deserving of punishment; moreover, the world may be evaluated as unsafe and one's social support network as overbearing or abandoning.

For instance, a trauma-generated negative belief such as "No one understands how I feel and no one is there for me" may encourage the victim to socially withdraw, hence depriving them of needed social support and foreclosing a possibility of revising such belief. This belief can also cause feelings of depression, loneliness, and isolation that often accompany PTSD.

Another aspect of Ehlers and Clark's theory is the nature of trauma memories and a sense of a current threat. The nature of trauma memories may contribute to persistent symptoms rather than remedial processing and recovery. This may be because traumatic memories often lack coherence and elaboration, and also do not fit into the time and place context of the trauma victim. Such memories may suddenly intrude only as sensory experiences and fragments of traumatic experience. The re-experiencing symptoms have a sense of the trauma happening all over again in the present moment.

States, schemas, and emotional information processing theory is consistent with the cognitive behavioral explanations of Foa (1993, 1995, and 1996), who based her theories on Pavlov's (1941) and Skinner's (1968) theories of classical and operant conditioning. Foa describes a "fear structure" that consists of stimuli during trauma, responses during trauma, and meanings about self and the world constructed as a result of trauma. Fear structure is linked together with an associative network and drives the victim to avoid any of the elements associated with it. Such avoidance impedes recovery and is a target for change in exposure treatment techniques.

## The Role of Action

Action is the prototypic terminator of stress states because action changes events. The knight who slays an attacking dragon terminates the threat. He also changes the state of his own rage and rage-action plans as activated by the effrontery of the dragon's attack. The knave who runs faster than the dragon can also cancel the stress of the attack and discharge (or change) his fear and fear-action plan. In either case, successful action terminates the stress event.



Emotions such as fear of the dragon or rage at it also are reduced by successful action. Such termination of states of emotional appetite can be conceptualized in two ways. An evolutionary psychology view is that there is a discharge of aroused emotions through action. With the evolution of consciousness as trials of action that can be compared and contrasted for efficacy, a reduction of mid-brain-aroused emotions may occur because of the completion of a successful plan for coping, that is a kind of script, and by a modification of schematized belief structures, or cognitive maps.

Eventually, identity itself may need to change in order to accord with new realities and acquisition of new coping skills. Acting in accord with new competencies in a later phase of rebuilding the self-action is needed to repeat and make automatic such new, adaptive self-concepts.

## The Need for Completion

I find it useful to think of a person's need to match new information with inner subconscious belief models based on older information, and the revision of both until they agree, as a *completion tendency*. My focus on a post-stressor completion tendency is not new. Festinger (1957) described similar forms of cognitive processing as part of a need to reduce *cognitive dissonance*. Mandler (1964) observed a completion tendency and a tendency to even intrusively repeat interrupted behavioral responses. After an organized response system has been interrupted, it usually resumes later and continues until the initial plan has been completed (Miller, Galanter, and Pribrum, 1960). Script theory and parallel distributive processing theory elaborate this point of view (Schank and Abelson, 1977; Rommelhart and McLellan, 1984). As mentioned, contemporary PTSD theorists such as Resnick and colleagues 1992; Foa, 1995; Ehlers and Clark, 2000, described similar processes, the reconciliation of information from before and after the trauma, as one of the curative elements in their therapies.

### ACTIVE MEMORY AND THE COMPLETION PRINCIPLE

The completion principle describes the human mind's intrinsic ability to continue to process new information to update inner schemas of the self and the world. News from within the trauma memories needs to be matched with existing cognitive categories and maps. When a match is reached, by revising appraisal of the news and by revising the previously enduring schematizations within the mind, completion can be said to have occurred. Repetitive and intrusive re confrontation with fragments of a trauma memory or story can then diminish or stop.

Psychic models are now in accord with current reality and these internal working models can guide decisions toward the next most effective possible actions.

After deaths, personal injuries, and other serious life events, beliefs about and schemas of self, relationships, and other aspects of the personal world must be revised. Such processes require considerable cognitive change and extended time for the necessary information processing, and therefore, the point of completion cannot be achieved at once.

In addition, every recognition of the discrepancy between the new state of affairs and the inner habitual model may bring emotional responses that are sufficiently painful so as to interrupt the information processing necessary to reach the completion point. Until completion, we assume that there is some type of memory that retains the important but incompletely assessed set of memories, ideas, and feelings.

#### REPETITION OF REPRESENTATION AS A PROPERTY OF ACTIVE MEMORY STORAGE

A key assumption is a type of memory for information tagged in the brain as "highly important." These memories have motivational properties that instigate the next step in processing by repetition in conscious representational systems. The evolved adaptive function of such active memory properties would be to use conscious processing as a special tool for appraising very difficult topics of high concern to survival and stability of self and attached others. Because of this intrinsic "active" property, contents tagged in this type of memory storage will repeat until "completion." This repetition will cease when the contents held in active memory have been terminated by a matching between external reality and internal expectations, intentions, cognitive maps, and schematizations of self-in-the-world.

Active memory storage, with a tendency toward repeated representation in thought, is contrasted with inactive memory. *Active* and *inactive* memory can also correspond to current usage of the terms *short-term* and *long-term memory*, respectively. But the term active memory is preferable here to short-term memory because intrusive stress-event recollections may occur for a long time. This assumption of an active memory with special properties of recurrent representation is compatible with experimental findings in the fields of perception, attention, and memory. For example, Broadbent (1971) and Posner (1993) summarized this research and developed models of several forms of short-term memory that occur after sensory registration and before transformation of information into several types of long-term memory, including procedural and declarative memories.

Broadbent describes three kinds of short-term memory. One is a “buffer storage” that holds images for a while after the sensory registration ceases. The second is a “rehearsal buffer” that retains important images for longer periods than does the rapid decay of information in buffer storage. The third is “primary memory by slots” in which certain memories remain in a kind of active information bank. It is of greatest relevance to our formulation that information is retained in the primary memory slots until it is terminated by replacement with other, presumably more important, information. Stress-related information is, by definition, very important and hence is not terminated until it is assimilated.

Active memories include conditioned association between stimuli and threat response. They are also processed so they articulate with declarative as well as procedural knowledge. Extinction of conditioned threat responses would occur as completion was reached, that is, as articulations led to integrations. In that sense, working through a stressor event would involve many finer-unit linkages that were desensitized because a “normal” slow extinction process was enabled.

## TAGGING OF TOPICS OF CONCERN

The recurrence of a familiar nonstressful event is likely to be quickly and automatically assimilated. The cognitive processing will be completed, and the information in active memory storage will be rapidly terminated. The information in novel and stressful events, however, cannot be processed rapidly. It remains as a topic of concern to the self. Until relative completion the topic remains in active memory.

Assuming a limited capacity for processing, such codings will remain stored in active memory even when other programs (those used for processing other sets of information) have greater priority in the hierarchy of claims for the brain’s information processing channels. These actively stored contents, however, will generally be repeatedly represented. Each episode of representation will trigger a resumption of processing. Thus, whenever this set of information achieves a high enough priority, representation and processing will resume. If the contents are interrupted by controls that regulate priorities, they will remain in coded or “tagged as important to review” in active memory.

## INCONGRUITY

Completion requires the resolution of differences between new information and the enduring mental models. Thus, news of the death of a loved one is incongruent with an entire world picture that includes not only wishes and hopes but also

habits and routine roles and self-images. Cognitive processing is reinitiated when unprocessed memory representation occurs.

Every repetition is a confrontation with a major difference between what is and what was. When, as preconsciously appraised, emotional responses are likely to increase beyond the limits of toleration, controls are activated that will modify the topic of attention and the cognitive processes used to move it towards completion (Horowitz, 1998; Horowitz and Znoj, 1999). This reduction in processing reduces anxiety and, in turn, reduces the motivation for controls. With the reduction in control, the tendency of active memory toward representation then reasserts itself. Intrusive experiences of consciousness of fragments of the trauma story may then occur.

With each "on" phase of information processing, more and more alterations of inner working models and plans for adaptive action are accomplished. This process continues until completion. With the relative completion of information processing, the cycle terminates, because the relevant contents are cleared from active memory storage. The "new" information has now been integrated with the inner mental models and organized memories.

## UNCONSCIOUS INFORMATION PROCESSING

One aspect of the processing of traumatic perceptions and memories can be conceptualized as a series of matchings of present appraisals and preexisting attitudes. For example, new stimuli are matched with expectancies based on current needs or fears; new information about the world is matched with schematic representations of the world; current body sensations are related to body images; images are matched with relevant labels such as words; new demands are matched with available coping strategies; and so forth. This involves largely unconscious information processing.

When there is not an immediate good fit between the new information and the existing schemas, further information processing is instigated. Conscious thinking may then be used for its very special properties of rational problem clarification and problem solving. This work involves, usually, a combination of modification of meaning of the recently acquired information and/or to progressive modifications of the preexisting expectations or attitudes. This processing for fit leads to a series of approximating representations of the stress event and the relevant schemas.

When there is a limited channel capacity for processing and when these channels are "claimed" by problems with greater priority, then the progressive series of representations that do not yet "fit" together are stored in active memory. This set mixes information from the life event with preliminary associations

to it. This topic of concern will be represented again when it has relatively high priority—for instance, when it is associatively triggered, primed, or when more urgent business is finished when the driver of a car finds a place to stop after calmly driving through a nearly disastrous accident, then reconsiders the events and only then has a sense of panic.

## THE MEANING OF A TRAUMATIC EVENT TO THE SELF

A single traumatic event may set in motion several trains of thought and feeling. It may help to label each of these several topics of concern. This process can help break down the overwhelming experience in pieces that are tolerable to contemplate, dose by dose. Each topic may also be interpreted somewhat differently in the psyche, depending on which of several potential self-schemas is most active in organizing a conscious and communicated train of thought. In other words, each aspect of a trauma story may be associated, in different states of mind, with different constellations of memories, personal agendas, and schemas of self and relationships.

The matching between inner sets of organized meaning and the traumatic event may lead to varied emotional states. Some states may be overcontrolled, as in denial/avoidance phases; some states may be undermodulated, as in intense pangs of emotion and unbidden image flashbacks. A specific traumatic event may lead to an appraisal of the self as being strong enough to cope in some states of mind or too weak to cope in other states of mind. Gradually, as the memories are assimilated, a more harmonious sense of self-competence will hopefully return and will possibly be even further developed through post-traumatic growth.

A traumatic event or a cascade of events might also be associatively linked to previous themes of personal blame. This can activate usually latent schemas of the self as a bad person. The strong emotion of guilt and shame or self-disgust might result from the thought of the traumatic event. To reduce guilt, the processing of the given theme might be interrupted.

Anticipation of once-experienced emotional states is a part of unconscious thinking. The person may have learned to interrupt processing of themes that lead to emotional states that once felt particularly out of control, overwhelming, and unbearable. Although such interruption may prevent entry into intrusive, emotionally flooded states of mind, it also prevents completion of the work of integrating the stressful life event with its meanings to the self.

Some themes may be worked through relatively completely at a given time; other themes may be warded off and hence left unprocessed. In the latter case they have a “dynamic unconscious” property: they are preserved in active memory, and tend toward repeated representation for further problem-solving types of process-

ing. When they are represented, it may be with an intrusive quality. When inhibited, a sense of numbing and avoidance may be present, or denial may be a totally unconscious mechanism without reflection in immediate consciousness.

## Retrospective Traumatization

In Complex PTSD, we sometimes see retrospective traumatization. The typical event is sexual molestation of a young child by an older domestic figure. At the time the actions may feel loving and affectionate, rather than rape-like, or the self may be dissociated from experiencing what seems dream-like but was actually real. Later, realization of the wrongness occurs and the memory becomes “traumatic,” that is, overwhelming.

## Explaining Intrusive Symptoms

The entry of traumatic memory into conscious awareness may be experienced as intrusive for several reasons: the association of the thematic content with the threat and emotional pain of the states of mind during the traumatic events, the unusual vividness of representations derived from memories and traumatic perceptions, the intuitive knowledge that the representational process has been opposed by inhibitory controls, and the emergence of topics of concern seemingly unconnected to the immediate focus of deliberate attention. Despite the experience of intrusiveness, however, the end result may be adaptational, because the processes initiated by the conscious representation may lead to revising the automatic processing of such information, to the revision of the relevant schemas, to inventing new solutions, and to completing the processing of the stressful information.

## Change Processes Facilitated by Psychotherapy and New Experiences after Trauma

In trauma-focused psychotherapy, we use attentional change to stabilize overwhelmed states and still engage aspects of the trauma story. The interventions of the therapist establish a safe relationship and then reduce avoidances and inhibitions. The active discrepancy between the new trauma appraisal and the patient’s previously enduring schemas will then tend to evoke overwhelming emotions in the patient, but the social connection with a safe supportive figure may provide a container of safety for their contemplation.

Then, interpersonal communication and the patient's intrapsychic conscious contemplations are used as tools for unlearning automatic alarm associations and resolving seemingly irreconcilable conflicts. The result is a better continuity of memories of the traumatic experience with other life memories, and the reintegration of selfhood. The goal, then, is providing security for stabilization of states of mind that are conducive to coping and trauma processing, while avoiding excessive levels of emotional flooding and retraumatization.

In this optimal condition, some intrusiveness will occur with repeated representation, and some denial will occur when the controls operate more pervasively, but the overall result will be adaptive in that the reaction to the stressful life event will eventually be mastered and completed. The schemas will also eventually conform to the new reality, as in completing mourning through a process of grieving well (Horowitz, 2010).

At any given time, different topics of concern within an individual patient may be at different levels of processing. For example, at a given phase of therapy, fear of repetition of the trauma or fear of merger with the victim may be reported as a recurrent intrusive experience, whereas survivor guilt themes may be totally inhibited from conscious experience. In later stages of treatment, the warded-off guilt theme may surface as an intrusive experience.

A psychotherapist will also pay attention to observations and inferences within their own mind about how well the traumatized person is regulating affective representations and expressions. Theory on emotional regulation will help clinicians in making important decisions on how to promote processing but also how to avoid retraumatization through affective overload. One wants the traumatized person to increase coping capacity, not succumb further to stress.

## Emotional Regulation: Processes and Outcomes

Emotional regulation is a largely unconscious mental process but it is also strongly influenced by social context, biological capacities, and conscious intentions in the current moment. A patient with a stress response syndrome will have a greater capacity for regulating feelings when discussing a stressor event with a therapist if that patient is rested in terms of brain functional capacities, if there is a strong therapeutic alliance, and if the patient intends to contemplate the impact of the events on the self. On the other hand, if it is in the middle of a sleepless night, when alone at home, and if the patient desires only escape from the finality of certain events, then thinking of those events can lead to unregulated storms of emotion and disorganized thinking about what to do about the whole situation.

In other words, deploying attention towards or away from addressing the incompletely processed emotional meanings of a traumatic event can have good or bad outcomes in terms of the health value of adapting well. A good outcome is coping by rational planning based on realistic appraisals. A bad outcome is succumbing further to the stress induced by the traumatic events, as might be evidenced by strange amnesias for the memories or stormy intrusions of the stressor topics, possibly leading towards further alarm reactivity and more sensitization. In between good and bad are defensive outcomes, the results of compromises which maintain a measure of calm but may limit the accuracy of appraisals of what it all means to the self.

For the above reasons, theory of emotional regulation as it relates to the recent stressor experiences is both important and one of the current frontiers for advancing knowledge about stress response syndromes. To enable clinicians to observe carefully patterns of change towards more coping or more succumbing to stress, I summarize a theory of emotional control discussed in detail elsewhere (Horowitz, 1998). The vehicle will be reported in three tables organized by processes and outcomes.

There are three sequences we may abstract from a coping of such discussion train of thought about an aspect of the trauma story. First, as in Table 5.1, there is selection of the topic to be addressed, the problem that needs to be solved. Table 5.2 deals with the next issue, the question of which respect of the self is working on this problem (e.g., a more competent self or a degraded, victimized self). Then, in Table 5.3, the issue is organizing the sequence of problem solving thought.

To repeat, after selecting a dose of the trauma story to consider, that topic will be organized by issues in the background, the continuity of selfhood over time (this involves person schemas as organizing cognitive maps that affect emotionality). The third step of coping then deals with how a topic and the attendant self-views are contemplated in sequences of beliefs.

## ATTENTION: SELECTING THE TOPIC AND MODE OF THOUGHT

Table 5.1 concerns the present state of mind in terms of mental set, meaning how the person intends to examine trauma memories and related worries. While the patient is working through serious news, such as a sudden death of a loved one, any of several related topics may be inhibited or facilitated, resulting in the experience of time on and time away from considering that topic of concern. This attention control operation can lead to coping experiences, to defensive avoidances, and relative failures of emotional regulation can lead to symptoms that represent succumbing to stress.

Another type of intentional set involves a selection of time frames to consider. One such operation is separating into long or short segments for planning



how to cope. Extremes of such controls are common during responses to serious life events. One frequent end result is concentration on extremely short time intervals as a person handles a seemingly overwhelming situation by breaking it down into a series of steps, dealing with them one at a time, and describing only what should be done in the next minute or two, or by taking things “one day at a time.” Another common response is to scan unusually long sweeps of time in order to place a bitter moment of suffering into a stretch of time that allows it to pale in significance.

Another control over organizing stress-related information is selecting a sequential set. This sequential set determines the kind of flow from one bit of information to another. For example, problem solving is a mode in which bits of information are arranged by principles of logic and by fidelity to real probabilities. A quite different set is used in fantasy or dreaminess in which the next bits of information can be associatively linked by hopes and wishful, magical thinking.

Control of representational set is another way to modulate expression of emotions. These controls determine whether the flow of information will proceed in lexical, image, or enactive (motoric) forms. By using such controls, some people think back on a serious life event, such as a car accident, only in words, and block memory images to avoid emotional arousal from quasi-perceptual thought. Such operations help coping and also lead towards rationalization and intellectualization. Some control operations set the locus of attention such as the search for internal or external sources of information. The end results may be a successful search for relevant external information that also wards off the internal, memory-generated feelings that will emerge when personal implications are contemplated. These aspects of emotional regulation are shown in Table 5.1.

## CONTROLLING THE ORGANIZERS OF INFORMATION PROCESSING

Controls select which of a person’s several possible self-schemas will organize a series of ideas (Horowitz 1997, 1998, 2005). The results include the various progressions and regressions of identity that commonly occur after serious life events such as the death of a parent. The failure to select or stabilize a self-concept may lead to experiences such as chaotic lapses in identity. Similarly, a person can shift self-schemas leading to a variety of common stress responses, such as either unusually heightened senses of a strong self or a weak degraded self. At the extreme, dissociative experiences may become apparent.

Pre-existing repertoires of self and other schemas affect how a stressor memory will be processed in the various states of mind that follow the apparent end of the external episode. For example, a person with insecure or persecutory attachment patterns may be more liable to test new people in their support sys-

**Table 5.1 Controls of Mental Set**

PROCESSES	SAMPLE OUTCOMES		
	<i>Coping</i>	<i>Defense</i>	<i>Succumbing to Stress</i>
Selection of next topics for thought	Dosing (periods of time on and off topic)	Denial of importance of an important topic	Amnesic states, intrusion of topics
Mode of organization: temporal set (viewing theme by short or longtime orientation)	Looking at only one step at a time, relating the event to a life span	Denial of urgency of threat	Distraught states such as panic
Mode of organization: sequential set (problem solving versus reverie modes)	Thinking only about what to do next, restoring fantasies of lost situations	Workaholism, obsessive rumination and doubting, fantasy preoccupation, faith in unrealistic views	Confusion
Mode of organization: representational set (words, images, muscles, autonomic nervous system, hormones)	Solving problems in words because images evoke too many emotions (intellectual analysis)	Denial of emotional responses to threat, isolation of topics into one mode of representation (words without images, images without words, ideas without emotion)	Emotional flooding
Mode of organization: locus set (external or internal sources of information)	Making restorative changes of activity and contemplation	Compulsive action to avoid thought, fantasy to avoid action	Illusions, hallucinations, felt presences
Activation Level (excitation or dampening various systems, regulating rate of information flow)	Creating cycles of working and resting	Hypervigilance, avoidant sleeping	Exhaustion

tem, to see if the new people might reject or victimize them. In this regard, case formulation will include preexisting personality factors, as discussed in terms of Complex PTSD in Chapter 2.

Person schemas as organizers can change from state of mind to state of mind. Clinical work includes efforts by the clinician to soothe fear and establish trust, to evoke a working state of mind in both patient and therapist. The coping results of such efforts and succumbing to stress are possible outcomes, summarized in Table 5.2.

### **CONTROLS OF IDEATIONAL SEQUENCES TO REGULATE EMOTIONS**

Every clinician has the experience of noting that a patient who has been in a working state, and who is regulating the intensity of negative emotions so as to maintain cognitive organization, may have lapses in which a surge of emotion disrupts rational appraisals and future planning efforts. These lapses do not necessarily imply that an individual is succumbing to stress; the patient can often recover enough equilibrium to restore the working state. The clinician pays close attention to dosing traumatic material and to observing if understanding is increasing and if problem solving is advanced. These are all coping type outcomes. They are related to the signs of succumbing to stress, which warrants a change in techniques, as shown in Table 5.3.

## **Biological Factors Affecting Memory and Emotion About Traumas**

In clinical work with trauma victims it is important that a therapist understand the difference between deficits, which may be biological in nature, and conflicts, which may be psychological in nature (as in the conflict between aims to work through active memories and aims to avoid the emotional arousal that such work will entail). Sometimes a memory is not so much inhibited as it is not recorded. Activation of the neural systems into extremely high arousal or into alarm and shock may interfere with the consolidation of memory traces. This in turn may lead to memory impairments such as amnesias.

Christianson and Nilsson (1987) reported four experiments in which normal and horribly disfigured faces were presented to experimental subjects. Data from physiological measurements and post-experimental interviews indicated that intense negative emotions were aroused by the presentation of the disfigured

**Table 5.2 Controls of Schemas as Organizers of Information: Sample Outcomes**

PROCESSES	<i>Coping</i>	<i>Defense</i>	<i>Succumbing to Stress</i>
Altering which self-schema is an activated self-concept	Heightened sense of identity by using the most competent self-concept in the subject's repertoire of self-views	Omnipotent denial of personal vulnerability, "as-if" self-concepts, regressions to earlier self-concepts	Depersonalization, chaotic lapse of identity, annihilation anxiety
Altering dominance hierarchy of available role relationship models and scripts	Seeking help, sublimation	Dissociations and splitting, passive-dependent expectations	Sensation of helplessness, separation anxiety
Altering dominance hierarchy of available world-views	Increased sense of unity or ideological commitment, altruism, increased sense of reality, sublimation	Altruistic surrender, increased self-centeredness	Sense of meaninglessness or derealization

**Table 5.3 Controls of Ideas and Sequences: Sample Outcomes**

PROCESSES	<i>Coping</i>	<i>Defense</i>	<i>Succumbing to Stress</i>
Controlling Ideas by			
Facilitation	Contemplation of implications	Rumination	Inability to think clearly
Inhibition	Dosing, modulated arousal, selective inattention	Denial, repression, suppression, isolation, numbing, dissociations, use of drugs, flight, or suicide as avoidance	Intrusions and emotional flooding
Sequencing ideas by seeking information	Understanding, learning new skills	Intellectualization	Apathy
Switching among attitudes	Emotional balancing	Undoing	Indecision
Sliding meanings and valuations	Humor, wisdom	Reaction formation, exaggeration or minimization, displacement	Intrusions and emotional flooding
Arranging information into decision trees	Problem solving	Denial by rationalization	Inanition
Revising schemas	Adaptation, identifications, acceptance	Inappropriate role reversals by externalization or introjection	Giving up and hopeless states
Practicing new modes of thinking and acting	Deautomatization of outmoded linkages, automatization of new ways	Counterphobic rehearsals	Lack of preparedness for repetition of threat

faces. Each face was accompanied by four verbal descriptors, and amnesia was discovered for those items associated with the most intense emotional experiences. Various analyses of their data suggested that this amnesia was developed by limited encoding of the memory trace rather than by problems in retrieval or reconstruction. Such limitations on encoding traumatic perceptions probably have a biological basis. Other researchers, in agreement with Christianson and Nilsson, noted the role of excessive cortisol release during trauma, which often impairs memory formation (Ravindran and Stein, 2009).

Other biological factors found in post-traumatic amnesias may be due to head trauma. Even if there are no positive brain imaging findings, the post-concussion syndrome may include general mental deterioration as well as particular memory disturbances.

A third type of biological response may be the disruptions in a relationship attachment to another person, especially when a domestic partner was involved in mutual emotional regulation, as is the case with bereavement. There may be several hormonal and immunological changes, such as in the levels of oxytocin. Such changes in the biological systems can affect psychological capacities and change a person's ability to exert regulatory operations. These involve not only the adrenal cortex and the noradrenergic system of neurotransmitters but other electrochemical messenger systems as well. Facilitations, inhibitions, and disinhibitions may occur at synapses along particular pathways, and the mechanisms may change the configuration of protein molecules in different ways along neural pathways. Telomere-shortening after stressor events can even possibly affect gene activations (a telomere is a region of DNA repetition at the end of a chromosome) (Epel et al. 2004). In other words, hormones may determine which genes in a neuron's nucleus will form the template for protein synthesis. This in turn will affect the vesicles near the synaptic cleft that contain neurotransmitters, and that may affect the synaptic potentials and information transfer (Kandel, 1983; Xie et al. 2009).

The brain under stress may also have an altered functional capacity, but the brain-to-mind connection of such factors is not completely understood. One may speculate that enduring psychological change, as in chronic fear arousal or extended despair, can set in motion a pathological brain state such as depression, which then secondarily impairs the kind of information processing emphasized here. Such factors would be in addition to the concomitant physical effects of certain traumas, such as head concussions during automobile or other accidents, or the malnutrition and sleep loss from some disasters.

People vary in their genetic inheritance and in how their basic neural systems are organized during development. Some people may be predisposed to certain vulnerabilities that are then noted only in situations of stress. Biological predispositions to a "short supply" of certain neurotransmitters, disruptive

alarm reactions, or stabilization of a maladaptive state may be different for those who can work through a stress response syndrome and those who may develop chronic symptoms.

## Summary

Everyone fears the trauma of a capricious disaster. When serious life events occur they can shatter a person's reality, and the inner models of the world that have sustained the person must now be changed to accord with the new situation. Such revisions take time and can be facilitated by social supports, trusted confidants, and psychotherapy. In therapy, natural processes of integration are facilitated. In addition, reschematization and mourning are processes that are encouraged, and that are promoted by the therapy's supportive, safe, and secure relationship itself. These processes that add to the natural tendency to adapt to stressor events by processing information in realistic ways are discussed in the next two chapters on reschematization and grieving well. Then we will reconsider treatment in more detail in all the remaining chapters.

## CHAPTER 6

# Reschematization

Traumatic stress often profoundly affects the unconsciously held organizing beliefs that comprise the fabric of personality. Traumas can cause a shift from a competent to an incompetent self-attribution or self-concept, with concomitant shifts in interpersonal behavior and internal working models of self-other roles. Such shifts are characterized by severely diminished self-esteem and self-confidence, irrational self-criticism, and heightened dependency or help-rejecting self-imposed isolation. The self is experienced as unattractive, and contact with others is avoided to protect against *their* expected rejections. Disturbances in identity and relationships exacerbate symptoms such as intrusive memories, phobic avoidances, anxiety, dissociation, and depersonalization (Ursano et al. 1999).

Such disturbances are reduced as self and other views are reschematized to accommodate new stress-related facts. Such reschematizations can also lead to positive changes (Updegraff & Taylor, 2000; Bonanno, 2004; Joseph & Linley, 2005). We know that in spite of stressors, some resilient children can grow to their full potential (Cryder, Kilmer, Tedeschi, & Calhoun, 2006; Garmezy 1985; Rutter 1987). Stressful events in adulthood may be followed by a period of disequilibrium but can lead to a higher level of maturation than was present before the event (Cryder et al. 2006; Calhoun and Tedeschi, 1990; Pollock, 1989; Taylor, 1983).

Growth as a response to stress may occur when people are able to reach new levels of adaptation with respect to the personal meanings of the dire events (Aldwin et al. 1996; Antonovsky, 1987; Horowitz, 1997b; Park et al. 1996; Tedeschi et al. 1998; Littleton, McGee, & Axsom, 2007). This process involves giving up outmoded concepts, accepting the realities of the post-traumatic existence, and drawing upon strengths—both their own, and those within their



social context or community (Epstein, 1992; Horowitz et al. 1984a; Lazarus and Folkman, 1984; Linville, 1987).

In addition, some adult traumas reactivate childhood traumas. Adaptive change after the adult trauma achieved by effectively working-through can repair the prior damage and aid in self-reorganization (Horowitz, 1998). This self-reorganization can result in an increase in self-esteem and a decrease in ambivalent attachments when compared with the pre-trauma personality.

The following case histories illustrate post-traumatic shifts in identity. The cases of Harold and Jennifer illustrate a comparatively mild shift, and the case of Sophia, a major one.

## Harold

While traveling on business in another country, Harold, a heterosexual Japanese-American imports manager, and his wife escaped a hotel fire with minor smoke inhalation injuries. Their schedule was disrupted and Harold and his wife agreed that she would return home at once while Harold rescheduled local appointments.

Five days later, in the midst of work, Harold felt unreal and numb. He became extremely talkative, and attention seeking with the women he encountered in the business world, which was out of character for him. That night he awakened from a nightmare screaming “Mommy, mommy.” The next day he felt tense, anxious, and had a sense of chaos about his life roles. He canceled his business appointments, flew home, and sought professional help.

Upon evaluation, Harold had intrusive memories of the fire, of seeing his wife off at the airport, and of being embarrassed by his inappropriate encounters with businesswomen. He felt phobic and avoided planning future business travel even though his work depended upon it. He had chronic tension and episodes of hyperventilation. In case formulation it was decided to focus brief therapy on how and why the fire and its sequelae led to an activation of maladaptive latent self-concepts. These included feeling like a needy, dependent boy requiring maternal attention, and feeling abandoned without it.

The therapeutic task of restoring equilibrium was rapidly accomplished. Harold had fewer intrusive, avoidant, and hyperarousal symptoms but he still felt vulnerable and lacking in his usual verve and self-confidence. Additional therapy sessions then focused on his relationship with his wife. This work increased his sense of self-confidence and identity coherence and enabled him to engage more closely with her than he was able to before the event. He recovered all of his pre-traumatic functional levels and felt even better about his capacity for intimate affiliation.

In the case of Harold, the trauma was minor as compared to the next example where a cascade of traumatic results was experienced due to an unfortunate accident.

## Jennifer

Jennifer, a 34-year-old Caucasian heterosexual female attorney, was raped by a senior male colleague while on a business trip. After a social outing where they both drank alcohol, the colleague asked Jennifer to come into his hotel room to discuss business and there sexually assaulted her. The next day, the perpetrator, with whom Jennifer had a friendly relationship prior to the sexual assault, acted as if the sex was consensual and asked Jennifer not to tell anyone, appealing to their “friendship” and alluded to them both being fired if she did.

Jennifer reacted to the rape with a great deal of confusion and self-blame. When she came in for a medical exam two weeks later she was referred for therapy. It became increasingly difficult for Jennifer to see the perpetrator and other men at work on a daily basis. Moreover, her ability to focus at work was very impaired and she experienced strong feelings of fear, shame, and profound confusion, as well as a desire to isolate herself in her apartment.

Upon the initial evaluation, Jennifer had difficulty sleeping, making decisions, frequently dissociated, felt afraid and unprotected, and thought almost constantly about the rape, ruminating on what led up to it and what role she played in it. Moreover, Jennifer presented as vulnerable and dependent, which was a stark departure from her pre-trauma confident, assertive, and independent demeanor as a successful lawyer. As therapy continued, Jennifer asked for, and received, sick leave from work and was hence able to fully focus on healing.

The initial focus of Jennifer’s therapy was discussing who was to blame for her assault. The therapist gently countered Jennifer’s self-blaming cognitions by facilitating a realistic reconstruction of the trauma story and a new assessment of the cause and effect of its events. This functioned as validation of her distress and confusion. Jennifer’s sense of injustice quickly grew, and she expressed anger at the perpetrator for betraying her trust, traumatizing her, and manipulating her into silence. Her guileless and nervous presentation shifted into a more appropriately angry and assertive one in the therapy room.

Jennifer also remembered an incident from her past, where at age 16 she experienced a wounding betrayal by a best friend, Sarah, who suddenly began dating Jennifer’s boyfriend. Sarah told Jennifer, when the situation was revealed, that everything was fine because they were still friends. Jennifer never fully labeled the incident as an outright betrayal and was left feeling confused; she even continued the friendship for a while longer, convinced that she was partially

responsible for losing her boyfriend's affections. A similar dynamic had played out in the current assault, that she was somehow responsible, and should accept what had happened without expressing disapproval or pain.

Further, Jennifer gained awareness of how her passive, appeasing behavior had been encouraged by her family her entire life. Jennifer was inappropriately shamed for her expressions of anger, which led to an unconscious belief that she was "bad" and that others' needs should come before her own. Jennifer's realizations led to further expressions of a great deal of anger, grief, and emotional anguish, all of which were met with support and validation by the therapist, thereby helping to shift her self-schemas to accurately represent her self-worth.

By the end of psychotherapy, Jennifer's trauma-related symptoms remitted, she was calmly assertive in relationships with others, and had fully internalized a belief in herself as a worthy person with rights equal to those of others.

## Sophia

Sophia, an attractive 27-year-old lesbian Chinese woman, was a successful and highly paid model until a sudden 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 weeks in the hospital and then months in a convalescent home.

Initially, Sophia did not allow herself to be aware of her blindness; she would not discuss the topic. She did, however, think and talk about the loss of her leg. Her lack of recognition of blindness was astonishing to staff members since she had to be constantly assisted in many functions.

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 modeling appointments. Only after weeks passed did she communicate about being blind; the topic of her facial disfigurement, loss of an identity as a conventionally beautiful woman, and her career was discussed even later. After three months passed, she was willing to have a psychiatric consultation and she then accepted a recommendation for psychotherapy.

In the context of this therapy for the next two years, Sophia gradually recovered psychological equilibrium and developed an identity that was coherent with her altered bodily functions and social opportunities. She learned new self-concepts through a variety of means, including identification with the effective roles and positive attitudes she observed in various health professionals. She trained as a counselor specializing in music therapy. Later, she married an older woman, and still later she became a teacher who trained music therapists.

In order to comprehend the processes of such adaptive changes, we need to understand theories that explain both shock mastery and complex processes of reschematization.

## Shock Mastery and Reschematization

### SHOCK MASTERY

As discussed in the prior chapter, traumatic memories have excessive associative linkages with stress-related ideas and systems that arouse alarm emotions. If the person is exposed to stimuli similar to those of past traumatic perceptions, then the entire associative complex may be activated and lead to intense emotional flooding. Shock mastery is a shorthand term for the complex and multiple memory-cognition-emotion processes that reduce some of the strong associative connections that cause painful flooding. Habituation, extinction, and desensitization are outcomes of such processes.

Shock mastery leads to a decrease in the frequency and intensity of intrusive flashbacks and startle reactions. Reschematization is helped by shock mastery, but it involves even more extensive modifications in large and complex networks of associations. The remainder of this chapter provides theory for understanding such changes in person schemas.

### RESCHEMATIZATION OF PERSON SCHEMAS

Person schemas store generalizations of knowledge in a cognitive map or model that contains views about self and others. The large networks of associational linkages that function as schemas include meanings that maintain bonds and can lead to a sense of attachment (Wright, Crawford, & Del Castillo, 2010; Horowitz 1992b, 1998). An important aspect of person schemas is their multiplicity: each person has a repertoire of different possible selves, each leading to a different possible state of experiencing one's role in relation to others.

Post-traumatic responses often involve shifts in relationship roles. For example, Harold's and Jennifer's altered behavioral pattern after their respective traumas occurred with activation of a usually dormant role, that of a dependent self rather than their usual active sense of themselves as autonomous adults. They experienced post-traumatic growth by integrating a latent and usually warded-off dependent role with his and her realistic, desired, and usually competent adult role.

In the other, more severe example, Sophia's body image, self-organization, and relationship to herself as well as others underwent changes. Sophia continued to

activate her pre-trauma body image long after her accident. Concurrently she slowly and unconsciously formed a new body image that could accord with the drastic post-traumatic changes in her body. Her adaptation increased as her new body image gradually evoked less horror and self-disgust because she slowly forged new role concepts for herself, thereby creating new avenues for the expression of self-worth.

A comparison between a desired and a dreaded body image can generate horrifying emotions. Control processes can attenuate such distress by inhibitions or distortions of meaning. Such control processes, if used persistently, numb emotion at the cost of impairing the processes of reschematization. Conversely, control processes that allow flexible appraisals of new realities can foster adaptive behavioral coping and can also promote gradual identity reschematization.

In adaptive coping, post-traumatic emotions are titrated by control processes to levels that are tolerable. A reduction of Sophia's defense against mental imagery (a function not impaired by her blindness) was approached gradually so that the fear, anger, and sorrow evoked in her by ideas of her bodily changes felt manageable. In the short term, she appeared worse because of the unavoidable arousal of distressing feelings. Over the long term, she improved because of the reschematization of her sense of how she appeared to others. She was less apprehensive about their possible responses to seeing her in her disabled physical state. She gradually revised her initial self-evaluation from an "I am disgustingly ugly" response to a later response of "This is how I look now, and others and I and can accept me as a worthwhile person."

Being a worthwhile person in the appraisal of others is an intrapsychic motive for most of us. In our minds lurk expectations of how others may lose interest in us or may no longer need us. Without reflections from others, self-esteem may be diminished.

Sophia had an extreme, traumatic, and catastrophic disruption in her self-concepts. Before the trauma she founded her self-worth on her physical beauty and its power to attract interest and earn a livelihood. According to this preexisting standard of self-worth, she now saw herself as ugly and abandoned without beauty. Her posttraumatic growth established new grounds for self-worth. Sophia was caring, empathic, articulate, compassionate, and she was becoming a person of measure who could teach well and earn a living. She gained self-reflectance by being valued from others according to her newly recognized and self-owned qualities.

Post-traumatic identity reschematization involves modification of schemas of attachment to others (Bowlby, 1969; Parkes & Weiss, 1983). Entire configurations of role-relationship models for the affected significant affiliations have to be revised. This slow change process can be complicated and prolonged in people with prior personality deficits or conflicts that resonate with the meanings of stressor events (van der Kolk et al. 2009; Charuvastra & Cloitre, 2008; Horowitz et al. 1998; Horowitz, Siegal et al. 1997; McFarlane, 1989; Ozer, Best, &

Lipsey, 2003; Prigerson et al. 1995; Resnick et al. 1992; True et al. 1993; Zaidi and Foy, 1991; Zisook & Schuchter, 1991a,b; Zisook et al. 1990). For example, in one study of conjugal bereavement (in a mixed-gender sample), we found that low levels of self-conceptualization six months after the loss were correlated with prolonged high symptoms of Complicated Grief Disorder and PTSD or Major Depressive Disorder (MDD) 14 months after the loss ( $r = -0.47$ ,  $n = 78$ ,  $p < 0.001$ ) (Horowitz, Milbrath, & Bonanno et al. 1998). Scores on self-report of "other as an essential support to identity" averaged 4.1 in the proportion of those subjects diagnosed by clinicians as having Complicated Grief Disorder and PTSD or MDD as compared to scores of 2.7 in the proportion of subjects diagnosed as having normal grief reactions ( $p < .0005$ ) (Horowitz et al. 1996).

In other samples, when people with Complicated Grief Disorders were treated in psychotherapy, issues of self-organization were among the most important but difficult topics to discuss. This was shown empirically by a statistically significant association of such topics with concurrent intensification of objectively scored verbal and nonverbal defensive maneuvers to control emotion (Horowitz et al. 1995). A successful therapeutic process required work on irrationally dependent attitudes, deflated characteristics of self, and ambivalent attachments to the deceased (Horowitz, Marmar et al. 1984a, 1996).

As the patients learned to form new goals, representative values, and harmonious variations characteristics of self, they felt stronger than they had been before the loss. Person schemas theory helps us understand how such post-traumatic growth can take place, and can be facilitated by the empathic holding environment of supportive and expressive psychotherapy. In this change process, a caring, sincere, non-critical, understanding therapeutic alliance is of high importance.

## Person Schemas Theory

As described previously, person schemas influence relationships with self and others. The following section discusses person schema theory in greater detail. Traumas change the worldview of their victims, and identity has to be modified to accord with new realities. The substrates of identity experiences are conceptualized in terms of various self-schemas, their level of integration, and the way in which they are sustained in models of how the self relates with others.

### SELF-SCHEMAS

A sense of identity varies from state to state in non-traumatized individuals, and trauma makes such shifts more pronounced. Each state of mind that is common

and recurrent in a person is organized by an active schema of self. A self-schema is an organized compendium, a patterned aggregation of elements, and a package of usually unconscious associated meanings about the self. Each self-schema is a constellation of such subordinate elements as body image, role, scripts for relating to others, symbols, values, fears, desires, constraints, intentions, expectations, action plans, and styles of self-control.

The connectivity pattern of the schematic elements is a nested hierarchy of beliefs: each element combines many subordinate bits of information that can be associatively combined and built into supraordinate patterns. The self-knowledge assembled in such schematizations can be simultaneously reality-based and fantasy-based, procedural and declarative, explicit and implicit, current, past, and projected into the future.

The store of self-knowledge is primarily unconscious, though its derivatives are represented for conscious self-observation. Trauma frequently activates usually dormant aspects of self-schematization, and alters usually active aspects of self-schematization. A change in the conscious sense of identity results.

A self-schema, one of several within the repertoire of a person, can be active or inactive in its influence on current thought, emotion, perception, and action. An active self-schema leads to a style of thinking, communicating, and acting. Traumas alter the relative activity mode of self-schemas by a shift in the associations that are primed by implications of the event.

As previously mentioned, a conscious sense of identity, as in the shifting states of Harold, Jennifer, and Sophia, is based on derivatives of self-schemas. Since multiple self-schemas are activated, different identity experiences may result with experience and acceptance, a harmony of roles of the self can be achieved. If that harmony is achieved, then an identity over time will tend to occur. If not, there may exist a lower degree of schematic integration before the trauma, then there may be a mean greater possibility for chaotic identity experiences after the traumatic experience.

Several theorists propose that self-schemas are associated with other person schemas in various internal models of attachment bonds (Bowlby, 1969; Epstein, 1992; Horowitz, 1992b, 1998; Parkes and Weiss, 1983). In the clinical situation, these associations of self with other can be inferred in the process of case formulation as role-relationship models. Such models form a cognitive map of self and other attributes, characteristics, and scripts of potential interpersonal transactions. Scripts include future plans of the self intending to move toward desired possible future identities and away from dreaded ones.

As a person forms fantasies of dreaded and desired future identities, and these fantasies are retained in memory, these possible future identities become motivational. Some people employ identity compromises in self-view and self-presentation to others to defend against dreaded future states. When these

encapsulated, defensive ways of relating become chronic, they are akin to what Winnicott viewed as false selves (Winnicott, 1971).

If a desired future self is too idealistic for realistic attainment, as occurred in the case of Sophia's continued post-trauma desire to continue to be a famous model, a catastrophic mismatch occurs, leading to a self-state of feeling ugly, unwanted, and worthless. A compromised role such as a completely isolated loner might have been used to avoid these dreaded humiliating experiences of self. Therapeutic intervention enabled her to construct a more adaptive, desirable sense of a future self which could be projected as a possible future for relationships. Such a future self-concept motivated Sophia to set new personal goals, reframe her values about self-worth and work to develop new skills in order to achieve her new ambition. Sophia's new self-concept allowed her to form new relationships with others, which have come to serve as her new self-reflective references.

## POST-TRAUMATIC IDENTITY GROWTH

The post-traumatic identity reschematization rests on highly complex theories of associated meanings, complex connections within neural networks, or both. Part of this complexity, at the psychological level of cognition of meaning, has to do with how supraordinate schemas might combine multiple subordinate self-attributions into an associative organization.

Larger structures of meaning foster a conscious sense of harmony, coherence, and continuity in a sense of identity. Of importance is how a person can become mindful of how to combine several self-concepts (or several role-relationship models) into a more complex and wise network of beliefs. An important consideration in psychotherapy with respect to promoting post-traumatic identity growth is the patient's ability to hold several ideas in his or her mind at one time. Some people can focus on one belief, but are low in cognitive self-reflective awareness in being able to compare two disparate beliefs.

In other words, people differ in the degree to which they can integrate multiple self-schemas into a supraordinate schema. An experience of identity is simple when it is derived from information in just one self-schema; it is complex when it derives declarative beliefs from a supraordinate schema combining several possible selves. Research reported elsewhere (Horowitz, 1998) supports the hypothesis that people who have formed more integrated supraordinate self-schemas are more likely to have harmony of character and are less likely to dissociate, depersonalize, or explosively shift their state of mind. They can achieve post-traumatic identity reconstruction somewhat more rapidly.

Some people have many contradictions across schemas, while others have fewer antithetical intentions and expectations. Those with major contradictions and with-



out supraordinate schemas are vulnerable to sudden and even dissociative variations in their states of mind. That tendency to identify segregations may be exacerbated after traumas. Under stress, such people are vulnerable to a sense of identity chaos, leading to heightened impulsivity and use of pathogenic reality-distorting defenses (Vaillant, 1977). Therapy with them has a good prognosis but it may need to proceed slower and last longer. Table 6.1 provides a sense of this dimension.

**Table 6.1 States of Self-Organization**

Level	Description
<i>Harmonious self-states</i>	When in these states of mind, people have a cohesive identity. Their sense of self as intending, attending, and expecting is unified. When experiencing conflicts and negative moods, they own these as "of the self." They think in terms of realistic pros and cons and employ rational actions and restraints. Emotional governance is at its best. In these states, people view others as separate people with their own intentions, expectations, and emotional reactions. In the mind, perspectives on relationships approximate social realities of the present moment.
<i>Mildly conflicted self-states</i>	In these states, an intuitive sense of self may contain contradictions of intentions, expectations, and values. Maladaptive relationship behaviors may have approach-avoidance conflicts concerning issues of control, sexuality, and power. Irrational views of a relationship may stand in the way of developing close and genuine connections.
<i>Vulnerable self-states</i>	In these states, people shift between intense divergent emotions; for example, feeling grandiose then deflated. Illusions about extraordinary personal traits may cover over illusions of failure. Emotional governance is reduced. Rage may erupt at others who are perceived as insulting to the self. In such states, people may view others as tools of self, or they may externalize blame onto others.
<i>Disturbed self-states</i>	In these states, people organize mental life using various self-schemas that break with reality. Rage in the air is seen as being the fault of another person. Self may be confused with other in terms of who did or felt what. Within self, thoughts may be confused with memories or plans for real action. The result can be a social rupture.
<i>Fragmented Self-states</i>	In these states, a massive chaos of selfhood can occur. People may regard self and other as merged. Parts of the bodily self may be disowned. This is very painful and can give rise to poorly regulated suicidal or homicidal urges. For that reason, explosive shifts into such states are dangerous. The result may be stigmatization and rejection of the person in this state.

Associative processing compares the possible meanings of a trauma to each organized schematization of self. Some dreaded self-schemas that are usually latent may be activated because of strong associative linkages. If these dreaded self-schemas have not been previously contained by harmonization with more worthwhile self-judgments then a decomposition of self-organization may occur.

For example, an adult may have a current trauma that seems similar to a childhood trauma, and may then become especially distressed if the childhood experience has never been mastered. The result may be Complex PTSD. Contently, that adult may adapt resiliently if the roles have been previously mastered. Some people believe their character has been strengthened by prior traumas, and others believe they have a residual vulnerability of character.

To recapitulate, any traumatic event may be associated with multiple self and relationship concepts as a part of cognitive processing. Some realistic implications of the trauma may conflict with existing schemas, expectations, and intentions. The more discordant the elements are in schemas before the trauma, the harder it is to reorganize meanings after the trauma. In such instances, attention to self and relationship conflicts are important for post-traumatic growth in psychotherapy.

Reschematization of identity, relational attitudes, and worldviews takes time. Mourning, for example, extends over many months for most people after the loss of an important relationship. Mourning itself is a part of many stress response syndromes, as in Sophia's grief work over loss of her leg, her vision, and other capacities.



## CHAPTER 7

# Mourning

The mourning process in many ways parallels the process of healing from trauma. This passage involves an unconscious change in mental structures of meanings about the self and other people. Grief is also a process that unfolds in phases. By passing through the phases of grief, the bereaved person prepares to make new commitments to others and to accept new personal roles. This chapter examines mourning in terms of such person schemas.

Unconscious processes lead to extremes of conscious experience during grief such as intrusion and numbing. Sometime after a loved one dies, a preoccupation with the deceased may dominate the mourner's conscious experience. Visual or auditory hallucinations of the deceased may occur unexpectedly. The bereaved person may experience unwelcome and intrusive emotions: not merely the expected sadness but also fear, rage, and guilt. Numbing or emotional blocking, an opposite extreme of intense painful emotional experience, may also occur. The bereaved person may consciously attempt to recall a memory about the deceased and fail. Or the mourner may try to cry but cannot.

The following case excerpt illustrates both intrusive and omissive types of deflection from voluntary control of conscious representation.

### MARY

Mary's elderly mother died when Mary was middle-aged. Mary felt sorrowful, cried at the funeral, took a week away from her work and usual social activities, and then went through her mother's belongings, quietly contemplating her memories. She then resumed her life as usual, until, weeks later, when she found herself preoccupied with unbidden images of hostile exchanges with her mother.

These malevolent and dominating images were based on memories and fantasies of the past. When Mary tried deliberately to recall her mother in the context of pleasant, loving memories, she could not conjure up any image at all of her mother's face.

## Unconscious Processing

Unconscious mental processes dictate much of the experience of mourning. The person in mourning can seldom accurately predict *when* she might enter a particular mood, *what* memories of the deceased would then be recalled, *when or if* strong emotions would be triggered by some reminder of the loss, or *why* a new behavior emerged in the mourner who exhibited traits of the deceased. Few people ever predict the quality of anniversary reactions accurately, yet most people have them. The unconscious mind is tracking time and recording dates in ways not necessarily reported to conscious awareness. The next two vignettes illustrate such phenomena.

### ANNE

Anne attended my talk on the relation of unconscious factors to the phenomenology of grief experiences. At the coffee break, she said that just that morning she had finally put on the earrings left to her by her mother upon her death two years before. Up until the day of the seminar, she had left them untouched in her jewelry box. She had attached no significance to the act that morning, but during the talk she realized she had decided—unconsciously—to symbolically complete her mourning by claiming the earrings as her own. Anne thought she had also probably signed up for the conference for the same reason.

A more detailed vignette indicates a series of unpredicted anniversary reactions following the death of a loved one.

### ENGEL

The noted psychiatrist Engel (1975) wrote of his anniversary reactions after his twin brother died suddenly from a heart attack, in the same way as their father before him. His brother died at age 49; the father had died at age 58. When Engel heard of the death, at first he felt stunned disbelief, and then began crying, twenty minutes later. Within a few hours he was experiencing chest pains. On later examination it was discovered that Engel, too, showed evidence of coro-

nary heart disease, although not an infarction. During the next months, Engel worried that he would have a heart attack. Eleven months after his twin brother died, he did have a coronary occlusion. Afterward, Engel felt relief; he no longer had to fear that a heart attack would ruin him at any moment.

As the years passed, Engel became less concerned by the upcoming anniversary of the death, and so did not anticipate he would have any reaction on the five-year anniversary of his brother's death when Engel himself was 54 years old. When the date arrived, however, he had a dream with a theme of guilt about surviving a heart attack when his brother had died from one.

On the five-year anniversary of Engel's own heart attack, he had another dream wherein he remembered that a friend had died suddenly. In the dream, he felt sad and agitated, and tried to tell a colleague about the death. Engel awakened in a depressed mood. The deceased friend, in many associations, had the characteristics of Engel's twin brother. Engel then realized that he had been looking forward to the anniversary as a cause for celebration that he had survived for five years after his brother's death. Yet, during the actual day, he blocked out any conscious memory of its significance.

When Engel reached 58, the age his father had been when he died, Engel made a number of unlikely errors in conscious thought. He remembered his father as dying at age 59 instead of age 58, although for many years Engel had feared that he, too, would die at 58. In this way he passed his fifty-eighth year without conscious anxiety, since the threat of death was projected into the future. After the threat had passed and he had survived his fifty-ninth birthday, Engel recalled that his father in fact, had died at the age of 58.

Such anniversary phenomena indicate how unconscious defensive control processes can serve to reduce levels of consciously felt anxiety and guilt. The balance between impulsive aims at mastery by recurring intrusive thoughts and unconscious defensive aims at avoidance of emotional pain varies over time, leading to phasic variation in conscious experience of the grief process.

## Phases of Response during Mourning

Shear, Frank, Houck, and Reynolds (2005), Zhang and colleagues (2006), and Pollock (1978) described variations in affect as the mourning process progresses. The degree of conscious experience of affect provides an index of change. Parkes (1964, 1972) and Parkes and Weiss (1983) reviewed Freud's (1917), Lindemann's (1944), and subsequent models of the bereavement process, and differentiated specific phases of grief: (1) initial denial and avoidance of the loss; (2) subsequent alarm reactions, such as anxiety, with restlessness and physiological complaints; (3) searching to find the lost person; (4) anger and guilt; (5) feelings

of internal loss; (6) adoption of traits or mannerisms of the deceased; and (7) acceptance and resolution, including appropriate changes in identity. To these seven phases Pollock (1972, 1978) added the importance of revived mourning on anniversaries and of phases of creativity during mourning. One can condense the phases of mourning into the phases already described for stress response syndromes in general.

## Normal and Complicated Grief

Grief has normal forms and complicated variations. Complicated grief is often a highly intense and out-of-control experience version of the ideas and feelings found during normal mourning (Bowlby, 1980; Deutsch, 1937; Freud, 1917; Glick et al. 1975; Lindemann, 1944; Pollock, 1978; Raphael, 1983), often to the point of causing significant impairments in daily living. Sometimes, however, complicated grief is a failure to mourn (Clayton, 1974; Horowitz et al. 1980b, Osterweiss et al. 1984; Windholz et al. 1985), and, at other times, it is a set of signs and symptoms atypical of normal grief (Abraham, 1924). In one of his most important theoretical papers, "Mourning and Melancholia," Freud (1917) presented the decisive effects of the nature of the previous relationship with the deceased in predicting whether normal or complicated grief would occur. Preexisting ambivalence in this relationship predisposes the person to both more intense and turbulent affects, as well as the greater emergence of regressive defenses.

Normal grief reactions, as already mentioned, may change in the quality of subjective experience during various phases of mourning. So, too, complicated grief reactions may have signs and symptoms with a phasic change pattern, as shown in Table 7.1.

The phases shown in Table 7.1 are generalizations. While the phases are often sequential as tabulated, no one person must necessarily follow the order presented, or even experience all of the phases. Furthermore, in the recent years several treatments have been shown effective for complicated bereavement (Shear et al. 2005; Zhang et al. 2006) Personality style, current conflicts, and developmental level of the personality, all affect the experience and length of the phases. People with obsessive compulsive personality traits often remain longer in a low-emotion denial phase, while those with histrionic personalities are often more prone to extended intrusive phases. Sometimes people with narcissistic personalities show few direct manifestations of grief after a brief outcry phase. They may be too developmentally immature to have an adult type of relationship and so cannot exhibit an adult type of mourning at its loss.

**Table 7.1 Common Experiences during Grief and Their Complicated Intensification**

<i>Phase</i>	<i>Normal Response</i>	<i>Complicated Bereavement Intensification</i>
Dying	Emotional expression and immediate coping with the dying process	Avoidant, overwhelmed, dazed, confused, Self-punitive, inappropriately hostile
Death and Outcry	Outcry of emotions with news of the death and turning for help to others or isolating self with self-succoring	Panic, dissociative reactions, reactive psychoses
Warding Off (Denial)	Avoidance of reminders, social withdrawal or blunting of feeling, focusing elsewhere, not thinking of implications to self or certain themes	Maladaptive avoidances of confronting the implications of the death, drug or alcohol abuse, counterphobic frenzy, promiscuity, fugue states, phobic avoidance, feeling dead or unreal
Reexperience (Intrusion)	Intrusive recollections, bad dreams, reduced concentration, compulsive enactments	Flooding with negative images and emotions, uncontrolled ideation, night terrors, recurrent nightmares, distraught feelings from intrusion of anger, anxiety, despair, shame or guilt physiological exhaustion
Working Through	Recollections of the deceased and contemplations of self with reduced intrusiveness of memories and fantasies, increased rational acceptance, reduced numbness and avoidance, more "closing" of recollections and a sense of working it through	Sense that one cannot integrate the death with a sense of self and continued life, persistent warded-off themes may manifest as anxious, depressed, enraged, shame-filled, or guilty moods, and somatization
Completion	Reduction in emotional swings with a sense of self-coherence and readiness for new relationships, ability to experience positive states of mind	Failure to complete mourning may be associated with inability to work, create, or feel emotion or positive states of mind



## The Phase of Outcry

Outcry contains a rapid, unconscious assessment of the implications of the loss for the self. The sudden confrontation with bad news leads to a sharp rise in the experience and expression of such raw emotions as fear, sadness, and anger, and to physiological changes in sympathetic, parasympathetic, and immunological systems. The result may range from hyperarousal to shock. Because unconscious thought proceeds further and more swiftly than conscious thought, intrusive emotions can take subjective awareness by surprise. A cascade of emotional experiences occur during this phase, as different implications of the death are touched upon. A deeper review of these topics will take place during subsequent phases of response, but the first emotional indicators of their importance are now present.

### FICTIONAL EXAMPLE OF OUTCRY AFTER A PERIOD OF NUMBING

I found an insightful illustration of this power of emotion during the outcry phase in James Agee's *A Death in the Family* (1957). The following excerpt illustrates the outcry phase of a woman whose husband died in a car accident only a few days earlier. She dons her mourning veil for his funeral, thinking as she does so that she has grown up almost overnight, for she realizes her loss and knows that terrible pain lies ahead. As she leaves the bedroom that she shared with her husband, she is stunned by grief.

After confrontation with a sudden and unexpected death, a person may form a working model in which the deceased is viewed as seriously harmed and critically in need of help. This working model sharply arouses emotional systems. Because the deceased is modeled as harmed, the self is aroused to act to reduce threat. The alarm emotions prepare the body for action and motivate the conscious mind to interrupt other activities in order to plan this action. As a result, the person may undertake frantic but hopeless activity to repair the hazardous condition of the deceased. Some funeral rituals serve this obligation to "do something!" The working model can be a bit irrational in regard to the reality of permanent loss, since it depicts the other as harmed but not completely beyond help.

The nature of the internal working model or schema will determine the content of the emotional ideas during the outcry. The emotional expression of an outcry phase may come as actions and images, as well as words. There may be appeals for divine help ("Oh God!") or expressions of rage ("God damn it!") or remorse ("I'm so sorry!"). Rapid, unconscious appraisals of the repercussions of the death may lead to defensive opposition to alarming ideas and emotions. Some form of denial can occur in the emotional exclamations that characterize this phase ("Oh no! It can't be! Say it isn't so!"). A rapid appraisal of the self

during the outcry phase leads to conscious vows like “I’ll survive this,” or “I’ll never enjoy life again—ever!” These inner assertions become an important part of the memory of receiving the bad news.

The term *working model* applies to a transient schema derived from both perception and enduring schemas (Bowlby, 1980; Bretherton and Waters, 1985). It is based heavily on immediate perceptions of external reality, although schemas organize (and potentially distort) that perception. An enduring schema of a role relationship model is less situationally dependent. It is activated by inner wishes. Thus, we may infer that the mind unconsciously compares the working role-relationship model and the enduring role-relationship model. If they do not match, intense emotions may arise, serving to motivate either plans for correcting the mismatch or defensive avoidances to reduce recognition of it. This mismatch, which is illustrated in Figure 7.1, is the usual state of affairs in the outcry phase. The sharp expression of emotional alarms itself may serve an evolutionary adaptive purpose. Sobbing may summon aid; shock and fear may elicit protection; remorse may cause renewed support; and rage may alert others to treat the subject with tact and caution.

EVENTS:	Ordinary Relations With Other	News of Death of Other
CURRENT WORKING MODEL OF RELATIONSHIP	$\begin{array}{c} \text{Self} \\ \updownarrow \\ \text{Mutuality} \\ \updownarrow \\ \text{Other} \end{array}$	$\begin{array}{c} \text{Self} \\ \updownarrow \\ \text{Need} \quad \updownarrow \quad \text{Help} \\ \updownarrow \\ \text{Other} \end{array}$
ENDURING SCHEMA OF RELATIONSHIP	$\begin{array}{c} \text{Self} \\ \updownarrow \\ \text{Mutuality} \\ \updownarrow \\ \text{Other} \end{array}$	$\begin{array}{c} \text{Self} \\ \updownarrow \\ \text{Mutuality} \\ \updownarrow \\ \text{Other} \end{array}$
ACCORD OF WORKING AND ENDURING SCHEMAS	Match	Mismatch
EMOTIONAL SYSTEMS	Equilibrium	Alarming Rate of Arousal
RESULTING STATES OF MIND	Calm	Fearful Outcry

**Figure 7.1 Modeling a State Shift from Calm to Alarm.**

## The Phase of Denial

Denial phase can occur concurrently with the intrusion phase during outcry. As a result of the initial defensive inhibitions of death-related emotional themes, the alarm reactions characteristic of the outcry phase are reduced. An individual is often aware that denial is operating, and is aware of feeling numb or emotionally insulated. This experience of numbness has been captured in literature. In his work *Threnodia Augustalis*, seventeenth-century poet John Dryden (quoted in Moffatt, 1982) spoke of this phenomenon when he wrote “Tears stand congealed and cannot flow/And the sad soul retires into her inmost room.” Likewise, Emily Dickinson (c. 1862) wrote, “After great pain, a formal feeling comes. The nerves sit ceremonious, like tombs.”

During the denial phase of mourning, the active memory of some themes about the loss is avoided by an inhibition of topics for, and this process unfolds unconsciously. The outcome is repression of loss-related topics, omission of recollection, avoidance of recognizing personal implications of the death, and often a conscious but vague sense of being frozen, insulated, derealized, or depersonalized. However, unlike some other posttraumatic reactions, in bereavement, total suppression or repression of the theme of loss is seldom observed. Some recognition of short-range consequences of the death to the self occurs, while many other long-range effects are not contemplated. The use of schemas that model notions that the deceased is alive, is most prominent during this phase. The preserved role-relationship model of the self with the deceased represented as alive contributes to such phenomena, as does the use of the present tense in describing the relationship with the deceased. This is reflected in statements such as “*We* like to travel during vacations.” In other words, there is some dissociation of role-relationship models during the denial phase. The person preserves a role-relationship model of the self as related to the living other, while separately developing recognition of the self as alive and the deceased as dead when situational reminders force that recognition. The latter role-relationship model is inhibited from organizing ideas and feelings during the denial phase.

## The Phase of Intrusion

The denial phase may last for days, weeks, or even months. During this time, the mourner may have returned to many of the customary forms of his life. A sense of safety may be returning. It may be just then, surprisingly, that intrusive experiences increase in frequency and intensity.

## P'AN YUEH

In the fourth century, the poet and courtier P'An Yueh (Rexroth, 1970) wrote "In Mourning For His Dead Wife." The poem indicates that a year has passed since her death, and yet:

Her perfume  
Still haunts the bedroom. Her clothes  
Still hang there in the closet.  
She is always alive in  
My dreams. I wake with a start.  
She vanishes. And I  
Am overwhelmed with sorrow . . .

Conscious recognition of the significance of a loss to the self becomes prominent during the phase of intrusive re-experiencing of memories about the stressful event and the previous relationship to the person lost. There is less use of repression as an unconscious defensive operation. Conscious efforts at suppression, however, may continue to curb the sharp pangs of emotion associated with this phase. This conscious, suppressive, defensive avoidance paradoxically contributes to the intrusiveness of recollections at this time because the conscious representations of ideas and feelings are a kind of breakthrough phenomenon.

During this phase one may become preoccupied with an aspect of identification with the deceased in which one views oneself as vulnerable to death. One may experience the physical symptoms of the disease that killed the other, or in fantasy reveries strike mental bargains with the gods to reduce fear and protect the self from the perceived threat of death. One may feel guilty for worrying about dying when it is the other who is actually dead. This is a type of survivor guilt experienced by some people in mourning.

Existing schemas still organize an expectation that the deceased will be alive and present in certain situations. Therefore, these situations feel particularly empty. Cooking a meal, going out with friends, or going to the movies painfully emphasizes the absence of the habitual companion. Emotional reactions to such empty situations are heightened during this intrusive phase of bereavement because the working schema of being alone still differs from the enduring schemas of being together. This discrepancy between the role-relationship models leads to alarm affects as shown in Figure 7.2. The person may be motivated to renew efforts to bring back the dead loved one, with an increase in pining and searching, use of magical thinking, and efforts to undo the incidents that led to the death.

Wishes for restoration of the deceased go on unsatisfied, obviously, and frustration mounts. In the face of death, the survivor mounts a last-ditch effort

EVENTS:	Empty Situations	Empty Situations
CURRENT WORKING MODEL OF RELATIONSHIP	$\begin{array}{c} \textit{Self} \\ \text{Need} \downarrow \\ \textit{Absent Other} \end{array}$	$\begin{array}{c} \textit{Self} \\ \text{Need} \downarrow \\ \textit{Absent Other} \end{array}$
ENDURING SCHEMA OF RELATIONSHIP	$\begin{array}{c} \textit{Self} \\ \text{Mutuality} \updownarrow \\ \textit{Other} \end{array}$	$\begin{array}{c} \textit{Self} \\ \text{Need} \downarrow \\ \textit{Absent Other} \end{array}$
ACCORD OF WORKING AND ENDURING SCHEMAS	Mismatch	Match
EMOTIONAL SYSTEMS	Alarming Rate of Arousal	Equilibrium
STATES OF MIND	Agitated Sadness	Poignant Sadness or Resignation

**Figure 7.2    Reduction of Alarm States, with Development of Schema of Other as Lost.**

to fulfill his wish that the deceased be alive. Memories of prior satisfaction with the deceased are dramatically different from the emptiness of the current situation, and this has sharp emotional consequences. For example, great joy during a dream of wish fulfillment is replaced by a great pang of sorrow upon awakening to the realization that the dream is not real. The same dream of being with the beloved deceased people may be remembered with pleasure, not sorrow, in some later phase of mourning, when more grief work has been accomplished.

At the same time, ideation proceeds with lessened inhibition. Unanswered questions during the outcry phase of initial realization, such as, “Who is to blame?” and “Why did this happen to me?” reemerge during the intrusive phase. These themes may be organized during this phase by usually dormant and often irrational schemas, such as those wherein the self is viewed as bad and harmful to the other, or defective and abandoned by the other. Survivor guilt, guilt over feelings of anger at the deceased, shame over feelings of helplessness, and fear of future repetitive suffering may recur as intrusive preoccupations.

## The Phase of Working-Through

During the working-through phase, there are recurrences of avoidant and intrusive phenomena. These omissions and preoccupations oscillate, taking the edge off either extreme and helping to promote equilibrium. Periods of relaxation occur in which neither defensive numbness nor emotional flooding is prominent. This type of progress is excessively postponed in complicated grief and may require psychotherapy in order to create a sense of enough safety for working-through the hard topics that will begin.

Intrusive memories of the deceased begin to change in form. Current concerns and relationships with living people blend with scenes involving the deceased. These blends occur prominently in dreams. Not infrequently in such dreams, the bereaved occupies the role of the deceased, and vice versa.

Between the initial unconscious view of the deceased as still alive, yet, contradictorily lost to contact with the self, and the eventual, full, unconscious acceptance of the death, these unconscious beliefs undergo many changes. These beliefs also lead to varied conscious experiences during the working-through phase, as the following case example illustrates.

### FRANK

A young husband suffered the death of his wife in a scuba diving accident. Six months later, during his waking hours and in dreams, he had intrusive, intolerably sad and frightening images of her blue face when the body was recovered. These unbidden images gradually subsided in frequency during a brief psychodynamic psychotherapy.

Before his wife's death, he never experienced a sharp elevation in heart rate when he saw her or a woman who resembled her. After her death, during the earlier denial and intrusive phases of his grief experience, he still did not have these sensations. The everyday situation of being with his wife, his earlier phase of grief after her death, and his later recognitions of his loss were very different contexts.

During the working-through period of the mourning process, however, he did develop this intrusive bodily sensation in a specific context. He worked as a trainer of personnel for a large corporation, and began a new class every two weeks. During this period, when he saw a woman in the class who resembled his wife, at first glance he would feel his pulse surge in his chest, wrists, and throat.

The everyday situation *before her death* was mainly one of calm belief in their continuing commitment to each other. The *intrusive phase of his grief* was

characterized by visions of her as dead, primary-process beliefs in her continued life, and alarming pangs of sadness mixed with fear. The later phase of *working-through* contained a growing recognition of loss, but still a pining for her return. With this phase near relative *completion*, the intrusion of physiologic arousal subsided.

During the phase in which he felt the sudden surges of pulse, he had no conscious ideas about the women who resembled his wife; his cardiac reaction felt instantaneous. Yet from our vantage point as observers, we may infer that there was some type of unconscious construction of meaning about the women that led to his excitation. He was hoping his wife had returned from death (primary process) while knowing that she was dead (secondary process). The primary process was rapid and unconscious, using ideas incorporated in a schema of finding and being reunited with his harmed, living wife. Fluctuation of that schema led to the emotional responses that would occur in such a reunion.

Changes in schemas occur most prominently in the working-through phase. Many repetitions of intrusive ideas and feelings will have occurred, and trains of thought will have been set in motion. These thoughts and the repetition of new situations and their working models will gradually build new, enduring role-relationship models.

During the grief work, one reviews the relationship with the deceased in terms of all the varied self-concepts that have participated in working models of the attachment. This may include weak, dependent, childlike self-concepts in relation to the deceased loved one as a parental figure, even when the real relationship was between peers. It may include strong, dominating, or rivalrous views of self and other. The good and bad, clean and dirty, selfish and caring, and loving and hating themes will all have their time on the stage of reminiscence and decision—I say “decision” because this review is not just a searching, inner magical, primary-process restoration of things now gone. As mentioned above, the process serves an evolutionary, survival-of-the-species function in that it prepares the person to make new commitments after a loss and also to accept the realistic view of oneself and of the present situation. Before this adaptive end of mourning is reached, the schemas and memories of the relationship require review in order to decide what is now true, what is now fantasy, and to discriminate the present from the past.

Sometimes it is a relief when a frustrating, hated, significant other dies. Even so, *the more ambivalence and conflict found in the themes for review, the harder it may be to reach the conclusions that complete the mourning process* (Bowlby, 1980; Freud, 1920; Lindemann, 1944; Raphael, 1983). The reasons for this are the following: the thinking process will be complex and contradictory, the negative emotional experience will be intense and threatening, and the avoidant defensive maneuvers will tend to disrupt thinking.

## PERSONALITY DISTURBANCES

Preexisting personality disturbances make ambivalence and an unfair sense of abandonment more likely. Expectations of rejection can impair one's ability to ask others for emotional support and reactive decompensation may result, as the absence of the bolstering functions of the deceased damages the bereaved's sense of self-organization.

Part of the griever's task is to recognize the finality of the loss. It is hard to accept at an unconscious schematic level that the deceased is permanently, irrevocably gone. However, with repetition of the empty situations, a new, enduring role-relationship model develops in which self was engaging in activities with the deceased person only in the past, but not in the present or future. Empty situations lose their threatening surprise; the person no longer dreads abandonment or losing contact; rather, the person is simply alone. Yearning remains but loses its component of alarm. The resulting state of mind may be *poignant sadness* rather than the more emotional *agitated sadness*.

With the reduction in frequency of distraught states of mind the person may attempt a new relationship of the type that was lost. Another person is found to care for, relate to sexually, or serve as a companion, similar to the deceased loved one. Commonly the new relationship is then colored by efforts to restore within it some aspects of the lost relationship. The discrepancy between the preexisting role-relationship model with the deceased and the patterns occurring with the new person may lead to emotional responses like alarm. In effect, an illusion of restoration occurs until it is suddenly seen as an error. This illusion is a form of transference reaction.

The new companion may react negatively to inappropriate transference-based expectations. This contributes to distress, confusion, and disruptions of poise. After spending time with the new person, and with the mourning process closer to completion, the bereaved is capable of separating the relationship with the new companion from the previous relationship with the deceased. A more committed and realistic attachment with the new person is now possible because a schema of the new person is different from the deceased and has been established, as illustrated in Figure 7.3.

## Completion

Although listed as such in Table 7.1, completion is not actually a phase so much as it is a milestone. It marks the relative end of mourning. It is "relative" because some mourning for a major loss persists throughout the lifetime, and may be reactivated by reminders such as anniversaries (Pollock,



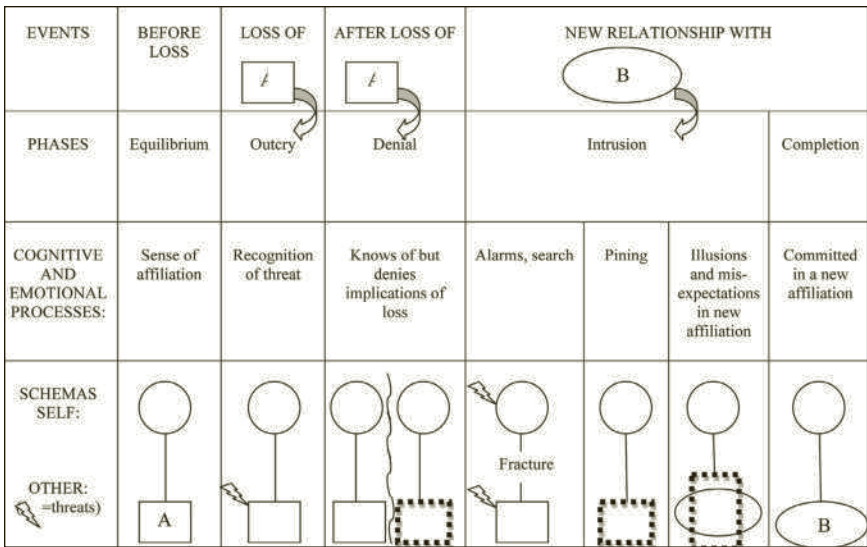
EVENTS:	New Interpersonal Situation	New Interpersonal Situation
CURRENT WORKING MODEL OF RELATIONSHIP	$\begin{matrix} \textit{Self} \\ \Downarrow \Uparrow \\ \textit{New Companion} \end{matrix}$	$\begin{matrix} \textit{Self} \\ \Downarrow \Uparrow \\ \textit{New Companion} \end{matrix}$
ENDURING SCHEMA OF RELATIONSHIP	$\begin{matrix} \textit{Self} \\ \Downarrow \Uparrow \\ \textit{Dead Companion} \end{matrix}$	$\begin{matrix} \textit{Self} \\ \Downarrow \Uparrow \\ \textit{New Companion} \end{matrix}$
ACCORD OF WORKING AND ENDURING SCHEMAS	Mismatch	Match
EMOTIONAL SYSTEMS	Alerting Arousal to Strangeness	Equilibrium
STATES OF MIND	Perplexed and Awkward	Poised

**Figure 7.3    Reduction of Uneasiness in Reestablishing Relationships of the Types Lost.**

1972, 1978). It is listed as a phase because it contains the sense of self-coherence and readiness for new relationships. In complicated or pathological grief this sense may never be achieved. There may be continuing impairment in work, creativity, or intimacy that can go on distorting the person's character for years. In contrast, in some states of completed mourning, the person feels an enhancement of competence and a freeing from the work of grief as well as from its symptoms.

## Schematic Change through Phases of Grief

The overall progression of schematic change discussed in the proceeding text is outlined in Figure 7.4.



**Figure 7.4 Schematic Change through Phases of Grief.**

## Conclusion

The human species has evolved with a capacity for mourning that reaches expression in the adulthood. During the outcry phase of mourning, alarming pangs of emotion may occur as the mind reacts to the serious mismatch between working models of the new situation and enduring schemas. The deceased may be modeled as harmed rather than dead. By the time of entry into a denial phase, the person has reconstituted defensive inhibitions. During this phase dissociations are prominent, with operative schemas of the deceased as both dead and alive. With entry into an intrusive phase, the real finality of loss starts to be confronted. In the working-through phase, the mourning person contemplates and makes new decisions about what the loss means. This leads to new models in the mind as the new working models are repeated and so they begin to be established as enduring schemas. This work reduces the discrepancy, or mismatch, between working models and enduring-person schemas. As the bereaved person slowly develops schemas that match the reality of permanent separation, the work of grief enters the completion phase. Equilibrium is restored and identity growth may have occurred.

It takes a long time to reach such a point of relative completion and the work of mourning cannot be rushed. Mourning is not heartbreak; rather, it prevents the heart from being broken permanently.



Part III

# TREATMENT AND INDIVIDUAL VARIATIONS



## CHAPTER 8

# Treatment

As has been discussed in detail, stress response syndromes include symptoms of emotional flooding with intrusive images and ideas. To avoid dreaded states of mind, people automatically inhibit information processing, which leads to denial, numbing, and avoidance. Because of the prominence of avoidance behavior, attention to fear of and resistance to treatment is important. The cognitive-psychodynamic integrative approach presented here addresses patterns of defensive coping, efforts to counteract dysfunctional beliefs, and disturbances in roles of self and others. A curtailed therapist's manual for this form of treatment is available (Horowitz, 2011).

## Overgeneralization, Alarm Reactions, and Extinction

Associative linkages to the trauma story often lead to a process of generalization according to contextual and thematic cues. For instance, a person who was assaulted in a dark alley at night may develop a phobia and subsequent avoidance of going out after dark, even in safe neighborhoods that in some ways seem too similar to where they were attacked. They may react with alarm upon seeing people who resemble the perpetrators but who are in actuality everyday pedestrians or bus riders. In transitory and sub-clinical reactions to stressor events there is a weakening of such wide-ranging associational linkages, in a process called *extinction*. Treatment aims to reduce overgeneralization of beliefs and to reduce unnecessary alarms by encouraging the natural process of *extinction*.

Overgeneralization is the opposite of symptomatic disavowal of the meanings of the event or constriction of associational width, often prominent during denial phases. Sometimes a contrived continuation of “life as usual” contains an altered subjective quality; the person feels like an automaton, carrying out habitual patterns in a devitalized and joyless manner. A person may intuitively know that extinction of alarm reactivity is gradually taking place. And a person may intuitively know that alarm reactions are persisting for too long.

## Establishing Initial Treatment Goals

The goal of treatment is to help the person work through the layers of meanings connecting the self and the stressor events, so that symptoms such as alarm reactions to similar perceptual triggers can be attenuated or terminated. The aim is to help the patient so he is neither emotionally blunted nor flooded, and is restored to a pre-event level of functioning. Sometimes additional efforts at personality development are indicated to foster post-traumatic identity growth. In such instances, character may be matured to levels that are better than before the traumatic events occurred. In general, therapists and patients plan how to achieve the following:

- Early in the treatment: a restored sense of safety.
- Into the midst of treatment: optimum skills in realistic decision making and adaptive coping.
- Later in treatment: A realistic sense of self as stable, coherent, competent, and worthwhile, with competence in community, family, and personal functions.
- After the treatment: The person would, desirably, have rational preparation and resilience for future stressors.

These therapy goals include plans of helping the patients protect themselves from dangers, for example: accidents (from inattention and slowed reaction time); inappropriate decisions (made on the basis of erroneous belief or compulsive repetitions); social stigmatization (as the consequences of loss, injury, culpability, or victimization); demoralization or suicide (due to impaired sense of identity and meaning); disruption of chemo-physiology (from prolonged fatigue, stress hormones, substance abuse, or excessive use of medications).

## Stages of Treatment

In real-life clinical situations, evaluation and treatment may be seamless; however, a didactic division of it into stages helps indicate how reappraisal of prob-

lems, goals and treatment techniques may occur over time. The following stages will be discussed in sequence:

1. Evaluation: diagnosis, formulation, and initial treatment planning
2. Support
3. Exploration of meanings
4. Improving coping
5. Working through
6. Terminating

An overview of what is probably going to be the activity in each phase with the therapist, the patient, and the process between them is presented in Table 8.1. This theory of therapy is an integration of approaches described by many, including Basch (1980), Beck (1976), Foa and Kozak (1997, 1988), Skaavitne, Gamble, Pearlman, and Lev (2000), Horowitz (1973, 1976, 1998), Klerman and Weissman (1993), Luborsky (1984), Malan (1963, 1976, 1979), Mann (1973), Sifneos (1972), Strupp and Binder (1984).

## Evaluation: Diagnosis, Formulation, Psychoeducation, and Initial Treatment Planning

An evaluation done well establishes hope and an alliance, as well as a plan for treatment. During treatment, formulations and plans are further revised.

### DIAGNOSIS

As previously discussed, several descriptive diagnoses (*DSM-IV*) relate to the etiological category of Stress Response Syndromes. This category is likely to exist in *DSM-V* and *ICD-11*. The diagnoses included under the frame of Stress Response Syndromes include, Post Traumatic Stress Disorder, Adjustment Disorder, and subtypes of PTSD as Compound PTSD, Complicated Grief Disorder, Trauma-induced Dissociative Disorder, and Complex PTSD.

The symptoms of Stress Response Syndromes include deflections from ordinary conscious experiences into extremes such as episodes of intrusive flashbacks and avoidance of contemplating some aspects of post-trauma reality. Most people do not have a ready vocabulary for describing such forms of conscious experience. The clinician often needs to ask focused questions. Familiarity with ways to ask about intrusive symptoms, avoidance and hyperarousal will be of help in the evaluative task. Examples of such symptoms are described once again



**Table 8.1 Phases of Psychotherapy of Stress Syndromes**

Overlapping Phases	Therapeutic Alliance	Patient Activity	Therapist Activity
1. Evaluation: Diagnosis, formulation and treatment planning	Agreement on initial treatment, with hope fostered by expertise and empathy.	Reports events and personal responses, as well as symptoms.	Obtains history, makes early formulations. Provides educational information if needed. Discusses treatment indications and options.
2. Initial support	Roles of a therapeutic partnership are defined.	Expands story and focuses on how to cope with current stress.	Acts to stabilize states if indicated, and establishes preliminary focus of the traumatic event and its meaning to self.
3. Exploration of meanings	Therapeutic alliance deepened by experience of safety.	Expands on meaning to the self of the trauma and its sequelae.	Clarifies how intrusive emotions and ideas are linked to stressor events and the patient's appraisals of them.
4. Improving coping	Deeper expression of thoughts and emotions with negotiation of how to handle them and maintain state stability.	Works on themes and plans previously avoided.	Acts to encourage desensitization to triggers and emotional reactions, and helps the patient modify dysfunctional beliefs.
5. Working through	Attitudes toward the future are examined and negotiated realistically.	Restores a sense of self efficacy	Helps patient modify attitudes about self and others.
6. Terminating	Emphasis on safe separation.	Considers gains and unfinished issues, as well as how to cope with the future.	Highlights the most helpful new attitudes and changes that occurred.

for the reader's convenience in Table 8.2. The framework is organized under headings of Avoidant, Intrusive, and Hyperarousal states and, under these headings, in rows about type of mental functions.

**Table 8.2 Common Symptoms and Signs during Avoidant, Intrusive, and Hyperaroused States**

Sector of Observation	Avoidant States	Intrusive States	Hyperarousal States
Perception and attention	Dazed Selective inattention Inability to appreciate significance of stimuli	Sleep and dream disturbances, flashbacks	Hypervigilance, startle reactions
Consciousness of ideas and feelings related to the event	Amnesia (complete or partial) Non-contemplation of topics that ought to be considered because of implications of the stressor event	Intrusive-repetitive thoughts, emotions, and behaviors Feeling disorganized when thinking about event-related themes	Feeling time-pressured; racing thoughts
Information processing	Disavowal of meanings of current stimuli in some way associated with the event Loss of realistic sense of appropriate connection with the ongoing world Constriction of range of thought Inflexibility of purpose Major use of fantasies to counteract real conditions	Overgeneralization of stimuli so that they seem related to the event Preoccupation with event-related themes with inability to concentrate on other topics	Bias towards information with negative emotional connotations
Emotional attributes	Numbness	Emotional pangs related to the event or to reminders	Gastrointestinal irritations, muscle pain, cardiac palpitations
Action patterns	Frantic non event related over-activity Withdrawal and failure to decide how to respond to consequences of event	Compulsive repetition of actions associated with the event (e.g., search for lost persons or situations)	Frantic event related over-activity

The current presenting symptoms are considered for further explanation through a bio-psycho-social explanatory framework. In other words, for each patient, and for each symptom try to identify biological, social, and psychologi-

cal causation. Then see how some causative factors might form several of the patient's most troubling symptoms. Treatment can then aim at altering these causative factors, as well as aiming at symptomatic management.

Simultaneously, a clinician also inquires about other common syndromes such as depression, substance abuse, and traumatic brain injury. Other issues to address include states of feeling dazed, dissociated, depressed, hypomanic, impulsive, vengeful, annoyed, homicidal or suicidal. Several diagnoses may be appropriate to make on a single patient, then the clinician can evaluate further the story surrounding the stressor events, the patient's capacities for coping, and available support from social and health services.

### **THE STORY OF BEFORE, DURING, AND AFTER TRAUMATIC STRESSORS**

The story of the trauma begins by trying to understand what the patient was like prior to the event. When someone comes for an evaluation, the story of how they experienced the traumatic event will be told at some point, including symptoms and problems that emerged after the event. During the processes of treatment the initial story may be modified. Memory is seldom completely accurate. That is why the word "story" is helpful, as it will need re-telling.

### **PSYCHOEDUCATION: CONNECTING THE TRAUMA STORY TO POST-TRAUMATIC REACTIONS**

Sometimes the onset of trauma-related symptoms is delayed, making it difficult to link them to the precipitating traumatic event. A survivor of an accident may have experiences of distress months later, and not see the connection of recurrent nightmares of shattered windshields to the car accident. In addition, most people expect psychological responses to a trauma to subside faster than they do. Prolongation and swings of back-and-forth emotional responses are not necessarily psychopathology. The clinician can provide education on what is normal and what is sufficiently problematic to warrant treatment.

### **PSYCHOEDUCATION: UNDERSTANDING POSSIBLE PHASES OF RESPONSE**

Some patients may overpathologize their states of mind because they feel out of control over their experiences and emotional reactions to others. Some normal-

ization of symptoms can restore morale and reduce secondary fears of losing self-control. The five phases of a normal passage to recovery from a Post-traumatic period of disturbance to explain to patients are:

**Outcry.** The first emotional response involved in a traumatic experience.

**Denial, numbing, and avoidance.** Adaptive emotional strategies in which an individual does what is logistically necessary to deal with an immediate crisis, and defers extremely intense emotions that could otherwise cause a disorganized state of mind.

**Intrusions, pangs, and repetitions.** After a period of relative avoidance, memories and associations occur often giving rise to more sorrow, anger, remorse, or fear than was felt in previous days, weeks, or even months.

**Working-through.** The meaning of the trauma to the self is reappraised and attitudes are revised. New coping skills are acquired as needed to adapt to altered circumstances. Swings between intrusion and avoidance may occur, and gradually attenuate. The trauma story may change.

**Restoration of equilibrium.** As this phase is achieved, there may be post-traumatic growth, including an increase in self-coherence.

We may educate patients by discussing these phases, and in any individual we expect to have a lot of variation. Some patients will seem to go back and forth between phases, while gradually processing the meanings of the trauma with themselves and other potentially affected individuals. Oscillations between avoidance and intrusion are common. Telling patients that after some state-stabilization techniques they can expect phases of working-through and restoration may provide realistic hope. This information tells the patient what may occur; that they are not stuck in endless and distressing repetitions of their current phases of response.

Psychoeducation phase also includes a discussion of treatment options. Negotiations determine the next steps in establishing the framework of psychotherapy. An exception occurs if the judgment is made that the patient is at risk of violence to self or others, including suicidal intent. In that case, the clinician acts to secure protections for the patient, using legal means if necessary. Access to weapons should be prohibited.

## FORMULATION AND INITIAL TREATMENT PLANNING

A bio-psycho-social formulation that includes understanding of contexts before and after the trauma is important to treatment planning. This work may be repeated during the process of psychotherapy, as more information is gained and problems are remedied. Formulation helps clinicians see what topics should be addressed and focus the treatment in a way that will lead to stabilization. A sys-

tem for case formulation described here is Configurational Analysis (Horowitz, 1997c, 2005) which is summarized in Table 8.3. This approach first looks at the *phenomena* and selects the key symptoms and problems to be explained.

The second step in Configurational Analysis formulation is to describe *states* in which both unwelcome and avoidant phenomena occur. This may include *dreaded* states of intrusive images and horror, and less distressing and more *defensive* states of denial and numbing. The individualized nature of these dreaded and defensive states can also be contrasted with *desired* states of restored equilibrium.

In the third step, the clinician notes the *key unresolved topics and defenses*. The fourth step adds *self-other beliefs that lead to identity and relationships*. Pathogenic stress-induced shifts into such roles as degraded, incompetent, abandoned, shamed, scorned, abused, and unworthy are identified. The fifth step, integration and treatment plan, takes inferences and explanations and develops an integration that includes a linkage among states, unresolved topics, and core beliefs about self and roles in role-relationships. It also includes inferences about how defenses may shift schemas of self and other to alter emotionality. The treatment plan considers how to stabilize more adaptive states, when and how to address unresolved topics, and whether to interpret dreaded role-relationship models.

## ASSESSING PERSONALITY CHARACTERISTICS

Issues of identity and relationship patterns are addressed through the deeper levels of case formulation. Such levels reflect important personality factors. During early clinical contacts, personality factors are seldom clear because the trauma itself may cause identity regressions and interpersonal disorganization, thus presenting a somewhat skewed snapshot of patients' personality dynamics.

Personality and identity dynamics are assessed through the evaluations of signs. Signs are observable expressions of trauma-related pathology. Some signs suggest co-morbid disturbance in personality. When conducting an evaluation, I ask myself a series of questions to help me observe such signs. These questions are:

- Does the patient express sudden shifts in self-image and views of relationship characteristics?
- Do the patient's statements sometimes cause confusion between what has been thought and what action he/she has taken?
- Does the patient report radically impulsive decisions?
- Does the patient distort life stories and recent memories by excessively and remarkably removing his or her sense of responsibility?
- Does the patient become disorganized or out of control when angry or frustrated?
- Does the patient grossly misread communications and intentions?

**Table 8.3 Steps of Formulation for Stress Response Syndromes: Configurational Analysis Method (Horowitz 1997c, 2005)**

1. PHENOMENA	Select the symptoms and problems that need to be explained, and describe the stressor events that precipitated them.
2. STATES OF MIND	Describe states in which the symptoms and problems do and do not occur. Indicate triggers to problematic or dreaded states. Include states of avoidance and impairments to achieving positive states of mind. Describe any maladaptive cycles of states.
3. TOPICS OF CONCERN AND DEFENSIVE CONTROL PROCESSES	Describe unresolved stress-related topics and how they evolve to problematic states. Indicate persisting dysfunctional beliefs. Infer how enduring beliefs mismatch with the news from the stressors. Describe how expression and contemplation of these unresolved topics is obscured. Infer how avoidant operations are used to ward off dreaded states.
4. 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 model. Infer how compromise role-relationship models ward off danger. Describe repetitive dysfunctional belief about roles and cause-effect sequence.
5. INTEGRATION AND THERAPY PLANNING	Consider problematic bio-psycho-social interactions and how to ameliorate situations. Explain how schemas of self and other lead to problematic states, and how any pathogenic defenses prevent resolution of topics of concern. Examine factors that operate to prolong symptoms and state how to counteract them. From this formulation predict how to facilitate change. Plan how to stabilize working states and prevent pathologically impulsive actions. Consider how and when to modify belief and behaviors, alter social supports, and design treatments for biological impairments.

If the clinician responds with “Yes” to three or more of these questions, that may suggest Complex PTSD or a personality disturbance. As mentioned, disturbance in personality can be a regression due to the trauma reaction or a personality configuration that was present before the event. In individuals with signs of personality disturbances present before the recent trauma, the clinician should plan to proceed slowly. Attention to building a stable therapeutic alliance over time is indicated and, thus, time restrictions on the length of treatment are contraindicated.

It is important to assess current functioning by observing how in touch with reality that patient is and the nature (i.e., explosive or smooth) of his or her shifts in states of mind. Also of importance is the patient’s ability to compare and contrast realistic and unrealistic concepts about self and others. Patients who

have more vulnerability to loss of identity coherence often use reality-distorting projections to stabilize a sense of self-efficacy. As these projections occur or fail to protect them, such patients exhibit explosive shifts in their states of mind. Such more-disturbed patients may not differentiate well between internal versus external loci of action, or between reality and fantasy. Therapy with more-disturbed patients may need to include time to promote the acquisition of new skills for self-awareness and reflecting on the intentions of others. This will mean longer treatment with such patients.

## TREATMENT NEGOTIATION

After providing psychoeducation in terms accessible to patients, a treatment plan can be negotiated. Formulation is revised during treatment and the patient should be told that this early formulation is an initial effort to be reconsidered as more is known. Because crisis planning is often a part of the initial evaluation in trauma patients, it can be helpful to provide the patient with lists of appointments, crisis plans of “What to do if...,” and a list of which medications to take and which to avoid.

## Support

Patients often seek professional help weeks or months after a traumatic event, when they are symptomatic and have an intuitive sense that they are not recovering. Usually these symptoms occur in an undermodulated state of mind characterized by intrusive experiences, dangerous impulses, or a sense of loss of control. If so, state stabilization through initial supportive measures is indicated. At the biological level, this may include prescription of medications, restored nutrition, exercise, and more rest. At the social level, supportive measures include time structuring, advising other people on how to have contact with, and help the patient, and other contextual interventions such as work-responsibility modifications. At the psychological level, supportive measures involve the establishment of a therapeutic relationship and a plan for treatment. The patient gains hope for recovery after perceiving empathy, expertise, and a readiness to provide care from the clinician.

## BIOLOGICAL SUPPORT THROUGH MEDICATIONS

Many biological systems shift under stress. One system involves catecholamine chemistry. Changes affect neural networks that connect the limbic, frontal corti-

cal, basal ganglia, and hypothalamic structures. Disturbances in electrochemical physiology of these networks can affect arousal control and alter capacity to regulate emotional responses (as in increased frequency of flight and rage). The amygdala may alter its danger recognition set points, the hippocampus may alter its memory encoding properties, and the medial prefrontal cortex may alter its abilities to modulate impulsive emotional responses.

Other brain regions are connected to the emotional arousal regulating functions of the amygdala. These regions and various neurotransmitter chemicals may be involved in heightening biological propensities for hyperarousal, hyper-vigilance, and sudden alarm reactions to trigger stimuli.

Repeated alarms caused by excessive sensitivity along neural connections can lead to fatigue and further dysregulation of cognitive-emotional functioning (Ravindran & Stein, 2009; Southwick et al. 1993).

If and when assays or tests of dysfunction of the neurotransmitter and hormonal systems become possible, then a therapeutic prescription system will become possible. Until then *affect-dampening medications* are sometimes used to prevent extremes suggestive of excessive sympathetic nervous system arousal. The signs include excessive vigilance, tension, startle reactions, fatigue, emotional flooding, agitation, and racing thoughts. These sedating and possibly addicting agents can often be used in a single dose or as a night-by-night sedation. Transient use of anti-anxiety medications has sometimes been effective as a way of reducing explosive entry into extremely undermodulated flooded states. Regular, extended use of anti-anxiety medications is often inadvisable. Medications that reduce autonomic nervous system arousal, such as the beta-adrenergic blockers, have also been tried. In the main, however, antidepressant agents have been more useful in some cases than have antianxiety and arousal-blocking medications (Frank et al. 1988; van der Kolk et al. 1994; Davies et al. 2006).

A variety of *antidepressant medications* have been used for depressive disorders that often result from extreme stress, as well as for PTSD and panic attacks exacerbated by traumatic events (Davidson et al. 1990; Shetatsky et al. 1984). Selective serotonin reuptake inhibitors, tricyclics, and monoamine oxidase inhibitors have all been tried with some reported successes. The most widely prescribed are the SSRI agents. New research has also shown that some recurrent schizophrenic episodes may be precipitated by life events. At such times, prescriptions of antipsychotic medications (or adjustments in dosage) may be indicated.

Medications are best selected according to the symptoms and biological formulation of each individual patient. Prescriptions should be carefully considered in terms of the length of trial for each psychoactive agent used. Addictive use of alcohol, prescription drugs, and street or over-the-counter drugs should be avoided. Patient's use and abuse of substances despite recommendations not to



should be considered when prescribing medications. Poly-pharmacy and over-sedating drug interactions are common and dangerous.

## SOCIAL SUPPORT

People who are exposed to traumatic events often experience themselves as overwhelmed. Clinicians may in some cases involve the patient's social support systems into treatment. Interventions may consist of advice given to social companions who are less overwhelmed. This general advice is listed as follows:

1. The victim may need to be transiently protected from excessive stimulation. Helping them to structure time following a disaster should emphasize short-range activities that affect reality.
2. The patient should be provided with opportunities for communication and a sense of positive connection to others. Discussion of events with others may be useful because it clarifies differences between realistic and unrealistic interpretations.
3. Giving timelines for dose-by-dose coping can restore a sense of personal efficacy to a bewildered or overwhelmed victim. The Scarlett O'Hara approach of "I'll think of that tomorrow" can be adaptive if not prolonged.
4. Activities should include time for respite. It is important for the person to feel that it is all right to rest, use humor, or change to non-coping activities for a period of restoration.
5. Give the person something active to do in the role of helping self or other. Sometimes membership in a mutual support group can serve this purpose.
6. Remember that the more the person has been traumatized, the longer it will take for symptoms to subside. This may contrast with the expectation in some work environments that the traumatized person return to her usual functional level within a week. The workplace provides sustaining interest and social support; the victim should not be isolated from it, but neither should she have to meet excessive expectations.
7. Children may see repetitious film clips of a disaster that they have been thorough on TV and believe that the depicted event is really happening over and over again. They need adult explanations to reassure them that they are safe.
8. Because sleep disruption with nightmares is common, the victim may associate efforts to sleep with episodes of unpleasant imagery. It is helpful to increase a sense of safety. This can include leaving lights on or sleeping with a pet. Children may be allowed to sleep with a parent although that is not the usual domestic arrangement. In extreme cases, telling the victim that a companion will stay awake and watch over him during sleep can encourage rest.

9. The person may be more accident-prone while driving or operating machinery. For these reasons, keeping the victim from driving unnecessarily or doing hazardous tasks may be advisable for a time. It must be done tactfully so as to avoid incompetent self-concepts.
10. Right after a traumatic event, the victim's relatives and friends cluster around and want to know all about it. The victim recounts the story again and again. Later, companions may become tired of hearing about it but the victim may still feel the need to review what happened. At these later stages, listening is still useful. The therapist may advise family and friends that "being there" and listening fulfills a useful function, and that they do not have to offer solutions, directives, or unsolicited interpretation to be helpful.
11. The survivor may be extremely sensitive about others' questions and reactions to their trauma, and may react in an irritable, short, or impolite manner even with the well-meaning loved ones. It is advisable for loved ones not to take it personally, as this reaction is part of posttraumatic symptoms. Rather, it is advisable to approach such attitudes with a stance of calm acceptance.

## PSYCHOLOGICAL SUPPORT

Nearly all people experience a need for closer social support after a traumatic stressor event. Under strain, some may regress to desperate or excessively anxious attachment patterns. Unfortunately, those prone to the more desperate forms of help seeking alienate those who might otherwise help them. The therapist can provide some of that needed relationship support, as discussed under social interventions.

Establishing regular appointments, a diagnosis, and a formulation can be quite reassuring in these initial stages. Conveying facts about trauma-related disturbance can reduce secondary anxieties. Some people may, for example, presume that intrusive symptoms represent such a high degree of lowered control over mental contents and interpersonal emotional expressions, which means that they are losing their mind. The therapist can reduce patients' fears by giving them accurate information about the prevalence of such post-traumatic responses as well as the usual course of improvement (rather than deterioration) in such symptoms.

Patients may be told that they do not have to focus attention on intrusive memories, ideas, and feelings. Putting such topics out of mind can restore equilibrium and it does not mean that stories about traumas and memories of those who died will be either forgotten or avoided forever. Distraction through pleasant activities can be useful as a way to restore calm for a period of time.

Some patients feel less attractive or likable in their post-traumatic states of mind. They cringe because they believe others see them as cowards, weaklings, malingerers, bores, or ugly companions. Realistic reassurance can be given; telling the patient that this is a common response can partially restore a rational perspective. Stigmatization in social settings should be actively confronted and counteracted with realistic information.

Establishing a commitment to care by outlining a plan for therapy provides both empathy for the patient's level of current distress and hope for change. Such initial support can lead to a sharp reduction in symptoms. The patient can then move rapidly toward exploring meanings, improving coping, and working through in the ensuing phases of psychotherapy.

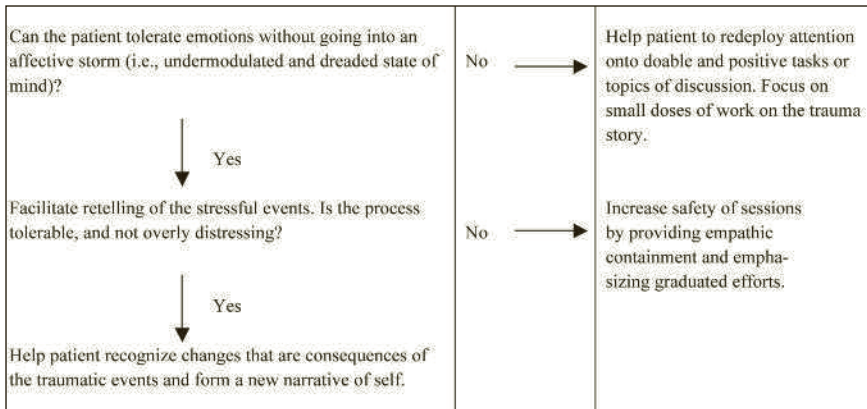
There are a variety of systems for relaxation that may be useful to people who do not already know how to use such procedures. They may range from deep breathing exercises to systematic muscular relaxation or other somatic slow-down practices. In addition, other stress management techniques such as periods of socialization and relaxation, regular diet, and frequent naps if sleep is disturbed, should be utilized.

## Exploration of Meanings

Once the patient is capable of tolerating intense and unpleasant emotions, the stressor event's meanings to the self can be examined. That is why intense feelings are sanctioned within a therapeutic alliance and overwhelming feelings are titrated into dose-by-dose experiences. The goal is a process of safe exploration and eventual explanation to reach conclusions about the stressor event.

When the clinician discovers a block to working through reactions to a trauma or loss, he may help the patient by clarifying differences between realistic and fantasy-based beliefs. In doing so, the clinician allows the patient to learn by identification, as well as by lucid trains of reappraising the implications of a trauma. The clinician is a person who is not overwhelmed by thinking about the implications of illness, injury, or loss. The presence of the clinician as a compassionate and empathic person who is caring, thinking logically and who is non-critical is reassuring and containing.

To maintain a safe situation, patients may be urged to take a one-dose-at-a-time approach, contemplating the most immediate consequences of what has happened and putting off long-range considerations for a period of time. This reassurance indicates to patients how to tolerate what has seemed intolerable. A decision-tree summarizing some of these issues for a middle phase of psychotherapy is shown in Figure 8.1.



**Figure 8.1 Decision Tree for Exploration of Meanings.**

## Improving Coping

After a reformulation of the meaning of event to the self is accomplished, the therapist can plan how to help a patient improve his or her future coping style. Attitudes that lead to unnecessary avoidances are challenged and, perhaps, the therapist can state the patient's apparent reasons for clinging to inhibitions. This usually entails explaining to a patient why they are inhibiting thoughts, perhaps they fear that contemplation of a part of the trauma memories (and its implications) will lead into an undermodulated, dreaded state of mind. A dose-by-dose approach is again encouraged: this means the patient will be shown how to discuss the hard topics of concern in tolerable amounts, using attention deployment controls rather than global inhibitions. This process will lead to expressions of negative emotions but these will be within tolerable limits. Additional desensitization procedures and relaxation exercises, such as deep diaphragmatic breathing, stretching, biofeedback, systematic body movement, guided imagery, yoga, and meditation might be considered.

### THE BRIEF CASE OF SARAH

The therapist may focus on reducing the shock of repeated unbidden images, as in the case of Sarah, a physically abused woman. Her husband had beaten her and during the attack, she saw an expression of pure hatred on his face and felt all connection between them was shattered. Her prior view of him had never included a concept of his wanting to annihilate her. That image of his malevolent face returned, intrusively, again and again.

The image of his expression of hatred was verbalized by the therapist, who then helped Sarah to do the same. The shocking realization that her husband was capable of wanting to persecute and victimize her seemed worse than her physical wounds. Nonetheless, she might hope to gradually understand and master this shock.

Sarah and her therapist put the unbidden image experiences into the context of examining the past, present, and future of the marital relationship. Repeated discussions about her relationship with her husband helped her form her own realistic goals for either leaving the relationship or re-negotiating its essential boundaries of safety for all parties.

Sarah reported unhelpful beliefs of “I must be married to him to appear to my community as a worthwhile person; I must never express my anger, or he will reject me” and, “If I don’t fulfill all his needs, I am a total failure.” These erroneous attitudes were clarified and the therapist helped her to form alternative realistic and achievable beliefs, leading to new, achievable attitudes. Sarah gained control over previously unbidden images, and now could deliberately recall them or direct her attention elsewhere by putting them out of her mind.

## AVOIDING UNWANTED THOUGHTS

To avoid dreaded states of mind, some people develop habitual styles of warding off unresolved and highly emotional themes. Obstacles to working-through may stem from automatic avoidance. Therapists may observe these defenses by noting how a patient minimizes, partially confronts and partially avoids, dismisses, or distorts the meanings within specific topics of concern. These defensive controls should be tactfully counteracted. Naming the topics of concern with verbal labels provides the patient with small but valuable increments of conscious control of how attentions will be deployed in a state of mind.

In other words, emotional self-regulation is a highly important topic to discuss in therapy with a trauma survivor. Paying attention to self-governance can be bolstered and increases reflective awareness in a patient. This increase in monitoring is sometimes called “mindfulness.” In developing this, the patient is learning a new cognitive skill and a measure of pride can be acquired in doing so.

In discussing habits of regulating emotional states or moods, it may help clinicians to understand attention deployments. Controlling, or failing to control attention deployment are processes that can lead to three kinds of outcomes. These outcomes range from 1) succumbing to stress, as in having emotional flooding and unbidden memory repetitions as vivid images, 2) excessive blunting of awareness from overcontrol, and 3) the preferable outcome of adaptive coping by rational thought.

## SUCCUMBING TO STRESS

Attention may engage trauma memories to the point of inducing a flooded state of reliving moments of terror, dissociation of self from reality, or destabilization of a sense of *identity*. This is succumbing to stress because it is re-traumatizing. The reason this phenomenon can be “retraumatizing” is that instead of encouraging extinction, emotional alarm reactions remain associated with stress memories and ideas. For instance, sometimes survivors experience this type of flooding when giving a police report of their assault immediately afterward, long before they are prepared to safely discuss such material. The traumatic information in the memory is erroneously regarded as here-and-now, and the self becomes terrified and perhaps chaotically threatened with fragmentation.

## EXCESSIVE INHIBITION

In contrast, attention to the trauma story memories can be inhibited as a defense against such dreaded states of mind. This defense is better than succumbing to re-traumatization and dissolution of efforts to re-establish a meaningful equilibrium. The result of the defense can be suppression, even if in order to accomplish it the person abuses substances such as opiates, alcohol or sedatives. But such defenses do not lead towards completion of processing the meanings to self of the stressor events. That requires coping types of control of emotion.

## COPING WITH EMOTIONAL TOPICS

Coping types of attention deployment include rational expectations of periods of respite and restoration. That is, the trauma story is contemplated in unthreatening circumstances such as that provided by secure attachments or therapeutic alliances. This may include intentional withdrawals of attention from the trauma story, expecting to return to examining its present implications at another time, in a relatively calm state of mind. Courage and stamina are encouraged and supported.

## HABITUAL DEFENSIVE STYLES

Defensive operations are common in the treatment by the psychotherapy of trauma-related disorders. In a study of 66 cases of Post Traumatic Stress Disorder (Horowitz and colleagues 1980a) treated in psychotherapy three of the most common ways of avoiding the emotional heart of trauma or loss story were (1)

excessively inhibiting associational connections (found in 69% of the cases), (2) excessively changing attitudes to avoid emotion (64%), and (3) unrealistically distorting reality to avoid deflations of self-esteem (41%).

Because defensiveness is often excessive, it is sometimes useful to direct patients' attention to this fact to counteract some avoidant control processes, in order to more fully explore meanings relating self to the stressor events. Some techniques for use with people who habitually inhibit ideas are illustrated in Chapter 10, for those who stifle emotion in Chapter 11, and for those who distort reality for self-enhancement in Chapter 12. They are briefly highlighted here in Tables 8.4, 8.5, and 8.6.

**Table 8.4 Obstacles to Therapy with People Who Habitually Inhibit Ideas**

<i>Defensive Style</i>	<i>Therapeutic Approach</i>
Global or selective inattention with impressionistic rather than accurate discourse about the events.	Encourage talk and provide verbal labels. Ask for details, and then construct cause-and-effect sequences.
Limiting disclosure due to inhibitions of ideas.	Encourage verbalization with repeated modeling of production through clarifications.
Short-circuiting to erroneous conclusions.	Keep the topic open and emphasize step-by-step decision-making (i.e., thought before action).
Misinterpreting based on past stereotypes of self and others.	Differentiate reality from fantasy. Clarify time frames, distinguishing past from future possibilities.

**Table 8.5 Obstacles to Therapy with People Who Habitually Avoid Emotion**

<i>Defensive Style</i>	<i>Therapeutic Approach</i>
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.	Hold discussions on one valence of a topic.
Endlessly ruminating without reaching decisions about how to act.	Interpret warded-off but dreaded possible negative consequences of seemingly positive choices.

**Table 8.6 Obstacles to Therapy with People Who Distort Reality for Self-Enhancement**

<i>Defensive Style</i>	<i>Therapeutic Approach</i>
Focusing on blaming others.	Support, encourage, and praise efforts at truthful reconstructions of memories. Do not blame or accuse of lying.
Avoiding information that deflates self-concepts.	Use tactful timing and wording to counteract deceptions.
Sliding meanings about who did what to whom (e.g., exaggerates the importance of other's actions in order to blame them and thus 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.	Clarify who-is-who, in terms of acts and expectations.
Forgiving self too easily when some remorse is realistically justified. Denies any culpability.	Support self-esteem with a genuine interest in the patient while working toward an appropriate plan for realistic acts of remorse.

## THE BRIEF CASE OF STEVE

Another defense is devoting attention to fantasy rather than reality. The avoidant fantasy may deny the actual outcome of a stressor event. For example, Steve was a resident neurosurgeon who unfortunately had a patient die during a brain surgery. In therapy, he reported dreams of triumphant surgical successes. The therapist said, "Your dream shows you would like only great successes. You would rather have seen the operation come out well than have had the brain tumor patient die." This sounds obvious, however, Steve experienced the remark as a surprising emotional connection. It helped Steve to add a future to his present-focused time frame: in the real past, the surgery failed; in the imagined present it succeeded in dreams; in the future, Steve could really save other patients.

## TECHNIQUES OF GRADUAL EXPOSURE TO ASPECTS OF TRAUMA STORY MEMORIES

During this stage of treatment it may be useful to introduce various types of exposure to the memory of the trauma or to situations associated with it (Foa et



al. 1991, 1995; Marks, 1981; Meichenbaum, 1977, 1980). Many patients will worry that such repetitions will lead to a retraumatization. This fear is a legitimate one. For that reason a rationale for exposure to threatening stimuli needs to be provided to the patient. The effects should be evaluated over several sessions during the evaluation of the therapy process. The desired outcome is a decrease in intensity and negativity of affective arousals and re-experiencing symptoms.

The rationale for exposure techniques involves a theory of habituation. Familiarity with the previously frightening stimuli can increase calm if the repetition occurs in calm states. The goal is desensitization of the conditioned associational link between the stress stimulus and the alarm emotions. That is why it is important to assess whether or not a relatively calm state of mind can be gained, if restoration of equilibrium does occur as a consequence of the use of the exposure techniques. Simple rating scales of distress can be used to indicate if reductions in alarm occur. A ten-point scale with "the most distress you could possibly experience" as ten, and "no distress whatsoever" as zero, can be helpful in obtaining patient reports of inner experiences during exposures.

In addition, exposure techniques can help the person reorganize his or her cognitive map of how the traumatic event relates to a revised current reality of the self. The repetitions encourage emotional information processing, which may include revisions of identity and attitudes about the future. The therapist encourages the patient toward a differentiation of how the current stimuli are similar and different from traumas in the past, and also encourages a heightened sense of self-efficacy (Foa & Rothbaum, 1998).

The most common exposure technique is to ask the patient to retell the experience of the traumatic event. Another technique uses writing about the meaning of the event and discussing it with therapist (Resick, 1992). Imagery is used during another commonly used method. During such *imaginal exposure*, gradations of imagery experience from mild to intense are used. The suggested images for review gradually move toward more painful and distressing experiences.

Another technique involves in vivo exposure, which is directly confronting fear situations. The patient returns, perhaps with a supportive companion, to the situation or place where the trauma occurred. Usually there is a hierarchy of avoided situations. The person first confronts those likely to induce only a mild level of anxiety. He then gradually confronts situations that might arouse more distress. This gives the person a learning experience that, with appropriate support, can make him calmer in previously avoided threatening situations.

It is helpful to teach the patient how to relax from tension during these imaginal, or in vivo procedures. The goal is to be able to think about distressing themes in calmer states of mind. Once again, muscle relaxation, breath control, and postural changes from guarded positions to more relaxed ones are sometimes useful techniques for this purpose.

After any recollection as in vivo exposure or imaginal exposure, it is important to review the experience. This includes assessing associations and clarifying any dysfunctional beliefs. The therapist may repeatedly contrast dysfunctional beliefs with more adaptive alternative ones, as well as highlight the patient's ability to tolerate exposure.

Because exposure can lead to an increase rather than a decrease of intense negative emotion, it is important to again emphasize a dose-by-dose approach and safety planning. That means the person can learn how she can stop paying attention to a threatening topic. At first, the therapist presents alternative topics for contemplation to encourage attentional shifts. The therapist may use role-playing techniques to show the patient how to both remember and how to change the topic of contemplation. Then methods for attention control without the presence of a therapist can be taught.

## Working-Through

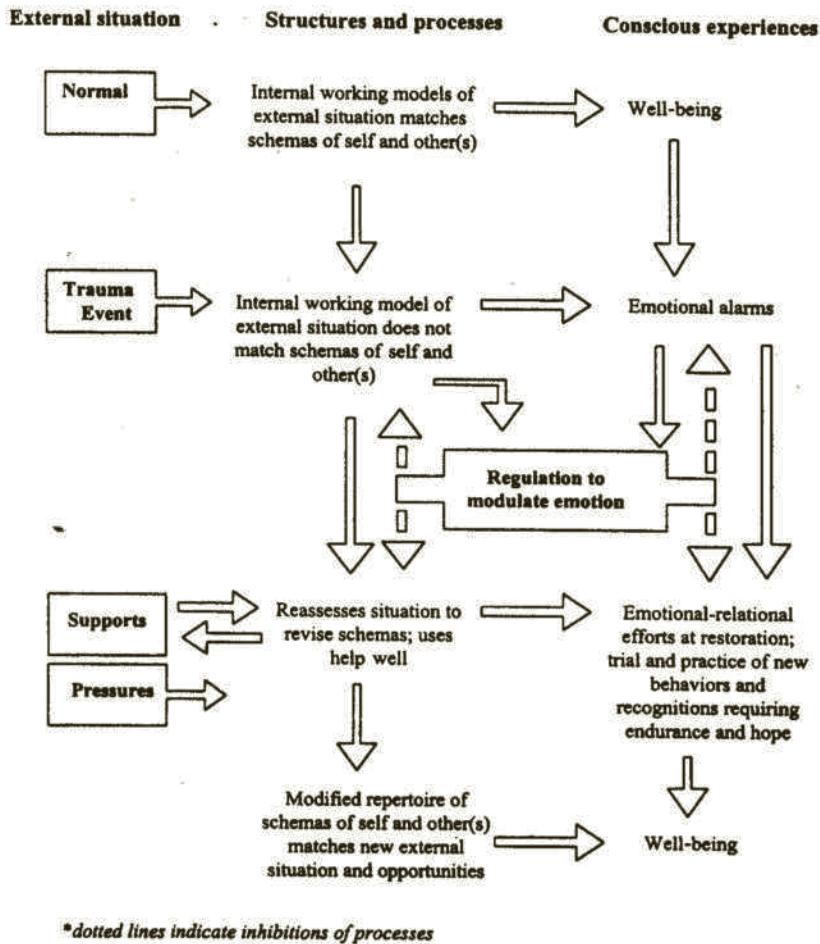
If the person has contradictory schemas and emotional conflicts *before* a traumatic event, as in cases of complex trauma, it may be more difficult for him to reschematize identity and relationship beliefs *after* the event. Defensive avoidances may have become habitual ways to avoid negative emotions and dreaded, undermodulated states of mind. That may lead to overcontrol after the event. The effect may be such that an emotion-avoidant inhibition of information processing occurs and reschematization is not accomplished. The result is prolonged problems.

The goal of therapy is then to work through the patient's dilemmas so that reschematization of identity and relationships can occur. The goal is to help a problematic response change to become an adaptive response. A review of what has been discussed previously on this topic is presented in the following Figures 8.2 and 8.3.

### WORKING THROUGH TOPICS OF CONCERN

Working-through usually adds reappraisal of prior personality-based beliefs, as related to beliefs that were processed with the trauma story. This often involves activation of any excessive fear of self-victimization, irrational shame over vulnerability or incompetence, and childhood themes of abandonment, envy, anger and impulses for revenge.

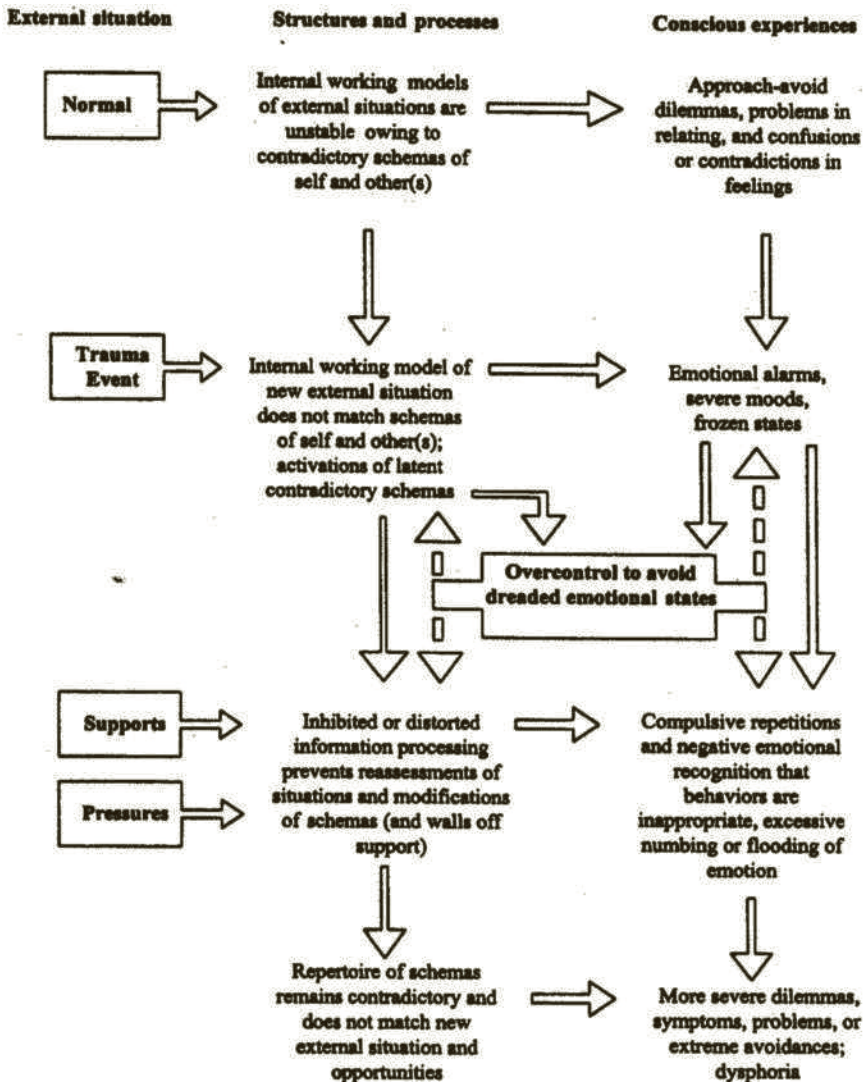
*The fear of victimization* relates to the dread that either the self or loved ones will suffer torments and horrors. During a disaster with multiple victims, the per-



**Figure 8.2 Normal and Adaptive Psychological Responses to Trauma.**

son might have felt relief for having survived; that relief might later be remembered with shame or guilt because others suffered terribly. There may also be a fear of merger with victims, of being dead or maimed like them. A current trauma with self as victim can be associated with past traumas or fantasies of self as victim, intensifying emotional reactions, and making cognitive processing more complex.

*Shame or vulnerability and incompetence* during a disaster or victimization can be associated with childhood views of self as weak and lacking in sufficient skills or in courageous values. Anger, in which others are blamed, can be a defensive lid on such dreaded feeling states and internalized roles.



**Figure 8.3** Problematic and Maladaptive Psychological Responses to Trauma.

*Anger at the source* of a trauma and a thirst for revenge upon the aggressor people (or displacement figures) is also a common but conflicted theme. This type of attitude may serve as a self-strengthening defensive shift away from shame. Blame is externalized. The result can be irrational attitudes that view actually innocent others as aggressors.

*Low thresholds for states of despair and depression* can ensue when events lead to loss. Loss may include loss of bodily sensations and loss of comfort, as in chronic post-accident pain syndromes. In cases of the loss of others, or one's own body parts, a mourning process usually takes place. Nevertheless, unresolved grief may be present and is more likely to occur in people who have been too frightened of sadness to allow grief work to take place.

Depression is likely in those with vulnerabilities to such states. People with prior insecure attachments may be especially vulnerable. In Complex PTSD these issues are more prominent, and extended treatment may be needed to facilitate post-traumatic growth in terms of identity coherence and capacity for relationships.

If and when some meanings of the stressor event are linked to anticipated but dreaded identity concepts and role-relationship patterns of the past, the therapist clarifies this link, challenges the expectation that the negative belief will come true, and offers more realistic attitudes. That is, for each conflicted theme in an individual patient, repeated attention is paid to how to envision and rehearse for a more adaptive future.

At this phase, the clinician and the patient will have identified "hard topics to deal with" resulting from the stressor events. For example, a hard topic may be reconsideration of aspects of the trauma story where an emergency self-preoccupation prevented helping others survive. Survivor guilt and how to resolve it is then one of the hard topics. The patient may be told that hard topics require a lot of time to think through and fully understand. Some of the time, contemplation and reappraisal required can occur outside of the therapy session, perhaps in the form of journal writing. What the patient wrote can then be reviewed with the clinician.

Working on a hard topic can follow a sequence that organizes an otherwise confusing jumble of ideas and images. Table 8.7 provides a useful outline which can be altered according to the patient's needs, and taken home by the patient as an instructional guide to writing. The format can also be followed by the patient and therapist together in treatment discussions.

In summary, during the working-through phase, the therapist deepens the focus of joint attention. This deepening involves processing of what has been warded off. The aims are differentiation of reality from fantasy, new decisions, and planning for changes in patterns of personal and social functioning. A reduction in emotional intensity and improved patterns of self-governance are achieved as an increase in self-coherence is fostered. The more there is a need for post-traumatic identity growth, the deeper the levels of attention that may be required. Table 8.8 illustrates gradual deployment from surface to, and deeper levels of attention in therapy. Such a deeper level of processing might include consideration of usually unconscious attitudes if needed in complex trauma cases.

**Table 8.7 Methods for Working Through a Hard Topic**

1. <i>Select a topic of concern</i>	<ul style="list-style-type: none"> <li>• One that has a tendency to often intrude</li> <li>• One with pangs of intense emotions</li> <li>• One that keeps you from moving on</li> </ul>
2. <i>Then get in the right frame of mind</i>	<ul style="list-style-type: none"> <li>• Create a calm state where you can give yourself time to proceed slowly.</li> <li>• Establish an intention to think openly while avoiding harsh self-criticism.</li> <li>• Aim at thinking about how you are thinking.</li> <li>• Stop and do something else if your calm disappears.</li> </ul>
3. <i>Use dose-by-dose thinking</i>	
4. <i>Plan to remember and return to your key ideas</i>	
5. <i>Examine contexts and scenarios of what is likely and unlikely to happen in your future</i>	<ul style="list-style-type: none"> <li>• Best (idealized) versions</li> <li>• Worst (dreaded or catastrophized) versions</li> <li>• More realistic or middle-ground versions</li> </ul>
6. <i>Separate reality from fantasy</i>	<ul style="list-style-type: none"> <li>• Challenge your current appraisals with more realistic alternative ones.</li> <li>• Consider what is preventing you from moving forward.</li> <li>• Be optimistic. Do not give in to an easy but inappropriate choice as a quick way out.</li> </ul>
7. <i>Make realistic decisions.</i>	<ul style="list-style-type: none"> <li>• Expect to practice new actions.</li> <li>• Expect new actions to feel awkward at first. With repetition they will come easier.</li> </ul>

As summarized in Table 8.8, therapy starts at the surface level of the trauma story and proceeds to work on a deeper level. Such a deeper level of processing might include consideration of usually unconscious attitudes if needed in complex trauma cases.

Through creating this multi-level process, the therapist aims for the in-depth discussion required to restore equilibrium. In most simple adjustment, loss, and PTSD cases, attention is focused at levels 1-5 (Table 8.8); these can often be accomplished in a brief therapy. If focusing on the deeper levels of 6 through 7 is necessary, time for more reschematization will be required and may require a longer time in therapy. An example follows.

## THE BRIEF CASE OF SALLY

Sally, a young Indian-American, single woman in her early twenties, had a complex fracture of her femur, having fallen from a ladder while helping her father

**Table 8.8 Levels of Attention May Gradually Deepen as Therapy Progresses**

<i>Level</i>	<i>Focus</i>	<i>Activity in Conversation between Patient and Therapist</i>
1	Stressor events and personal responses	Expectations of treatment and attitudes about recovery processes
2	Choices of how to cope with present crises	Plan best available choices
3	Avoidance of adaptive challenges	Counteract obstacles and challenging ideational distortions
4	Dreaded states of mind	Identify triggers, plan, and rehearse what to do in trigger situations
5	Irrational beliefs	Differentiate between realistic and fantasy appraisals, and learn corrective attitudes through repetition
6	Maladaptive interpersonal patterns	Clarify interpersonal problems and contrast with alternatives
7	Often unconscious, schemas of self and others	Correct identity and relationship attitudes

paint his house. A partial paralysis resulted from nerve damage. This complicated matters by disrupting her plans to accept a teaching position after graduating from college. She came for therapy with a diagnosis of Major Depressive Disorder and Adjustment Disorder precipitated by her accident and its sequelae.

One theme activated by Sally's injury was hostility toward her father for not taking good care of her. The relevant ideas about the stress event were that her father had given her a rickety, wooden ladder, while he used his solid new aluminum one. Awareness of her anger was partially warded-off by defensive inhibitions of contemplating this theme at the time of treatment onset.

During an early treatment hour, her vocal tone and momentary facial glares expressed signs of anger at the therapist because he would not prescribe sleeping pills for her insomnia. Though the therapist was able to see the non-verbal signs of this emotion, it was not expressed clearly in verbal form by Sally. The therapist considered possible statements he might make. He could say, "I think you may be angry with me but are afraid to say so," or he could link the exploration of anger at him toward the father. The latter approach could be worded as follows: "I think you may be getting angry with me right now because I am not meeting your need for a sleeping pill, just as you may be angry with your father because you feel that he did not protect and care for you properly by giving you that rickety, unsafe stepladder."

This type of wording links emotional reactions in the therapy situation to a relationship aspect of the current stressor situation. It maintains the focus of treat-

ment on resolving reactions to recent events. The therapist, by raising Sally's anger in therapy to verbal expression, increased in her the kind of contemplation that can lead to revised views of the trauma story. This kind of interpretation could lead to exploring her views of her father's motives about the ladder assignments and to the larger, deeper issues of their past, present, and possible future relationship.

## Terminating Therapy

During termination, the goals are to work through emotions about separating and to reinforce corrective beliefs and attitudes. Plans for repeating, rehearsing, and practicing adaptive cognitions and behaviors should be made and perhaps written down for later review. Termination of the treatment threatens reenactment of the patient's vulnerability as experienced during the original stressor events.

Therapists ideally introduce plans for terminating several sessions before the final one. This way, a loss of the therapy can be faced gradually, actively rather than passively, and within a communicative relationship. It may be helpful to inform the much-improved patient that internal work that digests the stress-inducing experiences, will continue after therapy itself concludes.

Some alarm reactions that have subsided may reoccur after therapy ends. Psychoeducation on such occasions is a part of termination. If such symptoms re-emerge, this should not lead to dismay. It is also important to advise patients to repeatedly practice on their own what they have learned in treatment.

### THE BRIEF CASE OF FRANK

The following case illustrates a formulation for planning treatment described in Table 8.3. Frank, a Serbo-Croatian immigrant, who at the age of nine immigrated with his family to the United States, sought treatment at age 25 for his experiences as a lifeguard at a neighborhood pool. On one busy summer day, the pool was full of children and adolescents. There were many people in the water, and acts of unruliness were occurring on the deck. Frank was quite busy and realized that he was so overloaded with demands for his attention that he could not be sure that 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 to the surface a small, limp boy to the deck. The child was not breathing. Frank began cardiopulmonary resuscitation. This 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 became upset by the grief-stricken faces of the child's parents.



Frank went through turbulent periods of remorse, insomnia, attacks of anxiety, guilt, and shame, and 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.

Six months after the event, Frank began having frightening nightmares, with visual images of a dead body in a pool, a blurred face of a child, and angry faces of adults. He was preoccupied with feelings of remorse, which disrupted his concentration at his new job. He had outbursts of anger with companions. These intrusions occurred despite his efforts to avoid them.

Frank could not sustain interest in his career or recreational activities. A desired lively state of productive working or focused concentration could seldom be maintained. Instead, in a defensive problematic state, he felt that everything in his world was cloaked in fog. At times, he had a dreaded and undermodulated state that bordered on panic: he felt that he was about to die. These states were markedly different from his usual amiability and enthusiasm before the drowning.

In the earlier phases of psychotherapy, Frank was remote and apathetic when pressed for details about his current feelings. It was hard to clarify those subjects that seemed to cause his most dreaded states. This was ameliorated as the therapist indicated empathic and compassionate recognition of his suffering.

During a working-through phase of psychotherapy it became clear that Frank viewed himself in terms of antithetical sets of self-concepts. His worst sense of identity was as an irresponsible, careless, self-centered caretaker however, he ideally wanted to regard himself as a truly caring person who was competent at protecting others. Early on, after the event, he externalized blame onto pool directors who did not care enough to hire additional lifeguards, or to control the number of people allowed to use the pool.

In the working-through phase his rage at the pool managers for putting him in an overly demanding situation was examined and exploring this topic led to a negative reaction toward the therapist, including rage aimed at the therapist who Frank thought was expecting too much of him. A warded-off feeling that recovery was too good for him was unearthed. Frank brought up a past memory of himself at the age of five, where he had piled toys onto his unwanted two-year-old brother, in an effort to get rid of him. This past memory added intensity to his guilt.

Frank was asked to explore the question of how much remorse he needed to feel in order to reduce his sense of guilt. As Frank worked on this issue, he decided to volunteer his services to teach drowning prevention to schoolchildren, even though it made him tense and anxious. He saw how he could be constructive; this differed from a need to be self-punitive as in seeking to fail in his current career efforts.

Frank felt that his equilibrium was restored after a long period of treatment. In the termination stage, the plan was to help Frank feel less dependent on the

therapist. Frank feared relapse after the treatment ended. By the next-to-last session, he felt that he could stop at the appointed time, provided booster visits could be available as needed.

## Efficacy: Results of Brief Cognitive-Psychodynamic Psychotherapy for Stress Response Syndromes

Colleagues and I developed useful measures for assessing the levels of distress, subject predispositions, and therapist techniques and therapy outcomes. These measures include the Impact of Event Scale (patient's self-report) (Horowitz et al. 1979; Zilberg et al. 1982); the Stress Response Rating Scale (clinician's assessment) (Horowitz, 1976; Weiss et al. 1984); the Patterns of Individualized Change Scales, which assess work, intimacy, caretaking, and other life functions (DeWitt et al. 1983; Kaltreider et al. 1981; Weiss et al. 1985); assessments of the therapeutic alliance (Mannar et al. 1987; Marzialis et al. 1981), therapist-actions (Hoyt, 1980; Hoyt et al. 1981); and patients' motivations (Rosenbaum & Horowitz, 1983). The dispositions measure of most importance was the *organizational level of self and other* schematization (Horowitz, 1979a, 1987, 1998; Horowitz, Marmar, & Weiss et al. 1984). Using all of these measures in the study of 52 cases of complicated or pathological grief reactions after the death of a family member, we examined the results of a 12-session, time-limited therapy (as reported in detail in Horowitz, Marmar, Weiss, et al. 1984). Before treatment, this sample had levels of symptoms comparable with those of other psychiatric outpatient samples studied in treatment research: intake on the Symptom Checklist-90 (SCL-90) (general psychiatric symptoms rated by self-report) (Derogatis et al. 1976) for our sample was a mean of 1.19 (SD, 0.59). This level is almost identical with the figure of 1.25 (SD, 0.39) reported by Derogatis and colleagues for a sample of 209 symptomatic outpatients. The mean depression subscale score in our sample at intake was 1.81, and in the Derogatis study it was 1.87. The scores for anxiety were also comparable: 1.39 in our sample and 1.49 in the sample of Derogatis.

A significant improvement was seen in all symptomatic outcome variables when pre-therapy scores were compared with follow-up levels. Our results can be expressed in terms of the standardized mean difference effect size coefficient recommended by Cohen (1979) for presenting before-after treatment data. He defined a large effect as 0.80 or greater. Our large effect sizes were in the domain of symptoms and ranged from 1.21 to 0.71. Changes in work, interpersonal functioning, and capacity for intimacy on the patterns of Individualized Change

Scales indicated improvements that were more moderate (Horowitz, Marmar, & Weiss et al., 1986).

This synthesized cognitive-psychodynamic approach was also shown to be effective in studies by other investigators in other institutions. The approach did as well as behavioral therapy in treatment of PTSD in the Netherlands (Brom et al. 1989). It also did as well as behavioral-cognitive therapy in brief treatment of Major Depressive Disorders (Gallagher-Thompson et al. 1990; Thompson et al. 1987, 1991). In both studies, the psychotherapy groups did better than waitlist controls. As reviewed in meta-analyses of equivalent studies, this cognitive-psychodynamic approach is one of the effective treatments (Crits-Christoph et al. 1988). The synthesis of cognitive psychodynamic theory is reported elsewhere (Horowitz, 1998), as is a systematic method of formulation (Horowitz, 1997c) and a Treatment Manual (Horowitz, 2011).

## Protecting the Clinician

As a final note to this chapter, I would like to add that vicarious traumatization and therapist burnout is an important issue to consider. A therapist may suffer from or develop counter-transference reactions to unjustified hostility from an easily angered patient. Some patient themes may painfully echo the therapist's own past experiences. Unremitting empathy for the suffering of others can be exhausting. For these reasons, it is vital to avoid therapist overload from seeing too many patients. In addition, clinicians should practice self-care and seek consultation when needed, as well as maintain a healthy balance in their own life. Study and consultation groups can be especially helpful as means of support.

## CHAPTER 9

# Inhibitory Operations

## REACTIONS TO STRESS AND PSYCHOTHERAPY WITH HISTRIONIC PERSONALITIES

This and the next two chapters model the defensive maneuvers used to counter the tendency of intrusion and painful emotional response after trauma: these are inhibition, switching, and changing appraisals in a way to alter valuation (sliding meanings). Inhibition has been frequently associated with histrionic styles, switching with compulsive styles, and the change of meanings with narcissistic styles. We begin with the histrionic style.

The development, diagnosis, and treatment of histrionic personality disorders are described in more detail elsewhere (Horowitz, 1977a, b; Horowitz et al. 1984a). Styles of thought, felt emotion, and subjective experience relevant to our discussion have been described by Shapiro (1965). Shapiro emphasized the importance of impressionism, that is, the prototypical histrionic character lacks a sharp focus of attention and arrives quickly at a global but superficial assumption of the meaning of perceptions, memories, fantasies, and felt emotions. There is a corresponding lack of factual detail and definition in perception, plus distractibility and incapacity for persistent or intense concentration. The historical continuity of such perceptual and ideational styles leads to a relatively nonfactual world in which the guiding schemas of self, objects, and environment have a flat quality.

Dwelling conceptually in this nonfactual world promotes emphasis on fantasy meanings. For example, the person may react swiftly with an emotional outburst and yet remain unable to conceptualize what is happening and why such feelings occur. After the episode he or she may remember her own emotional experiences unclearly and will regard them as if they were visited upon her rather than self-instigated.

This general style of representation of perception, thought, and emotion leads to patterns observable in interpersonal relations, traits, and communicative

styles. A tabular summary of what is meant by these components is presented under these headings in Table 9.1.

# Controlling Thought and Emotion

We shall now consider Harry as if he responded to stress and treatment in this manner. One of his six conflicting themes, as described earlier, will be used to clarify the mode of controlling thought and emotion. This theme is Harry's relief that he was alive when someone had to die. Harry's perceptions of the dead woman's body and his own bodily sensations of being alive matched his fear of finding himself dead. The discrepancy between his perceptions and his fears led to feelings of relief.

In the context of the woman's death, his relief was incongruent with moral strictures. Harry had survivor guilt on reviewing his immediate reaction at the accident scene that he was glad she and not he had been the one who had suffered bodily damage. This glad reaction at being the survivor and not the victim did not match his enduring attitude that companions should share good or bad events in a fair and equitable way. This discrepancy between current and enduring concepts led to self-accusation. Harry had a low tolerance for strong emotions, and the danger of experiencing guilt motivated his efforts to control the representations that generated the emotions.

**Table 9.1   Patterns in the Histrionic Typology**

INFORMATION- PROCESSING STYLE	<ul style="list-style-type: none"><li>• Global deployment of attention</li><li>• Unclear representations of some ideas and feelings, possibly with lack of details or clear labels in communication; nonverbal communications not translated into words or conscious meanings</li><li>• Only partial or unidirectional associational lines</li><li>• Short circuit to apparent completion of problematic thoughts</li></ul>
TRAITS	<ul style="list-style-type: none"><li>• Attention-seeking behaviors, possibly including demands for attention, and/or the use of charm, vivacity, sex appeal, childishness</li><li>• Fluid change in mood and emotion, possibly including breakthroughs of feeling</li><li>• Inconsistency of apparent attitudes</li></ul>
INTERPERSONAL RELATIONS	<ul style="list-style-type: none"><li>• Repetitive, impulsive, stereotyped interpersonal relationships often characterized by victim-aggressor, child-parent, and rescue or victimization themes</li><li>• "Cardboard" fantasies based on where for attention to self</li><li>• Drifting but possibly dramatic lives with an existential sense that reality is not really real</li></ul>

Although controlling his thoughts helped Harry escape unpleasant ideas and emotions, it impeded his information processing. Were it not for controlling efforts, Harry might think again of the woman's death, his relief, and his feelings about surviving at her expense. He might realize that he was following unrealistic principles of thought and forgive himself for feeling relief but if thinking itself were not enough, he could undertake some act of penance and remorse. But inhibition prevented the thought or act that would change his attitude and reduce the discrepancy between his feelings and his sense of morality.

If inhibition of emotion is what Harry accomplished, one can go further to indicate *how* it was accomplished in terms of cognitive operations. These operations can be abstracted as if they were in a hierarchy. The maneuver to try first in the hierarchy is inhibition of conscious representation. The initial perceptual images of the woman's body were too powerful to ward off, and immediately after the accident, Harry might have flooded himself with undermodulated emotions. Later, when his defensive capacity was relatively stronger, the active memory images could be inhibited, counteracting the repeated representation. Similarly, the initial ideas and feelings of relief might be too powerful to avoid, but later, as components of active memory, their reproductive tendency could be inhibited.

Suppose this inhibition failed or was only partly successful and the warded-off ideas were expressed in some modality of representation. In a secondary maneuver, the ideas' extended meanings could still be avoided by inhibiting the translation from initial modes into other forms of representation. Harry could have only his visual images and avoid verbal concepts concerning death, relief, and causation.

A third maneuver is to prevent association to meanings that have been represented. This is again, hypothetically, an interruption of an automatic response tendency. Harry might conceptualize events in images and word forms but not continue to develop the obvious associational connections. The purpose would be avoiding a full conscious awareness of threatening meanings.

Controlling efforts are usually found in three typical forms of inhibition: avoidance of representation, avoidance of translation of threatening information from one mode of representation into another, and avoidance of automatic associational connections. If these efforts fail to ward off threatening concepts, there are additional methods. A fourth maneuver is to reverse from active to passive. Harry could avoid thinking about his own active thoughts by studying how other factors (fate, the woman, the listener to his story) are involved. He could then change his belief that he is alive because he actively wished to be alive even if another person died, by thinking of one's passivity with regard to fate, of the woman's activity in hitchhiking, and of how she got herself into the accident.

The fifth maneuver is altering the state of consciousness by changing the organization of thought and the sense of self. Harry used alcohol for this pur-

pose, but no outside agents are necessary to enter a dissociative state, with loss of reflective self-awareness. These five cognitive maneuvers can be listed as if they were a hierarchy of “rules” in the inhibitory style for avoiding unwanted ideas (Horowitz, 1977a, b).

1. Avoid representation.
2. Avoid intermodal translation between verbal and image thinking.
3. Avoid automatic associational connections (and avoid conscious problem-solving thought).
4. Change self-attitude from active to passive (and vice versa).
5. Alter state of consciousness in order to change hierarchies of wishes and fears, blur realities and fantasies, dissociate conflicting attitudes, and alter the sense of self as instigator of thought and action.

In addition, Harry could manipulate situations so that some external person could be held responsible for his survival. This would reduce the danger of a sense of guilty personal activity. In regard to very long-range maneuvers, Harry could characterologically avoid experiencing himself as ever fully real, aware, and responsible. He could identify himself with others, real or fantasized, who would make any act or thought of a crime their responsibility and not his.

## Clarity in Therapeutic Interventions

If the person with a histrionic personality style enters psychotherapy because of stress response symptoms, the therapist will try to terminate the state of stress by helping him complete the processing of the stress-related ideas and feelings. This activity will include thinking through ideas, including latent conflicts activated by the event, experiencing emotions, and revising concepts to reduce discrepancies. The interpretation of defense may help remove impediments to processing, but the main goal in this model is to end or reduce a state of stress rather than to alter the character style. Even with such limited goals, character style must be understood and the usual therapy techniques used with appropriate nuances.

The nuances are versions, variations, or accentuations of major techniques such as clarification. One example is simple repetition of what the patient has said. The therapist may, by repeating a phrase, exert a marked effect on the hysteric, who may respond with a startled reaction, surprise, laughter, or other emotional expressions. The same words uttered by the therapist mean something different from those thought or spoken by the patient himself; they are to be taken more seriously.

Some meanings will accrue, and some meanings are also stripped away. For example, a guilty statement by Harry, repeated by the therapist in a neutral or kind voice, may seem less heinous. More explicitly, to call this “repetition” is to be correct only in a phonemic sense. Actually, the patient hears the meaning more clearly and also hears new meanings. The previously ward-off contents and meanings may seem less dangerous when repeated by the therapist.

Simple repetition is, of course, not so simple. The therapist selects particular phrases and may recombine phrases to clarify them by connecting causal sequences. At first, when Harry was vague about survivorship and said, “I guess I’m lucky to still be around,” the therapist might just say “yes” to accentuate the thought. A fuller repetition, in other words, such as, “you feel fortunate to have survived,” may also have progressive effects; it “forces” Harry closer to the potential next thought, “and she did not, so I feel bad about feeling relief.”

Left to his own processes, Harry might have verbalized the various “ingredients” in the theme, might even have painfully experienced pangs of guilt and anxiety, and yet might still not have really listened to his ideas. In response to this vague style, the therapist may pull together scattered phrases: “You had the thought ‘Gee, I’m glad to still be around, but isn’t it awful to be glad when she’s dead?’” Harry might listen to his own ideas through the vehicle of the therapist and work out his own reassurance or acceptance. This seems preferable because the therapist is giving him permission by saying, “You feel guilty over a thought that anyone would have in such a situation,” this is, of course, sometimes necessary.

As we shall see, these simple everyday maneuvers are not so effective with people with a compulsive style.

Other therapeutic maneuvers are equally commonplace. To avoid dwelling further on well-known aspects of psychotherapy, some maneuvers are listed that apply to specific facets of histrionic style. Each maneuver listed has additional nuances. For example, interpretations or clarifications should be very short and simple, delivered in a matter-of-fact tone that counters their vagueness, emotionality, and tendency to elaborate any therapist activity into a fantasy relationship.

## Nuances of Relationships

Histrionic people have a low tolerance for emotion, although they are associated with emotionality. One emotion is often used as a defense against some other emotion, but even the substitute may get out of control. Because motivations are experienced as inexorable and potentially intolerable, the ideas that evoke emotion are inhibited. If toleration for the unpleasant emotions associated with a stressed event can be increased, then the cognitive processing of that event can be resumed. The therapeutic relationship protects the patient from the dangers



**Table 9.2 Some Aspects of the Histrionic Style and Their Counteractants in Therapy**

FUNCTION	STYLE AS "DEFECT"	THERAPEUTIC COUNTER
Perception	Global or selective inattention	Ask for details
Representation	Impressionistic rather than accurate	Selective reliving in memory plus conceptual reconstruction
Translation of images and enactions into words	Limited	Encourage talk Provide verbal labels
Associations	Limited by inhibitions Misinterpretations based on schematic stereotypes, deflected from reality to wishes and fears	Encourage production Repetition Clarification
Problem solving	Short circuit to rapid but often erroneous conclusions	Keep subject open Interpretations
Avoidance	Avoidance of topic when emotions are unbearable	Support

of internal conflict and potential loss of control and so operates to increase tolerance for ward-off ideas and feelings. Therapists can affect the patient's sense of this relationship by his activities or restraint. How this is typically done is also a nuance of technique.

After a stressful event, the histrionic patient often manifests swings from rigid overcontrol to uncontrolled intrusions and emotional repetition. During these swings, especially at the beginning and with a desperate patient, the therapist may oscillate between closeness and distance, always staying within the boundaries that characterize a therapeutic relationship.

The histrionic patient may consider it imperative to have care and attention. This imperative need has been called, at times, the "oral," "sick," or "bad" component of some hysterical styles (Easser and Lesser, 1965; Lazare, 1971; Marmor, 1953). These are inappropriate terms. During the period of imperative need, especially after a devastating stressful event, patients need sympathetic concern and support from the therapist. Without it, the therapeutic relationship will fall apart, and the patient may regress or develop additional psychopathology (Myerson, 1969). During this phase the therapist moves, in effect, closer to the patient: just close enough to provide necessary support. This is not an endorsement of encouraging dependency. It is simply a matter of the degree of support needed and extended.

As the patient becomes more comfortable, she may begin to feel anxious at the degree of intimacy in the therapeutic relationship because there may be

a fear of being seduced or enthralled by her own dependency wishes regarding the therapist. The therapist then moves back to a cooler, more distant, or less supportive stance.

The therapist thus oscillates to keep the patient within a zone of safety by modifying his manner of relating to the patient. Safety allows the patient to move in the direction of greater conceptual clarity (Sandler, 1960; Weiss, 1971). Naturally, the therapist's manner includes his nonverbal and verbal cues, what the therapist allows himself to do in the context of his own real responses and qualities of being. This is not role playing; rather, the therapist allows or inhibits his own response tendencies as elicited by the patient.

If the therapist does not come in from a relatively distant position, and if the patient has urgent needs to stabilize his self-concept through relational support, then the discrepancy between need and supply will be so painful that the patient will be unable to expose problematic lines of thought. Inhibition will continue. By providing a therapeutic alliance of safe containments for relating the trauma story the therapist enables the patients' own emotional and conceptual processing.



## CHAPTER 10

# Switching Maneuvers

## REACTION TO STRESS AND PSYCHOTHERAPY WITH COMPULSIVE PERSONALITIES

Inhibitory controls are a capacity. Some people may have different predispositions or learning opportunities and, therefore, different abilities to inhibit emerging information. Even with a strong inhibitory capacity, other avoidance operations may be necessary to ward off a powerful theme. Another common defense is switching to alternative themes, which jam the representational systems and prevent painful recognition of the warded-off contents. This type of operation is commonly linked to a style that has been called compulsive, obsessional, and rigid (Salzman, 1980; Shapiro, 1965, 1981).

### Historical Background

The contemporary theory of obsessional style evolved from analysis of neurotic obsessions, compulsions, doubts, and irrational fears (Abraham, 1924; Fenichel, 1945; Freud, 1909). The manifestations of the neurosis were seen as compromises between aggressive or sexual impulsive aims and defenses such as isolation, reaction formation, intellectualization, and undoing. Underneath a rational consciousness, ambivalence and magical thinking were prominent. Common conflicts were formed in the interaction of aggressive impulses and predispositions to rage, fears of assault, and rigid and harsh attitudes of morality and duty. These conflicts led to the coexistence and fluctuation of dominance and submission themes in interpersonal relationships and fantasies.

Salzman (1968, 1980) emphasized the compulsive sense of being driven, strivings for omniscience and control, and concerns for the magical effects of hostile thoughts. Seeing the self as dominant is associated with sadism toward others and leads to guilt. And seeing the self as submissive is as-

sociated with weakness and leads to fear of assault—hence, either position evokes anxiety. Alternation between opposing poles, as in alternation between dominant themes and submissive themes, serves to undo the danger of remaining at either pole

To avoid stabilizing at a single position and to accomplish the defense of undoing, people with obsessive styles often use the cognitive operation of shifting from one aspect of a theme to an opposite aspect and back again. The result is continuous change. At the expense of decision and decisiveness, obsessional personalities maintain a sense of control and avoid emotional threats (Barnett, 1972; Schwartz, 1972; Shapiro, 1981; Silverman, 1972).

Although some compulsive people move so rapidly that their emotions do not gain full awareness, they cannot totally eliminate their feelings. Unwanted affective expressions can be undone by what Salzman (1980) called “verbal juggling.” This process includes alterations of meaning, use of formulas to arrive at attitudes or plans, shifts in valuation from over- to underestimation, and, sometimes the attribution of magical properties to word labels.

Shapiro (1965, 1981) described how such a person’s narrowed focus can miss certain aspects of the world while engaging others in detail. The ideal flexibility of attention is smooth shifts between sharply directed attention and more impressionistic forms of cognition. But compulsive personalities lack such fluidity. Shapiro also explained how the thoughts, emotions, and behaviors are driven by “shoulds” and “oughts” dictated by a sense of duty, by their fear of loss of control, and by their need to inhibit recognition of their wants. Despite their usual capacity for hard work, productivity, and willpower, such people may experience difficulty and discomfort when they must make a decision. Instead of deciding on the basis of wishes and fears, such individuals must maintain a sense of omnipotence and therefore must avoid the dangerous mistakes inherent in a trial-and-error world. The decision among possible choices is likely to rest either on a rule evoked to guarantee a “right” decision or else is made on impulse, to end the anxiety. The result of these cognitive styles is an experiential distance from felt emotion. The exception is feelings of anxious self-doubt, a mood instigated by the absence of true cognitive closure. These aspects of cognitive style are summarized with the common traits and patterns of behavior in Table 10.1.

## Compulsive Tendencies of Response to Stress

Stressful events may compel interest so there is little difference in the initial registration and experience of a person with histrionic or obsessional styles. But, short of extreme disasters, compulsive people may remain behaviorally

**Table 10.1 Patterns in the Compulsive Typology**

INFORMATION- PROCESSING STYLE	<ul style="list-style-type: none"> <li>• sharp focus of attention on details</li> <li>• clear representation of ideas, meager representation of emotions</li> <li>• shifting organization and implications of ideas rather than following an associational line to conclusion as directed by original intent or intrinsic meanings</li> <li>• avoiding completion or decision of a given problem, instead switching back and forth between attitudes</li> </ul>
TRAITS	<ul style="list-style-type: none"> <li>• doubt, worry, overly detailed productivity and/or procrastination</li> <li>• single-minded, imperturbable, intellectualizing</li> <li>• tense, deliberate, unenthusiastic</li> <li>• rigid, ritualistic</li> </ul>
INTERPERSONAL RELATIONS	<ul style="list-style-type: none"> <li>• develops regimented, routine, and continuous interpersonal relationships low in "life," vividness, or pleasure; often frustrating to be with</li> <li>• prone to dominance-submission themes or power and control struggles</li> <li>• duty filling, hardworking, seeks or makes strain and pressure, does what one should do rather than what one decides to do</li> <li>• experiences self as remote from emotional connection with others, although feels committed to operating with others because of role or principles</li> </ul>

calm and emotionless, in contrast with the emotional explosions of hysterics. There are exceptions, of course, to such generalizations. During some events, compulsive people may become quite emotional, and histrionics may remain calm. The difference is in the quality of the person's conscious experience. Histrionic people can have a calm state of mind because it is based on the inhibition of some aspects of potential knowledge, and there is no emotion because the implications of the stressful event are not known. If and when compulsives behave emotionally, they may experience it as a loss of control, one to be "undone" by a retrospective shift of meaning, rituals, apologies, or self-recriminations.

Compulsives respond to threatened repetitions in thought with cognitive maneuvers such as shifting. By shifting to something else, obsessionals are able to jam their cognitive channels and prevent emergence or endurance of warded-off contents, or to shift meanings so as to stifle emotional arousal. That is, by shifting from topic to topic or from one meaning to another meaning of the same topic, they can avoid the emotion-arousing properties of one set of implications.

## Controlling Thought and Emotion

To model Harry as using switching operations to avoid the hazard of strong emotions, a time in psychotherapy was considered when Harry began to talk of the unbidden images of the woman's body. At this period in therapy he began to associate to his memory of feeling relieved to be alive. The next conceptualization, following the idealized line of working through outlined earlier, would be association of his relieved feelings with ideas of survival at her expense. This cluster would be matched against moral strictures counter to such personal gain through damage to others, and Harry would go on to conceptualize his emotional experience of guilt or shame. Once this was clear, he could revise his schematic belief that someone had to die, accept his relief, feel remorse, even plan a penance, and reduce incongruity through one or more of these changes. But Harry did not follow this idealized route because he determined the potential of these emotional experiences as intolerable at a not-fully-conscious level of information processing. Thus he switched to another ideational cycle in order to avoid the first one. He also associatively related to the images of the woman's body.

A common element in both ideational cycles allowed a pivotal change and reduced Harry's awareness that the subtopic had changed. The pivot for the switch was the idea of bodily damage. In the second ideational cluster, Harry's concept was that bodily damage could happen to him, perhaps at any future time, as it had now happened to her. Through the comparison between his wishes for invulnerability and his dread of vulnerability, his fear was aroused.

Although fear is unpleasant and threatening as a potential experience, the switch allowed movement away from the potential feelings of guilt (the prior theme). When the second theme becomes too clear, fear might be consciously experienced. The procedure can be reversed with return to the former guilt-provoking topic. Harry could alternate conscious and communicative meanings between these topics without either set of dangerous ideas and emotions being fully experienced. But Harry did not need to limit his switching operations to the two contexts for ideas about bodily damage; he could switch between any possible themes and could transform, reverse, or undo guilt with fear or anger (Jones, 1929). He could see himself as a victim, then as an aggressor, then as a victim, and so forth. These shifts would dampen his emotional responsibility but reduce his cognitive processing of themes.

A compulsive Harry might attempt to use his shifts when inhibitory efforts failed. A histrionic Harry might shift from active to passive, as noted earlier, but the timing and quality of the shifts would differ. A compulsive Harry would shift more rapidly, with less vagueness at either pole. The shift could occur in mid-phrase, between an utterance of his and a response from the therapist, or even as virtually simultaneous trains of thought.

It is because of rapid shifts that therapists who attempt clarity with compulsives may be thwarted in their task. Suppose the therapist makes a clarifying intervention about the survivor guilt theme. The compulsive Harry might have already shifted to his fear of body injury, and thus hear the remarks in a non-congruent state. The clarification procedure might not work well because Harry was clear in the first place, was not listening from the earlier position, and ruined the therapist's intervention by further shifts. An interpretation to the effect that Harry feared bodily damage as a retribution for his survivor relief and guilt would be premature at this point because he had not fully experienced either the fear or the guilt.

## **Holding to Context: An Important Nuance with People Who Habitually Use Switching Maneuvers**

Holding a person who shifts to a topic or a given context within a topic is equivalent to clarifying for the person who typically inhibits ideas. Metaphorically, the switcher avoids conceptual time, whereas the inhibitor avoids conceptual space. The goal of holding is a reduction of shifting so that the patient can progress further along a given conceptual process. The patient must also be helped to tolerate the emotions that will be experienced when he cannot quickly divert ideas into and out of conscious awareness.

Holding to context is more complicated than clarification. One would begin with at least two current problems. When the patient is not shifting with extreme rapidity, the therapist may simply hold the patient to either one or the other theme. But the patient will not comply with this maneuver, and the therapist must not confuse holding with forcing. Ferenczi (1926), in an effort to speed up analysis, experimented with various ways to make the obsessive person stay on topic until intensely felt emotions occurred. For example, he insisted that his patient develop and maintain visual fantasies relevant to a specific theme. Then his patients did experience emotions, and they even had affective explosions, but the transference complications impeded rather than enhanced the therapy.

The therapist thus must shift, even though he attempts to hold the patient to a topic. That is, the therapist must shift at a slower rate than the patient does, like a dragging anchor that slows the process. This operation increases the patient's progress in both directions. That is, with each shift, he is able to go a bit further along the conceptual route of either theme, even though he soon becomes frightened and crowds the theme out of mind with an alternative.



The therapist may use repetitions, as with the histrionic, in order to hold or slow the shift of a compulsive patient. But this same maneuver is used with a different nuance. With the inhibitor, the repetition heightens the meaning of what the patient is now saying. With the switcher, the repetition goes back to what the patient was saying before the shift away from the context occurred. With the histrionic, the repetition may be short phrases. With the compulsive, greater length may be necessary in order to state the specific context that is being warded off. For example, if Harry were talking about bodily damage and shifts from a survivor guilt context to his fears of injury, then the therapist's repetition must link bodily damage specifically to the survivor guilt theme. With a histrionic, such wordy interventions may only diminish clarity.

At times, this more extensive repetition for the compulsive may include the technique of going back to the very beginning of an exchange, retracing the flow carefully, and indicating where the patient introduced extraneous or only vaguely relevant details. Reconstruction may add warded-off details. This technique has been suggested for long-term psychotherapy (Salzman 1968, Weiss 1971), during which defensive operations are interpreted so that the patient can increase conscious control and diminish unconscious restrictions on ideas and feelings. In shorter therapy, aimed at working through stress, this extensive repetition is still useful, because during the review by the therapist the patient attends to uncomfortable aspects of the topic.

Increased time on the topic allows more opportunity for processing and, hence, moves the patient toward completion. Emotions aroused by the flow of ideas are more tolerable within the therapeutic relationship than for the patient alone. Also, time on the topic and with the therapist allows continued processing in a communicative state, emphasizing reality and problem solving rather than fantasy and magical belief systems. Identification with and externalization onto the relatively neutral therapist also allows temporary reduction in rigid and harsh introjections that might otherwise deflect thought.

Focusing on details is sometimes a partial deterrent shifting in the compulsive person, just as it may also aid clarity with the histrionic. The nuances of focusing on details differ because the purposes differ. In general, the aim with the histrionic personality is to move from concrete and experiential information, such as images, toward more abstract or more extended meanings, such as word labels for activities and things. The aim with the compulsive person is to move from abstract levels, at which shifts are facile, to a concrete context. Details act as pegs of meaning in concrete contexts and make shifts of attitude more difficult. This maneuver uses the compulsive individual's predisposition to details but allows the therapist to select them. Again, the nuance of asking for concrete details is part of the general aim of increasing conceptualization time.

In states in which the shifts are so rapid as to preclude simple repetition or questioning, the therapist may use a more complex form of repetition. The therapist repeats the event, for example, Harry's intrusive image of the woman's body, and then repeats the disparate attitudes that the patient oscillates between in a single session. For example, the therapist might tell Harry that the image of the woman's body led to two themes. One was the idea of relief at being spared from death that made him feel frightened and guilty. The other was the idea of bodily harm to himself. Were the rate of oscillation less rapid, this form of "packaged" intervention would not be as necessary, as simpler holding operations might be sufficient and the therapist could focus on a single theme.

These efforts by the therapist encroach on the patient's habitual style, and the patient may respond by minimizing or exaggerating the meaning of the intervention. Compulsive-style personalities are especially vulnerable to threats to their sense of omniscience, especially after traumatic events. If the therapist holds them on a topic, compulsive people will sense their warded-off ideas and feelings and develop uncertainties that cause their self-esteem to fall.

To protect the patient's self-esteem, the therapist uses questioning to accomplish clarification and topic deepening, even when he has an interpretation in mind. The questions aim the patient toward answers that contain the important warded-off but now emerging ideas. Compulsive patients can then credit themselves with expressing these ideas and experiencing these feelings. With histrionic people, the therapist might, in contrast, interpret at such a moment, using a firm, short delivery, as a question might be followed by vagueness.

To compulsive people, incisive interpretations often mean that the therapist knows something that they do not know. A transference bind over dominance and submission arises as the patients rebel against the interpretation with stubborn denial, accept it meekly without thinking about it, or oscillate between both extremes.

Timing is also important. After experience with a given patient, the therapist intuitively knows when a shift is about to take place. At just that moment, or a bit before, the therapist asks the question. This interrupts the shift and increases the conceptual time and space on the topic about to be ward off. These technical nuances are shown in Table 10.2.

## Nuances of the Therapeutic Relationship

Therapists should create a safe situation for the patients by remaining stable within their own clear boundaries (e.g., objectivity, compassion, understanding, concern for the truth, or whatever are their own personal and professional traits).

Patients learn the therapist's limits within this frame. It gives them further that the therapist will react neither harshly nor seductively, and this trust will increase patients' breadth of oscillation. They can express more aggressive ideas if they know the therapist will not submit, be injured, compete for dominance, or accuse them of evil. Harry could express more of his bodily worries when he knew the therapist would not himself feel guilty or overly responsible.

If the therapist changes with compulsives' tests or needs, then they will worry that they may be too powerful, too weak, or too "sick" for the therapist to handle. Also, compulsives may use situations to externalize ward-off ideas or even defensive maneuvers. The therapist shifts, not they. This is not to say that such patients do not, at times, need kindly support after disastrous external events. But their propensity for shifting makes changes in the degree of support more hazardous than does a consistent attitude, whether kindly supportive, neutrally tough, or otherwise.

Suppose the therapist became more kindly as Harry went through a turbulent period of emotional expression of guilt over survival. Harry might experience this as an increase in the therapist's concerns or worries about him. Or he might shift from the "little" suffering position that elicited the therapist's reaction, to a "big" position from which he looked down with contempt at the "worried" therapist.

Similarly, if the therapist is not consistently tough-minded, in the ordinary sense of insisting on information and truth telling, but shifts to this stance only in response to the patient's stubborn evasiveness, then the patient can shift from

**Table 10.2 Some Aspects of Compulsive Style and Their Counteractants Therapy**

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

strong stubbornness to weak, vulnerable self-concepts. Within the context of this shift, the patient experiences the therapist as hostile, demeaning, and demanding.

Transference resistance will occur despite the therapist's efforts to maintain a therapeutic relationship. Patients will exaggerate the therapist's stability into an omniscience that they will continually test. When negative transference reactions occur, the therapist will act to resolve those that interfere with the goals of therapy. But some transference reactions will not be negative, even though they act as resistances. Histrionics may demand attention and halt progress to get it. Compulsives may take an oppositional stance not so much out of hostility or stubbornness, although such actors will be present, as out of a need to avoid the dangerous intimacy of agreement and cooperation. Because the therapist is not aiming at analyzing the transference to effect character change, therapists need not interpret this process. Instead, with a compulsive patient in an oppositional stance, he may word the interventions to take advantage of the situation. That is, interventions can be worded, when necessary, in an oppositional manner. Suppose Harry were talking about picking up the woman and the therapist knew he was predisposed to feeling guilty but was warding it off. With a histrionic Harry, the therapist might say, "You feel bad about picking up the woman." With a compulsive and cooperative Harry, he might say, "Could you be blaming yourself for picking up the woman?" With an oppositional compulsive stance, the therapist might say, "So you don't feel at all bad about picking up the woman." This kind of Harry might disagree and talk of his guilt feelings.

To summarize, holding to a topic or subtopic is a nuance of technique used to help people disposed to switching types of warding-off maneuvers to complete the processing of stress-related ideas. Clarity, though useful with those who inhibit, is not as directly helpful with the switcher, who may require both clarity and holding to a topic. Distortion of meanings, a third type of control maneuver, is used frequently to avoid conflicting ideas triggered by stress events and requires other nuances of technique, illustrated in the next chapter.



## CHAPTER 11

# Sliding Meanings

## REACTION TO STRESS AND PSYCHOTHERAPY WITH NARCISSISTICALLY VULNERABLE PERSONALITIES

Narcissism has been regarded as an important aspect of human character throughout recorded history, and it was summarized in Ecclesiastes: “Vanity of vanities, all is vanity,” Freud’s (1914a) explorations of the unconscious led Freud to emphasize the compensatory nature of such vanity, and Adler (1916) focused his theories on inferiority and narcissistic compensations for deflated self-concepts. There has been a major resurgence of interest in the psychodynamics of the narcissistic character (Kernberg, 1970, 1974, 1975, 1976; Kohut, 1966, 1968, 1971, 1972, 1977; Horowitz, 2009, 2011). Pertinent to such interest is the question of how people of narcissistic character respond to the inevitable stresses of life such as injury or loss. The typical narcissistic response of sliding meanings is contrasted with the classical typologies of the histrionic and compulsive personalities, as are the nuances of therapy that help change this defensive avoidance.

## Background

Freud (1914a) used the concept of narcissism as a polarity between self-centeredness and relationships with others. Instead, the development of self-interest and self-concepts is now seen in two simultaneously related but partially independent series. In one series the self-representation and self-regard gradually become an independent function. In the other series there is an interdependence of one person with another, that is, self-representation and self-regard gradually develop object representations, object interests, and patterns of self and object transaction (Kohut, 1971). Increased narcissism can be motivated by a need to compensate for a deflated self-concept (Kernberg, 1970).

In the narcissistic character, damaged self-concept underlies a more superficial self-love, grandiosity, or idealization of others regarded as appendages to the self (self-objects). Dominance of narcissistic traits in either or both parents may predispose a child to difficulties in developing a flexible, accurate, and independent self-representation because the parents may treat the child as if he or she were a function of themselves rather than a separate entity.

Being an only child or having a real or “special endowment” projected by a parent may build a sense of unusual importance into the child, one that is doomed to a rude awakening when he or she moves socially beyond the nuclear family. That is, any atmosphere that encourages and gratifies inflated self-representations will also predispose a child to traumas when realistic limitations, inability to perform, or depreciating types of interpersonal treatment are encountered. Such encounters will also occur in the family when the child develops enough will and ability to contest parental superiority and power and to feel betrayed and let down when her own power is insufficient to achieve her own goals.

## Narcissistic Responses to Stress

When the habitual narcissistic gratification that comes from being adored, given special treatment, and admiring the self are threatened, the results may be depression, hypochondriac tendencies, anxiety, shame, self-destructiveness, or rage. The child can learn to avoid these painful emotional states by acquiring a narcissistic mode of information processing. Such learning may be by trial and-error methods, or it may be internalized by identification with parental modes of dealing with stressful information. The central pillar of this narcissistic style is a polarization of good and bad, the narcissistic personalities externalize bad attributes and internalize good attributes in order to stabilize grandiose self-concepts and avoid entry into states of mind organized according to deflated self-concepts. These operations demand distortion of reality and imply either willingness to corrupt fidelity to reality, a low capacity to appraise and reappraise reality and fantasy, or a high capacity to disguise the distortions. The disguises are accomplished by shifting meanings and using exaggeration and minimization of bits of reality as a nidus for fantasy elaboration.

The narcissistic personality is especially vulnerable to regression due to damaged or defective self-concepts on the occasions of loss of those who have functioned as self-objects. When the individual is faced with such stressful events as criticism, withdrawal of praise, or humiliation, the information involved may be denied, disavowed, negated, or shifted in meaning to prevent a reactive state of rage, depression, or shame. If such measures should fail, in addition to exter-

nalization of bad attributes and internalization of good qualities, there may be a shift not only in affect but also in global being. This change in state includes changes in demeanor and style. If the stressful event—for example, criticism of the person—leads to a mild level of threat, then the behavioral response may be an increased effort to obtain external narcissistic supplies. That is, there may be a search for other people to erase the criticism, supply praise, or provide, through idealized power, a useful umbrella that can be extended over the self. Much like the histrionic personality, the narcissistic personality will try to win attention from sources that enhance self-esteem.

If the stressful event is of greater magnitude or if the restorative efforts outlined above should fail, then narcissistic types of deviation from realistic information processing will be more prominent. The goal of these deflections from knowing reality is to prevent a potentially catastrophic state in which a cohesive sense of self is lost. The hazard is not simply guilt because ideals have not been met. Rather, any loss of a good and coherent self-feeling is associated with intensely experienced emotions such as shame and depression, plus an anguished sense of helplessness and disorientation. To prevent this state, the narcissistic personality slides the meanings of events in order to place the self in a better light (Horowitz, 1975b). Those qualities that are undesirable are excluded from the self-perception by denial of their existence, disavowal of related attitudes, externalization, and negation of recent self-expressions. People who function as accessories to the self may also be idealized by exaggeration of their attributes. Those who counter the self are depreciated; ambiguous attributions of blame and a tendency to self-righteous rage states are a conspicuous aspect of this pattern (Horowitz, 1981; Kohut, 1968).

Such fluid shifts in meanings permit the narcissistic personality to maintain apparent logical consistency while minimizing evil or weakness and exaggerating innocence or control. As part of these maneuvers, the narcissistic personality may assume attitudes of contemptuous superiority toward others, emotional coldness, or even desperately charming approaches to idealized figures.

Reality testing and reality-fantasy differentiation are not as readily lost in the narcissistic personality as they are in borderline personalities. But the exaggerations and slidings of meanings force further distortions as cover-ups. The resulting complications lend a subjectively experienced shakiness or uncertainty to ideational structures. Lapses in these defensive arrangements of ideas may occur during states of stress. Paranoid states and episodes of panic, shame, or depersonalization may also occur. Self-destructive acts may be motivated by wishes to end such pain, to achieve a “rebirth,” to harm the offending self, to feel something, and to achieve secondary gains such as obtaining sympathy or enacting a “wounded hero” role. These and other attributes of the narcissistic personality are summarized in Table 11.1.



**Table 11.1 Patterns in the Narcissistic Typology**

INFORMATION-PROCESSING STYLE	<ul style="list-style-type: none"> <li>• Slides meanings of information that might damage self-concept; also uses denial, disavowal, and negation for this purpose</li> <li>• Attention to sources of praise and criticism</li> <li>• Shifts subject-object focus of meanings, externalizes bad attributes, and internalizes good attributes</li> <li>• Occasionally dissociates incompatible psychological attitudes into separate clusters</li> </ul>
TRAITS	<ul style="list-style-type: none"> <li>• Self-centered</li> <li>• Overestimates or underestimates self and others</li> <li>• Self-enhancement in accomplishments real or fantasized, in garb or demeanor</li> <li>• Avoids self-deflating situations</li> <li>• Variable demeanors depending on state of self-esteem and context: Charm, “wooing-winning” quality, controlling efforts, or charisma; superiority, contemptuousness, coldness, or withdrawal; shame, panic, helplessness; hypochondriac tendencies, depersonalization, or self-destructiveness; and envy, rage, paranoia, or demands</li> </ul>
INTERPERSONAL RELATIONS	<ul style="list-style-type: none"> <li>• Often impoverished in terms of true intimacy, oriented to power over others or controlling use of others as accessories (self-objects)</li> <li>• Absence of enduring compassion</li> <li>• Social climbing or using others for positive reflection</li> <li>• Avoidance of self-criticism by goading others to unfair criticism</li> <li>• Discarding of persons no longer of use</li> <li>• Pseudo twinning relationship</li> </ul>

## Controlling Thought and Emotion

During Harry’s psychotherapy, several conflicting themes activated by the accident became apparent. Prominent among these were his feelings of fear that he might have been killed, embarrassment over his own sexual ideas, guilt for “causing” the death of the hitchhiker, remorse for feeling relieved upon realizing he was alive and she was dead, and anger at her and the other driver for causing the accident.

Let us consider one of these various themes, worked through in different phases of therapy. The presumed context, now, was the time in psychotherapy when Harry was talking about the intrusive images of the woman’s body and the association between these images and his ideas about his own vulnerability to death. Conceiving his possible death was highly incongruent with Harry’s wish-

ful attitude of invulnerability. The hazard of the incompatibility of these ideas is especially great for narcissistic personalities, as they have to maintain a brittle, but inviolately ideal, self-concept.

Conceptually experienced, the incongruity tends to evoke fear beyond a level of toleration. For two reasons controls are instituted to prevent continuation or enlargement of such felt emotion: to prevent the threatening levels of fear and to avoid representation of fear because it would also be a narcissistic injury or Harry to admit that he was scared. This "double jeopardy" of the narcissistic personality makes insight treatment difficult, as will be discussed shortly.

The repetition of an image of the woman's dead body was an intrusive symptom Harry developed after the accident. The associated and responsive idea was that because she was dead he too might die. The concept of personal death vulnerability was grossly incongruent with an enduring concept of personal invulnerability, and this discrepancy evoked anxiety.

Defensive maneuvers are motivated by such signal anxiety. Subject designation is inhibited, leading to a more abstract idea: "someone dies," a less frightening concept than that the self may perish. Thus, by means of externalization and disavowal of the death construct, Harry slid the meaning of personal mortality into personal immortality, a version of undoing. Instead of anxiety, the shifts of meaning allowed a sense of triumphant excitement. The very image that evoked anxiety now led, by a slight irrationality, into a more positive emotional experience.

Meanwhile Harry disavowed any similarity between himself and the hitchhiker. Narcissistic Harry exempted himself from this group membership by thinking, in effect, "She is the kind who dies; I am not." To use an exaggerated version of this prototypical narcissistic defense, Harry classified himself as an exception, perhaps with an extension of the idea that someone had to die. If someone had to die, then someone had been chosen to die, and it was she and not he. This then meant he was saved by this selection, presumably because he was special. This membership in the chosen group is like a sign of immortality, and it is incongruent with the enduring concept of humans as vulnerable to death. This is a positive affect kind of incongruity: things are better than anticipated. Harry felt a kind of triumphant excitement in responding to this set of ideas. Thus a complete reversal of emotions was accomplished by shifting and undoing meanings and externalizing mortal contaminants such as death and vulnerability.

This sliding meaning maneuver is similar to the compulsive's control process that uses one train of thought to block out another. But unlike a prototypical compulsive, a narcissistic Harry experienced emotions, perhaps both fear and triumph. Also, the narcissistic Harry would not as readily go back and forth in endless undoing operations. In pure narcissistic form, he would not have to undo the triumph by feeling scared, even though he remained agitated

by earlier traumas that might be revived and reopened in this context. These recollections, when seen, would also require reconstruction in the light of the present. These reconstructions with narcissistic patients need special extended efforts clarifying self and object distinctions among motives, belief, actions, and sensations. During this process there will be shifts in topical meaning, and so holding to a given aspect of a topic, as with obsessional patients, may be indicated. The nuance common with narcissistic personalities is to arrive at more stable meanings by encouraging the one meaning that has implications of current importance. For example, the “someone dies” idea has multiple meanings such as “each may die” or the salvation of one through the “sacrificial death” of another. The grandiose idea of the sacrificial absolution is deflated by holding and discussing the more important fear themes around “each may die.” If necessary, interpretation of the corruption in reality adherence, as implied by the sacrifice-exemption theme, may be necessary but can be possible only if the therapeutic situation in some way provides adequate support for the patient’s self-esteem.

## Nuances of Relationships

Treatment of narcissistic personalities is often difficult for the therapist because the relationship with the patient is less infused by the real therapeutic alliance than in less narcissistic patients. The narcissistic patient uses rather than relates to the therapist. Despite feeling unimportant as a real person, or distant, or bored, the therapist must understand what is going on and provide a closer relationship with the patient. The therapist may have to be supportive for a period. With the narcissistic patient, support and closeness may not be so much a matter of warmth as of accepting externalizations without interpretations. This will not be done without consequence, however, because later in therapy it may be necessary to interpret and discourage such externalizations.

Narcissistic personalities achieve the sense of safety necessary to experience and express usually warded-off ideas and feelings through three types of quasi-relationships. One form is characterized by personal grandiosity with the expectation of admiration, another by idealizing the therapist with the expectations of being all right because she is related to by an ideal figure. The third is to regard the therapist as a twin who restores the self by simply being there, in the here and now, together (Kohut, 1971, 1977).

The grandiose quasi-relationship usually occurs either at the beginning of treatment or during recovery from an initially defeated state of mind precipitated by the stressful event. Bragging and self-endorsements come in subtle or gross forms and take away conceptual time from stress-relevant topics. Tact, as

**Table 11.2 Some Aspects of Narcissistic Style and Their Counteractants in Therapy**

FUNCTION	STYLE AS "DEFECT"	THERAPEUTIC COUNTERACTION
Perception	Focuses on praise and blame	Avoids being provoked into either praising or blaming but is realistically supportive
	Denies "wounding" information	Uses tactful timing and wording to counteract denials by selective confrontation
Representation	Dislocates bad traits from self to other	Repeatedly reviews in order to clarify who is who in terms of the sequence of acts and intentions in a recalled interpersonal transaction
Translation of images into words	Slides meanings	Consistently defines meanings; encourages decisions as to most relevant meanings and how much to weigh them
Associations	Overbalances when finding routes to self-enhancement	Holds to other meanings; cautiously deflates grandiose beliefs
Problem solving	Distorts reality to maintain self-esteem	Points out distortion while (tactfully) encouraging and supporting reality fidelity

emphasized earlier, takes the form of allowing these efforts to restore self-esteem, rather than insisting on staying with core conflicts or interpreting the grandiose effort as compensatory.

This tact and forbearance may be unusually difficult for therapists who are used to relying on the therapeutic alliance or positive transference to tide the patient over periods of hard work on threatening ideas. It is difficult to remember that the relationship with narcissistic patients is not stable and that their need is imperative but not coordinated with the usual concerns, however ambivalent, for the person toward whom they direct their needs.

In idealizing the therapist, the second most common form of quasi-relationship, the damage is repaired as the patient imagines that she is once again protected and given value by a powerful or attractive parent. The stress response syndrome becomes a ticket of admission for this kind of self-supplementation. Again, tactful tolerance is necessary early in the treatment when the person is still partially overwhelmed by the stress response syndrome. It would be an error to see behavior such as giving exaggerated testimonials about the therapist's unique ability as equivalent to the transference-motivated seduction gambits of some histrionic patients or to the undoing of negative feelings by compulsive patients. The testimonials simply indicate idealization that provides a momentary repair

of damage to the self, a safer time during which there may be some work on processing and integrating stress events.

Even externalizations can help patients gain sufficient emotional distance from loaded topics so that they can tolerate thinking about them. For example, if a patient projects a feeling of disgust about death onto the therapist, the relevant nuance would be to ask the patient to talk further about how the therapist feels. This allows the patient to work along the ideational route as if it were the therapist's route. A direct interpretation, such as "you are disgusted by death," should come only later.

Narcissistic considerations are present in every character type, not just narcissistic personality, and some of these nuances of treatment might be pertinent at any time. The "defects" commonly found in the typical narcissistic personality and comparable therapeutic counters are summarized in Table 11.2.

Part IV

# CLINICAL EXAMPLES



## CHAPTER 12

# Loss of a Limb

*With Robert Nadol*

A single external event can trigger divergent reactions. These separable yet interconnected responses may occur in different phases at any given moment in time. One set of ideas and feelings may be warded off, resulting in a period of relative denial; another set may be intrusive in terms of conscious experience. Xalia's story is presented here to illustrate such phasic differences and to show how these differences can orient a therapist in his intervention strategy.

Xalia is a 19-year-old woman. Her left leg and knee joint were mangled in a car accident. The injury was severe, but the doctors at her local hospital attempted immediate restorative surgery. Gangrene set in after the emergency operation; consultation with specialists led to a hospital transfer and an amputation. She was then discharged to recuperate at home.

Six weeks later, Xalia reentered the hospital so that the stump could be fitted with an artificial leg. She received intensive physical therapy to strengthen the stump and learn how to use prosthesis. During this hospitalization, she asked for a psychiatric consultation.

Initially, the surgical staff resisted her request because she seemed to be doing well. But they decided to comply with it when she persisted. Xalia was seen by a resident psychiatrist. She told him she had requested the consultation because she had become aware of a lack of appropriate emotional response to the loss of her leg. In the physical therapy exercise room and on the ward she met other persons with amputations. She recognized their losses often as less severe than her own. They grieved for the loss of part of their body, whereas she remained cheerful. She felt that she had not faced her situation and was going on as if nothing had happened.

The psychiatric consultant agreed that she was avoiding the implications of the amputation and explored some of the circumstances of the accident.



He recognized the defensive operations of thought stopping and inhibition of communication but did not know what thoughts and feelings she might be warding off. Moreover, he felt uncertain about disrupting her denial at this time. She was in the midst of active physical treatment and cooperating well with it. True, for a young, attractive, unmarried, and unattached woman to lose a leg would necessitate psychological work in reorganizing her body image, self-concept, and fixture plans. But should this work be done now or after she learned to use her prosthetics successfully? When is denial useful, and when does it impede adaptation? After talking with her and with the staff, the resident psychiatrist referred the patient to a stress unit therapist for further exploration and formulation.

This therapist then interviewed Xalia on the orthopedic ward. She was pleasant but urgent in her self-presentation. She communicated a feeling of pressure that could be verbally described as, "You really must help me right now." Following is a transcript of that interview and the one that followed, interspersed with commentaries on meanings and implications of what is being communicated. The psychiatrist has already introduced himself and obtained consent to tape the interviews.

## First Session

T: Therapist

X: Xalia

T: Why don't we start with you telling me why you asked for a psychiatric consultation?

X: What I asked for a psychiatrist for?

T: Yes.

X: Because, um, I think that I need somebody to help me.

T: Uh-huh.

X: Um, because uh (*pause*) well, since the accident and my stepbrother was driving, I start hating him later (*pause*), and I don't want to hate him.

Note that, almost at once, Xalia presents a new topic that was not mentioned to the consultant. This hatred of her stepbrother is a complex of ideas and feelings that intrude upon her: "I start hating him later, and I don't want to hate him." She had told the first consultant about a complex of ideas in a denial phase, that is, her intellectual observation of the absence of appropriate reactions to missing a limb. This psychiatrist had, of course, not heard about the hatred theme from the first consultant. He listens attentively to her further development of this theme.

T: Yes.

X: I don't want him to think that, um, it was his fault, but (*pause*) or, um, something 'cause, um, well, I don't want him to. And, ah, sometimes, well, I feel like yelling it to him and telling him it was his fault and, uh, that he can get out of that game (*pause*), so, um, so I just don't want to tell him never.

T: Yes.

X: Not even to my family 'cause I'm the only one who knows.

T: That's something we might be able to talk about. Anything else?

X: Mm mm.

T: Well, tell me what happened. I know you've had an accident, but I don't know anything else.

X: Well, um, we went to a dance (*pause*); I was, um, two of my stepsisters and me, we went with my stepmother and other. It was a dance for Andy, my stepbrother. So, after the dance, my parents were going to go somewhere else, so they told us to go with Andy in the car, and, um (*pause*) oh, yeah, and then when we were, we were going just to (*pause*) go in a street, it was a blind intersection. It was like this (she imitated the crash with both hands).

T: Yes.

X: And, uh, and, uh, he, he was, um, my, I think he was drunk, and um, I was, I was talking with my stepsisters in the back, I was in the front seat, and, um, and then I saw that, that he didn't put no brakes on and we were going to, getting to the corner. So, um, I saw him, I was thinking that was really strange. We were almost at the corner. He didn't put the brakes on, and we were going to crash. He didn't; he was just smiling; that's all I remember, and then I, I woke up in the hospital (*long pause*). Well, they were trying to save my leg for two weeks. And Dr. Smith told me that he was going to amputate it, and, uh (*long pause*) well, my parents didn't tell me nothing, you know, about Andy. After, only when I was over here, about a month and a half later since the accident, she told me that (*pause*) he was very, very, um, very bad, that he was (*pause*) um, crying all day in his room (*pause*), that he wasn't eating or nothing, that he thought it was his fault. And she told me it wasn't his fault, it was the brakes' fault (*pause*). But I knew it wasn't the brakes. I mean, I told, I told the police, I told the (*pause*) the, um, insurance man, everybody, that it was, uh, it was the brakes. 'Cause I didn't realize before; I still don't realize that I, I don't have my leg. And um, more, I guess I feel funny about it.

T: Yes.

X: See, I don't realize, I don't care. Right now I don't care about it, 'cause I don't realize that I need it.

T: Yes.

X: But when I was at home last month for a couple of weeks, and, uh, Andy was going out (*pause*), he was going to take the car, and, uh, and then I was

thinking that, uh, how could, how could my parents let him drive again. How? And how was he going out and I was staying, it was his fault. And I felt like yelling and telling him it was his fault, but I don't want him to blame himself.

T: Yes. But you're one of the only people that realizes how much he was at fault.

X: Yeah. I'm the only one who knows that it was his fault.

T: Yes.

I: See, 'cause I told the other people that it was the brakes' fault too.

T: Yes.

X: 'Cause I didn't want him, you know, if I'm, if I'm like this right now, I don't want another person to get (*pause*) hurt, or losing his feelings.

T: So, then, there are two things that you recognize might be helpful to talk out. One would be that you don't quite realize all the implications of what's happened.

X: Mm.

T: And then, you have this load about your stepbrother. You want him to be punished, but you don't want him to be punished. When did all this happen?

X: September 12th.

T: Uh-huh. And how long were you in the hospital the first time?

X: I was in the hospital there three weeks. Then I came (*pause*) for about, for about a month, then I was home for a month, then I came here.

T: And you've been here for 15 days now. Does Dr. Smith see you here?

X: Yeah. He's my doctor.

T: I'll give him a telephone call and see if it's all right with him that I talk with you. Would that be all right with you?

X: Oh, he's on vacation.

T: Well, I'll do it when he comes back, and we'll just talk anyway.

X: Yeah.

T: Now, what's your mood been like all that time?

X: My, um, what do you mean?

T: Oh, what has it been like for you day in and day out when you go home? Have you been cheerful or sad or numb or waiting, or . . . ?

X: No. That's strange. I live with my father and stepmother.

T: Uh-huh.

X: I lived in Canada, but I came two years ago here to study. And, uh, I don't know, I feel like, a little like, right now, I don't want to go home.

T: Yes.

X: My real mom was here since the accident. But right now, I don't want to go home. I would prefer to stay over here and, now, not to go away. I don't know why, and, well, sometimes I start to get angry at my father and my stepmother, even my stepsisters, and I feel guilty for it.

- T:* Just since the accident?
- X:* Mm-hm.
- T:* You get angry at them and irritated?
- X:* Yeah, it's funny because they think that, that Andy's very innocent and he's a very good boy and like he is sometimes, but (*pause*), I don't know.
- T:* Yes. You know something they don't know.
- X:* Mm-hm.
- T:* Okay. Well, you get around pretty well in a wheelchair and on crutches too?
- X:* Yeah.
- T:* I can't stay too long now. I just came up to see you. But could you come next door to my office? Would you mind coming over there? I think we'd have a quieter room. We could just set up a time, and then we can just have a little longer to sit and talk this over.
- X:* Yeah.

## Second Session

- T:* I'd like to know more about what you've been thinking about.
- X:* (*Pause*) Well (*pause*), I already told you, well, (*pause*) mm (*pause*), I think that I love my father and stepmother, but at the same time I don't. I don't know.
- T:* Uh-huh. You get angry with them.
- The therapist has already noted that instead of saying she is hostile and instead of describing family members as bad, she will inhibit her communications and presumably her thoughts by trailing off and saying "I don't know." She has, of course, made critical remarks about her stepbrother, but she regards such revelations as lapses in control. Knowing that she has such feelings is experienced as a threat to her sense of well-being. The therapist wants her to discuss her conflicted feelings so that they can examine them together in the therapeutic situation. He knows hostile ideas are at the surface because they intrude into her awareness. He refrains from questioning her about her warded-off ideas and feelings. If he were to say here, "I wonder if you are possibly angry at your father and stepmother?" it would be her style to answer either "I don't know" or "Yeah, I guess so" in a passive manner. Instead, the therapist labels her thoughts in a brief, firm, and direct way. He does this in order to clarify the thoughts and to establish a ground rule that in this situation there is to be open communication of those ideas and emotions that are usually suppressed in social situations.
- X:* A lot, yeah, (*pause*)
- T:* And yesterday we talked about your stepbrother and you.
- X:* Yeah.
- T:* How old is he?

X: Eighteen.

T: So he's a little younger than you are.

X: Mm-hm.

T: And what's he like?

X: (*Pause*) He's a very tall, strong, very nice guy. Kinda crazy, mm.

T: Kind of crazy? How?

X: Well, you know, always drinking and, uh, with me, I mean, he was my favorite.

T: Uh-huh.

X: And I was his favorite too.

T: Uh huh.

X: So, we were always going together; well you know, when I first came from Canada, then, uh, well, he was, uh, the first one, that, um, if one of my stepsisters came and started fighting with me or something, he came and told them to leave me alone, that, you know. And then, uh, he taught me how to drive, he taught me how to get around.

T: Mm.

X: The city and all that, uh, well he was—(*trails off*).

T: He was very close to you.

X: Yeah (*pause*). Sometimes.

T: Right. So maybe right now we could talk about the business with your stepbrother not pressing the brakes and then telling the police and everyone else that he did press the brakes. Maybe we can just see where we can get with that right now. That seemed to be a problem that you had coming back into your mind.

The therapist seeks to explore the more intrusive theme. He watches her facial expression as he talks. He slowly adds each new phrase until he sees that she is ready to take up the topic.

X: Yeah, I just remember that, um, that I, um, I thought that it was kind of strange when we were going to turn around the corner, he didn't put the brakes on (*pause*). And then, I suddenly saw he was smiling, and, uh, well, at the dance, I don't (*pause*), or I was sitting with some friends, so I saw that he was drinking. But, well, he always, he always drinks, but he never got, gets drunk; you know what I mean?

T: Yes.

X: So, then we get—got out, then some friends were outside, and, and they told him to, you know, how 'bout a race? He goes, "Oh, okay."

T: Mm-hm.

X: So, we left from the dance, and the car was working pretty good. So then, we left them, and we were going to go home and (*pause*), well, he didn't put the brakes on.

T: Uh-huh.

X: And he was going very fast.

T: Was there a race going on, a play race?

X: No, yeah, well it's kinda, it's kinda a park and, uh, it's named Boyle Park.

T: Uh-huh.

X: And, um (*pause*), they have a big place where they have bands some and they have a space to drive there (*laughs*) and, uh (*pause*), well, when we were coming back home, um, he was going kind of fast. Well, he, he admitted, he told everybody he was going very fast (*pause*). He was going over 80 miles, close to 85. So, I didn't get scared or nothing; nobody did and, 'cause he always goes that fast (*pause*). But then my stepmother told me, um, later that, and, uh, asked them when the car was there and then a lot of, you know, uh, the police and firemen, doctors came to take me out of the car and then, that he went out running into the car kind of crazy and that he was crying and all that, that it was his fault. So, partly because of that, I didn't tell them nothing 'cause I felt, I don't know, that, like, um, I was going to blame myself forever if I, I tell them the truth or something.

T: Yes.

X: So, uh, I didn't say nothing, and, uh, oh, when I went home, he was very nice with me. He didn't tell me nothing, though. One time when I was here in the hospital, I called home and he answered the phone, so he knew it was me and he started crying, telling me that it was his fault, to forgive him, and all that. And, uh, I told him it wasn't his fault and (*pause*), you know, to realize that it was an accident. But I, I wasn't thinking that.

T: Yes.

X: I would think that it was his fault, but I shouldn't tell him. And then when I'm home, I feel like yelling at him, telling him, you know? And I'm always in a bad humor sometimes, and I, I never was like that.

T: But you haven't told him?

X: Mm-mm.

T: Now there's something there, because, you see, while everyone else may not know, he knows. He knows what happened. And you've been very close with him.

X: Yeah.

T: So, you must be the kind of people who talk to each other. And you know something, and he knows something, but you don't tell him.

X: Yeah, but he knows this, but I think that right now he thinks that it wasn't his fault.

T: Ah!

X: Because, you know, everybody was telling him that it was the brakes. But it wasn't.

T: Yes.

X: The brakes were okay, and he didn't even put the brakes on.

T: Yes.

X: So, it wasn't the brakes. Now he probably doesn't remember because, oh, yeah, he said that, uh, well, yeah, it sounded like he was drinking, so he's probably been remembering.

T: Yes.

X: And, uh (*pause*), well, everybody's saying, you know, nobody mentions it anymore.

T: Well, do you have the feeling that maybe they're trying to protect him?

X: Yeah.

T: And you want to protect him too . . .

X: Mm-hm.

T: But, there are different levels of protecting. He's actually feeling very bad.

X: It doesn't sound like it (*angry outburst*).

T: It doesn't? He's not feeling very badly now?

X: Mm-mm.

T: You told me that he was crying?

X: That was at first.

T: That was at first, so he's forgetting about it now?

T: Yes. You've already thought about what would happen.

X: Yeah (*pause*). So I don't want it to; I don't want it to happen (*laughs*).

T: But let's just see what that would be like if it were like a script, you know, written out for a television program. You would have this talk with your stepbrother. He'd get mad, I guess, and he'd go tell his mother that you were blaming him for the accident, and then they'd make life miserable for you?

X: Mm-hm.

T: And then what would happen? Would you have to go home to Canada? They'd kick you out? Or they'd be mean to you?

The earlier clues have now registered in the therapist's mind.

X: (*Laughs*). No, well, they're not mean with me. We only don't, um, you know have a good relationship; well, we do, but (*trails off*).

T: You do and you don't.

X: Yeah, we do and we don't. Well, I was always, I was always thinking that they prefer, well, it does (*pause*) that's, um, logical, that she prefers her sons and daughters, well, yeah. I was the stepdaughter only. And, uh, well (*pause*), they didn't let me do nothing, not even to go someplace, because they said that they were responsible for me and that if something happened to me, they were, it was going to be their fault, their responsibility. That's, that's right; they don't like it.

T: Yes.

X: So, mm (*pause*), you know, they wouldn't tell me to go back to Canada, but I would (*laughs*). I would feel—

T: You would feel you had to go back?

X: Yeah, 'cause I, if I, I won't feel good staying there.

T: Well, what would going back feel like? What would you go back to?

X: My real mother.

T: Yes, well, I don't know what that's like.

A sign of this patient's immaturity and dependency is seen in her talking to the therapist as if he knew her history. The telling of her story to many persons in a university hospital contributes to this effect, but she reveals in many other ways a psychological development level of less than her chronological age. Her deportment, posture, and mannerisms are those of an early adolescent. The therapist believes that this is not merely a regression due to stress and hospitalization but, rather, a continuation of a preevent character structure. Other thoughts strike him: that she probably has an incompletely developed feminine self-concept and body image, is sexually conflicted, may use the injury as an excuse to avoid sexuality, and may have unusual problems in working through the sexual and other implications of the body loss. The stress, were this substantiated by later material, would be a complex of the new event, earlier conflicts, and impeded psychosexual development.

The patient gives her background history at this point, which indicates that she feels like a second-rate child with her real mother, who remarried and had more children, and with her stepmother and real father. She left Canada when she had difficulty in high school and felt excluded from her family there. She hoped to make a better home with her father and to form an attachment with her stepmother and stepsiblings.

The accident disrupted the refuge she found, and she is frightened that they will exclude her because she "knows too much." She must stifle her rage to avoid this threat. She reveals this story but is not actively aware of the psychological meanings, a relatively histrionic style of "not knowing." Nonetheless, this material is at the surface and is clarified by the telling process.

The therapist then summarizes, as the transcript continues:

T: There are kind of two things that are problems for you now, that you wanted to talk over. One is the business with your stepbrother, you know, your anger where you can't win, no matter what you do.

X: Mm-hm.

T: And the other was your feeling that you don't quite realize what it means that you were in the accident and that you lost your leg. And that's probably going to be a pretty gradual thing as you get used to using your new leg. It may feel artificial and funny at first before you get used to it. Do you want to talk at all about that today?



X: Well, you know, lots of people, they lost their leg too, and they were very sad and, uh (*pause*), even, because I saw a man down in physical therapy who lost his finger. He was crying (*pause*).

T: Yes.

X: And he was very sad, and I lost my leg and I didn't realize it. I was very happy. Well, I always have been happy; I never get mad or anything and, um, well, I was thinking that probably I'm not normal (*slight laugh*).

T: Uh-huh.

X: Simply 'cause I don't realize it.

T: Well, you know, I've seen people who've lost different parts of their body, and everyone doesn't get sad about it. It's not necessarily abnormal or crazy or anything like that. Some people just take it and go on with their life.

The therapist has made a quick decision to support her denial of the limb-loss complex for the time being and focus on the family support system, establish a therapeutic alliance, and then see what happens.

X: Yeah, but I mean, not even crying? Not even that?

The therapist realizes that by her response he may have erred: supporting the denial sets up a therapeutic misalliance that will perhaps disrupt the therapeutic possibilities. He thus tries to reverse himself.

T: Well, let's find out more about it, though. Do you find yourself having any dreams about yourself?

X: Yeah (*as if disappointed*).

The therapist persists in his error by asking too peripheral a question. Dreams are important to the self-concepts contained, but the timing of this question is poor and based more on the therapist's discomfort than on the need for this information at this point. It would have been better to have ended the remark with, "Well, let's find out more about it."

T: What are you like in your dreams?

X: (*Long pause*) Like I was before.

T: Uh-huh.

X: Dancing again, and then, uh, I see myself in a place and all my friends over there.

T: Uh-huh.

X: And then, they don't go over there to ask me for a dance 'cause they know that I have an artificial leg or something like that.

The therapist obtains useful information. Despite his procedural error, the patient goes ahead.

T: Yes.

X: And then, I see my stepbrother dancing (*pause*), and I don't know, I feel something against him. It's not, it's not only 'cause I don't have my leg. It's because I don't like the way it looks either.

T: Yes.

X: To say to me they had to do two, some operations and I didn't li——. I don't like the way it does.

This is a typical avoidance of words to clarify her repugnance at how her leg looks. The therapist decides to ask for details to see how deep-seated this defense is.

T: Would you describe it to me? Of course, I haven't seen your leg.

X: Well, it's kind of, um, well, they took skin from here to go over here.

T: Yes.

X: So, it's kind of, uh, looks black and all that.

T: Mm.

X: And, uh, well, I thought I was going to be, you know, there was, they were just going to amputate my leg and that's all.

T: Yes.

X: It wasn't going to look like that, but it does. And every time that I, I w——, I just saw it last month. The doctors wanted me to see it, but I didn't want to, and I said well, if they're going to do another operation, plastic surgery, it's not gonna look the same; it's not necessary for me to see it right now. So, I wait. And I thought I was going to look better.

T: So you didn't look at it then?

X: Only one time, and I, I didn't want to, but I did. And I didn't, I didn't like it.

T: Yes.

X: That's the only time that I cried for it and then, uh—

T: You did cry, though?

X: Yeah (*pause*). Only because it looked like that (*voice tone insistent*).

T: Yes, but that's part of the sadness. It's partly there. These things come in doses. But tell me more about it.

The therapist means the sadness is partly there and will occur in doses, but as often happens, his own process echoes the patient. "It's partly there" is the problem she has with the leg. These slips are not uncommon when treating persons with stress response syndromes.

X: I will cry, too, because, uh, well, I am (*pause*), all the time, you know, when I saw people in the streets on crutches and things, I felt (*voice very soft*) ashamed.

T: Yes (*empathically*).

X: You know that? And, uh (*pause*), when I was, when it was over, I didn't want to go to the store or something like they were going to bring me, just that I don't want to, people to feel ashamed of me; something.

T: Yes.

X: That's why I didn't go to graduation, either.

T: Oh, you didn't?

X: Mm-mm. Well, I wasn't, I didn't have to.

T: Yes, but you didn't want to go because you thought—

X: No (*Interrupts*).

The patient gets the incipient thought and wants to prevent the clear statement, but the therapist persists.

T: —people would look at you and—

X: Well.

T: —think you didn't look nice?

X: Y-y-y-eah, but (*pause*) I didn't like myself, you know, people staring at me 'cause I only had one (*pause*) leg.

Possibly identifying with the therapist, the patient does add the descriptive word *leg*, after a pause. Previously she had used the label *it*.

T: Yes.

X: So, um (*pause*), well, I didn't want to go.

T: Yes (*pause*). So this is something that's still tender emotionally for you (*pause*). And you don't like to look at it, don't like how it looks.

X: I do now.

T: A little better now?

X: (*Laughs*). Yeah, I guess.

The interview ended with their agreeing on a brief therapy to extend beyond the point of discharge from the hospital. During the therapy, the discussions were similar to the above material in that more time was spent on working through Xalia's rage and only a little time was devoted to the sadness and shame over her loss of the limb. In other words, Xalia's accident and amputation set in motion at least two main cycles of thought and feeling, both incomplete when the treatment began. One was more intrusive, and the other was still in a phase of denial and numbing.

All such statements are relative. For example, Xalia did have thoughts about looking different after the amputation or finding the stump ugly. But many more reactions lie ahead before she can adapt to an altered body. In comparison, the impulses to castigate her stepbrother are urgent and conscious, as is the opposing desire to maintain family harmony at the price of silence and thereby avoiding both guilt over harming her stepbrother and fear that she would be sent back to her real mother and stepfather in Canada. The discussion and working through of this conflict thus meant recognizing the implications of losing a leg.

One explanation for the inhibition of personal loss and the emergence of interpersonal anger is the association of personal loss with a more profound threat. There was a brief emergence of this theme during the therapy when Xalia told of intrusive ideas that came very briefly into her awareness, of wanting to be dead, and of persons on TV who killed themselves. The implication was that if

she were to realize fully her personal losses, of her leg and her family closeness, she was afraid she might commit suicide. The profoundness of this threat is one reason that techniques that would thwart or skirt her defensive denial would not be advised. The time to master these issues will come later, when her rehabilitation is more advanced, her social support system is stabilized, and she has a well-established relationship with a therapist.

The rage toward her stepbrother, a theme dealt with immediately in therapy, was not instigated solely by the accident. Though very close to him, Xalia also resented his being the complete child of her stepmother and the prize male in a family and the prized son. In addition, ambivalence and competition among the siblings was a major theme in the extended family, going back three generations. Work in this area meant recognizing the major themes of the conflict present before the stress event.

## Summary

The case of Xalia illustrates both intrusive thoughts and denial. Two complexes activated by the accident were described, and at a given moment in time one was the more emergent and one was more successfully inhibited. The inhibited complex, revolving around sadness and shame over bodily loss, was not purely denied but was partly recognized and contributed some intrusive thoughts. Nonetheless, therapy focused mainly on the more emergent themes, which involved preexistent conflicts and followed the patient's leads.



## CHAPTER 13

# An Automobile Accident

*With Richard Olson, M.D.*

Jane is a 23-year-old woman who developed a relatively severe reaction to an automobile accident. Her therapy was completed in five interviews which will be reported in detail here to illustrate the process of treating stress response syndromes. The relevant issues are the succession of intrusive and denial signs and symptoms, a technique of focal working-through, and the interaction of the external stress event with Jane's current tasks in personal development.

Six weeks after her automobile accident, Jane called asking for immediate help because she was tense, nauseated, and unable to eat or sleep. She had been seeing a physician for neck and back pain and had been placed on several medications for pain, muscle spasms, nausea, and insomnia.

Nothing helped, and her physician referred her to the stress research clinic for evaluation. When she telephoned, she sounded tearful, desperate, and complained of extreme nervousness and preoccupation with the accident. An appointment was made for later that same day. After discussing the research and teaching aspects of the clinic service, Jane gave an informed consent for participation. The following interviews then took place.

## First Session

Jane appeared for the first session looking pale, tense, and wearing a protective collar around her neck. A slender and moderately attractive person who dressed modestly, her face was rigid, and she moved in a guarded and halting manner.

T: Therapist

J: Jane

T: What's up?

J: I'd rather you didn't ask me that leading question (she appears to be very tense).

T: Well, you called this morning.

J: My doctor thought I'd better call because I was getting more and more anxious and I couldn't eat. He knows—he's treating me for a whiplash. . . (*long pause*).

T: Yes.

J: . . . and it brings on the pain . . . (*long pause*).

T: What does the not eating . . .

J: What does it do?

T: Well, how does it come upon you?

J: Well, whenever I get upset, I slow down on whatever I'm eating. I never have had an appetite too much. And when I got upset this week, I just began to vomit in the morning and couldn't keep anything in my stomach.

T: Well, that was just this week that you got upset?

J: Well, yeah, but this is like I've been upset before.

T: When did it seem to start, being upset?

J: I've never calmed down since the accident, not completely. I've been on the medication ever since.

T: What medication is that?

Ordinarily, at the very beginning of a contact, the therapist would not focus on a detail such as medications but would instead encourage reports of more central material. This focus is made in order to help the patient establish a therapeutic alliance as well as to evaluate the current situation. She is quite tense, resistant to the idea of communicating with the therapist, and focuses on somatic issues. She has not presented psychological reasons for coming. At the same time, she is indicating nonverbally that she is in great need and wants to be taken care of. A somewhat tangential discussion, thus, may establish a model of successful communication, provide a calming effect to counteract the extra stress of a first therapeutic contact, and pave the way for freer communication of the more central details.

J: It depends on what week you're talking about. He's been changing it as I change.

T: Uh-huh. Have you been taking antianxiety, antidepressant, or sedative medications?

Her remark, "it depends on what week," is sarcastic, and the therapist knows that the state of her relationship with her doctor may be important. Her dependence on and her irritation toward her physician already impressed the therapist. He expects that there may be a potential for this sort of transference in the therapy and considers the possibility of its being related to her reactions to

the stressful event. He chooses to persist in finding out the answer to his earlier question "What medication?" in order to establish the model for the therapeutic communication mentioned above.

*J:* Antianxiety, pain killers, and a joint deflatory medication 'cause I messed up my hips as well. I have to wear a lift on my shoe now.

*T:* Who is your doctor?

*J:* Doctor Smith.

*T:* What kind of a doctor is he?

*J:* He's an M.D., internist.

*T:* Uh-huh. Are you seeing him privately, or are you a clinic patient?

*J:* Privately. He is the one who I went to after the accident 'cause he was my doctor.

*T:* And he suggested you come here?

*J:* Yeah.

*T:* When was that?

*J:* I went to him Tuesday because I had missed work. I just started substituting as a nurse's aide, and I was really upset with some nurse, and I had to have a head nurse find another substitute at the last minute because I got all the way down to Zone City where I'm working and I couldn't stay. And I went to his office and I slept there for three hours while I was waiting for him to come. The receptionist let me sleep there. And then he changed my medication, and by Thursday, I was in the same state all over again. I got through Wednesday somehow, but by Thursday I couldn't so I didn't even leave and go to Zone City. And I called him, and he started making arrangements, so he contacted the clinic.

*T:* Yes, right. So here you are. Well, this is what we'll do now. I'll just try and find out what I can about you this time and maybe another time. Then, we'll try and assign you for appropriate treatment. It already sounds like something is indicated.

*J:* What?

*T:* I don't know, but something.

*J:* Something?

Her rejoinder is subdued sarcasm and is provocative. The therapist again has the impression that Jane will set up a passive-dependent or passive-dependent-aggressive type of transference situation. She is challenging him to do something before he knows what is going on. She has not said clearly that she is in psychological distress but has presented only physical complaints. He is comparatively certain that she is in psychological distress and chooses to focus on this issue. His next remark will, therefore, be made as a statement. This again points toward developing a therapeutic contract. The therapist illustrates his intentions here; he will clarify and interpret but not assume responsibility for her life. He already has a hunch that her physical complaints are both real and used as a defensive



denial of emotional responses to the accident. He is, in a mild way, undercutting that defense by focusing attention on the area of warded-off experiences. These early choices are often quite important, but unfortunately, they have to be made on very few data.

*T:* It sounds like you're in psychological difficulty.

*J:* Yeah, I know, it has to be psychological. There is no other reason to have all these problems at once (*long pause*).

*T:* Well, I'd like to know much more. Where do you think would be a good place to start; would it be to tell me about the accident, or—? (*trails off*).

The patient is still resistant to telling the therapist what kind of difficulty she is experiencing. The therapist now senses this is not simply a high level of anxiety or inarticulateness but that there is also an element of defiance. Perhaps he is being equated with the referring physician. She may be covertly communicating an accusation that would go something like this, were it to have been expressed verbally rather than nonverbally: "You see, you won't help me enough: I still hurt, and so I won't cooperate with you. Let's have you make me do what you think will help. Then we'll see that it won't help either. That will prove that if anyone is to blame, it's you, and not me." To avoid this type of transference, the therapist backs off a little from the firmness of his earlier remark, "It sounds like psychological difficulty" and places the responsibility for choosing their next topic partially with her.

*J:* Well, the accident stopped me from doing all kinds of things. On the day of the accident, I was on my way to an assignment to substitute in Zone City. And I took Banning Road because the school was near Banning. I never take it unless I have to, and in the fog, someone rear-ended me at a stop light. And after that, after I gave out flares and told everybody that my neck hurt, we moved the cars because other cars were bearing down and nearly hitting them again. And a policeman came and passed out flares and put them out on the highway, and another car came and smashed into my car and I went into shock. And I was just like a robot from there until a few hours later when I came down again.

*T:* Uh-huh. You were driving alone?

*J:* Yeah, I was on the way to work. I have to be alone to get there because substitute nurse's aides never know where they're going to be. But the doctor kept me off work for a month. And that same day, I was supposed to go to an interview for a regular job, and they were good enough to hold the job open for me. And I had to wait until I could find out whether I would be able to work. They decided that I could work and so I went to work with my collar on, about two and a half, three weeks ago. But they placed me in another ward, with new people because there was a rule about two people in the same family on the same service and my sister-in-law was working on that service. I'm supposedly teamed with two other aides, but they're very, very close and are roommates as well so

that they're together all of the time, and they're actually teaming and I'm way off, and I see them only during report.

*T:* Yes, so you're kind of isolated?

*J:* Yeah.

The theme of people's letting her down is repeated again: the nurses, nurse's aides, her doctor, and (by inference) this therapist. The therapist gently affirms this feeling by saying that she is isolated, and so she continues with a freer description of how tough things are at work. She says she broke down one day recently but does not reveal what that means. Only in later hours did she describe what had happened. She had grown so irritated with a complaining, senile patient that she slapped him. She was terrified that she would be reported and lose her registration as a paraprofessional, as well as the immediate job. After adding details about work, which seem to smooth out the communicative feeling with the therapist, she continues as follows:

*J:* But after I got myself upset Tuesday, I couldn't get myself calmed down, and I dragged through Wednesday, and I couldn't make it Thursday, and I stayed off today.

*T:* Yes. Well, can you tell me what being upset and nervous is like inside you? How is it going in there?

*J:* It changes. It started just to be stomach trouble, but along with it, my stomach would hurt and my bowels would be loose. The stress would go into my back, and now the small of my back and my hip joints and my neck all hurt, and just about every single muscle hurts by now. I haven't eaten enough in so long that I'm just exhausted, and—

*T:* How long has it been since you've eaten anything?

*J:* I eat little bits 'cause every day is like a cycle. In the afternoon, I'm pretty good, and by evening, I might even be able to eat solid food. But in the morning or the middle of the night if I wake up, I can't stomach anything, and I'll just be sick.

*T:* Will you throw up if you try to eat?

*J:* Yes. Or right now, I was throwing up on Wednesday before I went to work, and I got it into my nose and I always get sinus problems anyway, and I was sneezing all day and I didn't think about it, but that evening, it drained back down and burned my throat. I haven't been able to shake that yet; I'm still—like I was crying all day yesterday and the night before, and the more I cry, the worse it got. So, last night, I woke up hysterical; I couldn't breathe 'cause I couldn't clear my throat and I had a pain in my chest, and it turned out to be that I was sleeping on my side and a muscle had tightened.

During the therapy, this patient has symptoms related to her joints, bones, muscles, gastrointestinal system, eyes, and upper respiratory system. None of these are malingering; she tends to develop psycho-physiological reactions under stress.

Such symptoms should never be regarded unsympathetically. It will be seen that Jane has conflicts between dependency wishes and strivings for independence. She has already presented herself to the therapist as both needing to depend on someone and not wishing to depend on anyone. The somatic symptoms are presented as a reasonable basis for obtaining sympathy and attention, but they are presented in such quantity that the therapist is made uncomfortable with the load. He changes the topic, perhaps too abruptly, but does try to find out more about what may be real aspects of her dependency-independency conflict.

*T:* Are you staying alone?

*J:* No, I'm with my father and my stepmother.

*T:* Yes.

*J:* But I don't get along with my father. He's an alcoholic, and we have what he decided is a mutual agreement: we talk to each other as little as possible because if we say more than three words, there's an argument.

*T:* I see. Then it's somewhat of a tense living arrangement.

*J:* I wanted to get out of it before the accident. I had planned to leave in either August or in October, depending on whether I could sign a contract for September or not or get some other kind of work. I was taking typing lessons in case I couldn't find a job as an aide. But now, I have to stay home until I'm well 'cause I have no place to go and no money.

*T:* Did you finish training just recently?

The therapist notes with interest that the accident has forced her to stay with her father. She had planned to separate from him, a more-than-appropriate move for a 23-year-old. The topic deserves further exploration, but the therapist delays this because a therapeutic alliance is not yet established and because she is so distraught. He already believes that her dependency-independency conflicts may be important and that the establishment of a therapeutic alliance in itself will offer enough support to enable her to improve and not require hospitalization and probably not need medications. After details about her current work and training situation, the therapist tries gently to return to the situation of living with her alcoholic father.

*T:* Do I gather that you had a kind of plan of getting a job and then moving out?

*J:* Uh-huh pretty soon.

*T:* Yes, well (*long pause*), so there seems possibilities of that, but getting into the accident really set you back?

*J:* Yeah, right after the accident when I was pretty medicated, I felt really, really good because the pain hadn't set in; it took a few days. A job possibility came up for just the kind of job I wanted. Only it was a rumor; it was something the nurses were pushing, and the nursing director hadn't set her mind on it yet, and she had just asked around for nurses and aides to transfer into those positions

who were already employed in the hospital, so several people contacted me who had been contacted by her saying, "You really fit into this one." But in the days after that, my neck got tighter. I couldn't drive myself down to Zone City, so I couldn't go to an interview. And since that time, the woman who would have interviewed me committed suicide.

*T:* Now, what's been on your mind in terms of the accident itself? Does it come back to you at all?

It is advisable to ask directly about intrusive phase symptoms, as the patient knows them consciously but often does not know how to report them.

*J:* The only time I really think about it is when we're commuting on the freeway and someone changes lanes or does something stupid. Then I feel that it's about to happen because I saw the guy coming when I was hit. I could see him in the rearview mirror, and he was coming too fast. That's the only time I really think much about it.

*T:* Yes. And you said you don't drive now?

*J:* Yes, I do. I don't drive to Zone City because it's too far to go, but I drive around the city. Today I'm not driving because I haven't eaten in so long that I'm too weak.

*T:* And what's keeping you from eating? Is it lack of appetite?

*J:* Well, I don't have any appetite, and my throat was really sore, and my stomach wouldn't take food except for a few hours, and then it won't take much. But I talked to my doctor again; I talk to him every day, and he prescribed something so that my stomach will remain calm so that I can eat. I just picked it up before I came here.

*T:* What is that?

*J:* I'd have to look; it's in my purse. Do you really want to know?

*T:* No, just if you knew. Are you taking any other medicines besides this one you're going to be taking?

*J:* Uh-huh; I was taking Valium right after the accident, with the other medications, and then I went off of it last Tuesday. Then he put me on Compazine. That Compazine puts me to sleep. When it hits, I'm out. So today, he put me back on Valium, and he doubled the dose.

*T:* Does that help you?

*J:* Yeah, the only thing that bothers me is that it dulls my mind. After having studied medical stuff like anatomy, that just freaks me out because I like to be able to think clearly and know stuff. Like I couldn't even keep my charts. I had them all messed up as to which patients had what temperatures, which had movements, and all like that.

*T:* So it would be important to get through this stage that you're in—

*J:* Right. I really don't like to be on any kind of medicine at all, and I usually have to be coerced by the doctor to keep on it. I keep wanting to go off of

it and stay off of medication. It scares me because I've seen too many people with problems.

*T:* And what did you do at home yesterday?

*J:* Well, first I typed a couple of letters, and the phone was going all day with the doctor trying to find out where he could have me evaluated. And the people were calling me who were concerned.

*T:* Where he could have you evaluated?

*J:* For psychiatric help.

*T:* Oh, I see.

*J:* He had thought he could put me in Acme.

*T:* That didn't work out at Acme?

*J:* No, I'm out of the district. I'm reading a book and was watching TV. And I've got a dog and I usually walk her every day, but when my hip joints hurt, I don't want to walk. Yesterday, by late afternoon, I was feeling good, so I took her for a walk.

*T:* And do you have difficulty concentrating, like when you try to read or watch television?

*J:* It depends on what it is. Like I was reading a medical book the other night, and I kept having to put it down because I couldn't imagine the parts that you should imagine as you're reading. But when I'm reading really light stuff, like from the *Reader's Digest* or something, then I have no trouble concentrating.

*T:* And do you see anybody?

*J:* My family keeps coming in and out, but most of my friends are—like when I was working full-time and she's (her girlfriend) staying hopped up on uppers to keep working. And she doesn't really want to see me\* because I make her unhappy and mess her up. And another friend just took off\* for the country, and another one is leaving\* for back East, and she claims that she's really busy. And really, those are the only people I see much of; I don't see a lot of people. [\* More desertion themes.]

*T:* No boyfriends?

*J:* Not right now.

*T:* In the past?

*J:* Not lately, but yeah.

*T:* So, you're feeling pretty isolated except for your family? Why does your girlfriend say that you mess her up?

*J:* We act rather strongly against one another; we have different beliefs, but we're willing to be friends. She, right now, is kind of selling what she wants to be and what she wants to do and trying to convince herself. She's going around spouting it out to everybody. She's already tried it out on me and knows that I disagree with it. She doesn't want to be near me because she's trying to convince everybody that the things she's going to do next are right, and I don't believe her.

*T:* How would you characterize—or how would she characterize you; what are your strong attitudes?

*J:* Most of my friends, including her, say that I'm stable. Doesn't sound like it now, but I'm usually stable and very—if I do something one way, like help out in a strange situation, I can figure out ways to get out of them. And I'm always there when anybody wants to get out of that kind of situation. Like the car breaking down; I'm really mechanically inclined, and if it broke down and I was there, I would probably open the hood, and if it was simple, I would put it together or I'd know how to call for help.

She has added mention of three friends who left her and counters this with pride at having independent skills.

*T:* Right. Any other strong attitudes your friends would say you had that would characterize your personality?

*J:* People who don't know me very well think I'm an egghead or that I'm cold.

*T:* But it's not true?

*J:* Well, I've got other friends who say they thought that and then when they got to know me, they found out that I wasn't. So I don't think it's true.

*T:* Okay, let's go back; do you mind talking more about the accident? It seems like it's really centrally important.

This is a firm attempt to set a focus for a brief therapy. The therapist has gathered some general data and tried to foster a therapeutic alliance in the conversation so far. He has some preliminary concepts about contextual personality issues.

*T:* You were going to work, and you saw this car coming at you, and you knew it was going to hit you. Could you, could you just tell me all the details from there?

*J:* I had come to a red light, and one car had stopped in front of me, and I was stopped and waiting. And while I was waiting, I caught an action in the mirror, and so I watched it and saw the car coming at me too fast and tensed up, and then he hit. And the first sensation after the numbness, the first numbness, went away was that my shoulder and neck hurt. And after the person in the front had seen my car jump, he came back and said, "Are you hurt?" I said, "Yes," and he stayed to help us. And the man behind me, the one who had hit me, he took a look around and came up to see me and says, "Are you hurt?" I said, "Yes, my neck is hurt." But I had checked myself out, and I could tell that was the only thing hurting; nothing else was hurting at all. So, I got out of the car and looked at the situation, then I crawled into the back seat and got some flares out 'cause nobody had anything to mark off this accident, and it was in heavy commute traffic and deep fog. So, I used the flares and said, "Has anybody called the police yet?" Nobody had; nobody knew where a phone was; it was re-

ally eerie because we were completely fogged in. You could see the road, but you couldn't see anything else because it was really, really fogged in.

Both her willingness to relate the details and her pride in taking charge of the situation are noteworthy. But she became vague and distracted as she said "fogged in," and that prompted the therapist's next remark. She seemed, in a way, to be reenacting the accident.

*T:* You probably started feeling unreal.

*J:* Yeah, yeah. Then the man who had hit me decided that I was shaking, and we couldn't decide whether it was cold or pain. I didn't even know which it was, so he put me in his car, and we traded information. Then he left me in his car and went to use the phone, and after he came back, I decided we'd better move the cars, because I kept hearing cars braking to avoid my car. We moved them and I left the engine running and lights on and I moved it into a zone that was painted off, a safety zone next to an island, a right-turn island. And he moved off to the shoulder, and we got back into his car to keep warm. My car was still in a more dangerous position. And a police car came, and he said they had trouble figuring out what county we were in. So a police car came and didn't seem to see us. It came from the other direction, and it made a left turn and stopped. And then after a long time, the policeman that we saw came, and he pulled around and came and talked to us and pieced together the accident. Then he put out his flares and was going back to get this report book when we could hear this other car approaching, and we all turned and watched the next collision, which threw my car about eight feet out into the intersection, because he was going mighty fast. And then that man got out of the car and exploded, and he just ran and he swore all over the place. He stomped around—

*T:* Angrily?

Her facial expression and vocal inflection indicate a great emotional involvement in this new person, and the therapist intuitively picks out a central aspect.

*J:* Yeah, he was as mad as he could be. I wanted his name before he went anywhere. He said, "I'm going to find a phone." I insisted, and so he threw his license at me and stomped away (she is very indignant). And the officer was out of hearing range by then, and he came back, and they started calling tow trucks and stuff and then they had to decide whether to send for an ambulance for me or whether I knew someone I could notify, because I was the only one that was hurt. I said, "I'm really not hurt bad enough to call an ambulance; I can walk around, and I can sit without hurting myself. If I think for a minute, maybe I'll figure out somebody I know who can come and get me." And I thought about it and tried my brother-in-law, and he was home because it was finals week and he didn't have a final that morning. So he came to get me, and he handled my towing service and some of the policeman's questions about me and stuff while I wrote out a report. Then after we had checked the car and left it in an empty

lot, we called my doctor and took me in. But my doctor had two other emergencies that morning in his office, and they left me sitting in the waiting room for an hour and a half. Then they decided after he looked at me for one minute, he needed an X-ray before he could decide anything. So he sent me over to X-ray, which is in the same building. I'd been there before because I had had back trouble before, and I had X-rays and retakes and stuff. And I went back, and he decided there were no fractures and no nerves pinched; it was just a severe strain. He prescribed tranquilizers and painkillers and a prescription for the collar, and I went downstairs and got the collar, and I got the medications and stayed home. But my insurance company sent a field representative to my house that afternoon. And I was really, really—not the same as I am anxious now—but excited more, and I called a friend to stay with me, and my family kept dropping in, and the house was full of people, and they had like a party and joked a lot, having a good time. And then the guy with a tape recorder came and taped my version of the accident, and he wanted a medical release and—

*T:* And so your family didn't realize, because there was not any big deal like bandages, they didn't realize that you'd been hurt.

The therapist is picking up on her vocal tone, which indicates her hurt and anger that she got so little attention.

*J:* Right. And then when I started to hurt, it really scared me 'cause I didn't know it was going to start to hurt.

*T:* Right, and that was really frightening.

*J:* And then the following Tuesday, I started therapy, physical therapy. But a few weeks later, I had to call my doctor about pains in my hip joint. It was just one at first, and I've had something related to that before, but it wasn't the same; this was stronger. And he didn't understand what it was and couldn't find out, and so he looked up my old X-ray and found out it was in my other hip, so he went for another X-ray. And he then said that the joint didn't show anything, but in the days that followed, it got worse and has gone to the other side. It turned out that I was sleeping on my side. I always slept on my side before this, and so I was sleeping on my side. I was sleeping on my hip, and it was getting irritated. And then I'd turned over to the other side and done it to the other one. So—

*T:* How did you feel about seeing your doctor repeatedly?

*J:* Well, he had me down once a week, and it turned out that I made the once-a-week appointment. I might not have a new complaint every week, but I just got in on a once-a-week appointment until this week.

*T:* How did the relationship go between you and your doctor? Do you know what I mean?

*J:* Yes. Well, he's almost argumentative in manner, but not that strong. I don't know where—well, if I ask something, then he asks something back, and



we go back and forth. And it isn't as if he's trying to explain the whole thing to me; I need to ask him to find out how things are going to go.

*T:* Right, just like being surprised that it was going to hurt. Doctors sometimes feel, "Well, I won't say anything because I don't want people to imagine it." And then what happens is what usually happens in these things. Delayed symptoms come up, and then you're surprised. But I get the feeling throughout that your feelings are badly hurt, as well as your neck.

For her, this is a major interpretation and also a second round in trying to establish a therapeutic contract for exploring her ideas and feelings. The therapist attempts to focus on the link between the stressor event, internal reactions, and identity, plus relationship issues incorporated in reactions to the trauma.

*J:* Uh-huh.

Her response is vague, and so the therapist tries gently to rivet her attention to the issue. She has not yet fully agreed to the exploration of psychological issues.

*T:* Does it make sense to you?

*J:* My feelings hurt?

*T:* Yeah.

*J:* I'm awfully disappointed that all my plans got wrecked.

*T:* Yeah, but I don't think you've been able to tell anyone that.

*J:* But I talk to my sister-in-law all the time. Only thing is that she's talking about other things when she talks back, so I don't know if she's hearing (*long pause*).

*T:* Well, I think there's some working-through to do about talking over these things. That, at least, I see as being real essential for you to do. Anything else?

The therapist is once again working toward establishing a therapeutic contract centered on psychological issues.

*J:* Oh, on the day before the accident, I hadn't been called to work. And I have a choice; I can call in at the City Hospital where I used to work and say I'm there, or I can do what I please. So, I decided it was about time I got myself another car 'cause I had sold my car about a month before when it was beginning to give me trouble. It was an old Toyota, and parts were really hard to get 'cause mine was made for the Canadian specifications. So I sold it and was still convinced that Toyota makes a good car for an economy car. It's big enough not to scare me. I know that Volkswagens blow around on the freeways; that scares me, and being in an accident scares me. This is before the accident; I went down—I saw an ad in the paper and I made phone calls; then I went down to Danville where there was a good dealer. I won't trust the guy locally 'cause I've heard what happens. And I test drove a car, and I said, "Yeah, I'll put a down payment on it." Then I told him that there were a couple of things that needed work before I would pay for the car, and he wrote them up and then I had the accident the

next day. I was supposed to pick it up on Saturday, and I had arranged financing independently on my own through their bank which they had set up for me. But it was my own financing. I got home, and my father said, "Oh, no, I'll pay the whole thing for you; you can just pay me back." Which is the arrangement he did with my sister, and since I'm financially in a rotten position anyway, I decided, well, money is going to help me get out of the house faster; I'll do it. And so I canceled the loan financing, and I got all their correct numbers and had my father write up a cashier's check 'cause he has the money in the bank.

Dependency on her father and the link of cars to her father turns out to be an important dynamic issue in working through this particular stress event.

*J*: Saturday, I really freaked out about picking up a car 'cause I couldn't drive; I had the collar on, and the pain was getting bad, and I was taking codeine and was too doped up to drive. I convinced my brother and my brother-in-law to come along. They took me down, and they were really nice; and they took me in a car with back rests in it, shoulder harness, and drove real careful. And when we got there, they test drove it for me. They said they'd take it on a rough road and really see how it was doing but the salesman who was selling it to me and told me he'd be there wasn't there, and he turned me over to the manager.

The desertion theme emerges again. Note that she is talking more openly to the therapist and in a pressured manner.

*J*: And the manager needed all the details because the salesman had left in a hurry. And we made the arrangements finally and signed the papers and gave him all the money and took the car home. And since then, problems that I stated on the first form weren't solved. Today was the day we finally had an appointment to have it done, so I sent my brother down again, and he just got the car back, but I haven't had a chance to ride in it or drive it myself yet to see if it really is repaired or not.

*T*: So you have that hassle. Well, look, we have to stop. I'd like to see you again before we decide anything. But you know, I think we've already decided that whatever else, there is some talking to be done.

He had made another effort to reach agreement on a therapeutic contract.

*J*: Okay.

*T*: You know, I hope this won't interfere with you working.

He had suggested that she is well enough to work and should go on rather than regress.

*J*: I work in the morning only.

*T*: Oh, well, let's see what we can do in the afternoon.

*J*: It would have to be after 1:00 o'clock.

*T*: Um. I could see you if you could come Monday at 2:30. Would that be okay?

*J*: Okay.

## Second Session

Jane began by saying that she had done quite well over the weekend. She felt that the first hour had helped her: "It just worked; I don't know what it did. I know afterwards, I kept thinking, 'I sure didn't say a lot of details that were there that I could have said,' but at the time, I didn't think." This suggested to the therapist that she was in a denial phase of response. The hour helped both in the sense of socialization, discussing the accident with a therapeutically oriented person, and, in a general way, raising her concerns to a reality-oriented rather than fantasy-oriented level.

She went on to add that she had moved out of her father's house. She had asked her pregnant sister to take her in, and that had been an improvement over eating with her father, who often vomited at mealtimes because of his alcoholism. She indirectly attributed the idea of this move to the therapist's remark in the first hour that the situation at home was tense. Probably the therapist's repetition of what she herself had been saying acted as a type of permission for her to become more assertive.

She was worried about being a burden on her sister but said, "I'm going to turn it around, and I'm going to help her, and I'm helping because I don't have to be the one that everyone else is helping. It puts me one block away from the person I was commuting with, my sister-in-law. And I'm going to see if I can commute alone pretty soon, 'cause I don't like to be driven. I'm going to try it one time with her sitting beside me and if that doesn't have any problem at all, then I'm just going to commute by myself."

The therapist is pleased to see the reassertion of her striving for independence and activity. He has also been impressed by both regressive forces leading to searches for dependency as a secondary gain from the accident and the loaded but unexplored issue of her deterioration at the accident when yelled at by the driver of the second car. Also, she was at the point that her doctor was considering psychiatric hospitalization, and she was showing many somatic as well as psychological complaints. He favored further work rather than a termination at this point. His feeling that the improvement was in a way a relationship cure added to this decision to continue. First, he asked more about what seemed to be a fear of driving and then asked an open-ended question.

*T:* Well, what about cars and driving? How has that been on your mind the last few days?

*J:* Well, I drove here. I drove all over this morning doing stuff, getting keys made and stuff.

*T:* Alone?

*J:* Sure. Ever since the accident, I'm always able to drive short distances alone; no problem at all. The only problem that still scares me is getting on the

freeway in heavy-commute traffic, where merges are going on. That part scares me. But I think if I was behind the wheel and not having to watch somebody else do it, I could handle it fine, because I did it since January and never had an accident or even a close call. You know, I know how to do it; just whether I'm scared or not.

*T:* Okay. Well, where should we go from here?

*J:* I don't know. I'd kind of like to find out why I get into such deep depressions and can't get—well, this time I couldn't get myself out, because I wouldn't want to go into it again. If it ever happened again, it would screw up my career in nursing, being unable to attend or just breaking down like that. I mean, if I couldn't have pulled out this week, my contract probably would have been torn up and destroyed, and my record would have been messed up, you know. And I really would like to get to the root of why I throw myself into depressions.

*T:* Okay. That's something then that we should explore a little bit more. Maybe we'll have time now. But I wanted to ask you also where the memory is with you right now about the accident.

*J:* I can remember it fine.

*T:* Uh-huh. Does it come back to you when you don't want it to at all?

As mentioned earlier, patients often do not spontaneously report intrusive phase symptoms. Risking the danger of suggesting a symptom, the therapist asks pointedly about a common response to accidents.

*J:* No. I think—I don't usually remember what I dream. But since, like the last week or so, I have had nightmares, usually right when I wake up I remember something, some piece of it, and I think sometimes I have nightmares about the accident because it scared me so bad.

*T:* Yes. But you don't remember what they are?

*J:* No. Never have (*laughs*).

*T:* Do they sometimes wake you up out of your sleep?

*J:* Well, it's a combination, because I move around if I'm having a nightmare, and then I don't know whether it's the nightmare or laying on a hip joint or bending my back or what it is that wakes me up. But I wake up, and I can remember a piece of bad dream and being in pain at the same time. So, I don't know, is it the night—you know, I'm so wrapped up in too many things at once—I can't say. Like last night, I slept fantastic—no problem at all. And I know I woke up on my side which is supposed to be a no-no until the hips get better. And this morning, this hip joint was irritated, but after I was up and moving around and took a hot shower, after about 45 minutes, it's okay now. So I think pretty soon I'm throwing the book away and forget about it, so I can sleep like I want to sleep.

*T:* Uh-huh, and during the day, you don't find you're having thoughts about the accident coming in on you when you don't want them to?

*J*: The only time they'd come in on me is if I associate with something happening right now, like in the car—

*T*: That might trigger it?

*J*: Yeah, trigger it.

*T*: Well, you know, thoughts like that are always surprises.

This is a “moving closer” type of remark, meant to reveal empathy with the patient. The patient responds with associative memories.

*J*: Yeah, definitely. Well, I know, well, I mean, I kind of compare it with my mother's death a long time ago, and for a long time after that, things would trigger that memory, you know. And now it's so long that—and I used to counsel at the York Avenue place with the kids who had a lot of trouble. A lot of them had fathers who disappeared and people in the hospital dying and things like that, and I could handle that fine for them, too, you know. And I got out of that, and I'm confident that I'll be able to get out of the accident myself. But something else is still triggering depressions in me because I still get into them.

*T*: Well, there may have been a clue to that in our discussion Friday. It may not be the right one, but it might be there. I kind of got the idea that you experienced the accident, in one way, as just another insult.

*J*: Yeah.

*T*: Does that seem to fit with you?

*J*: Uh-huh.

*T*: And maybe there have been a number of other ones in your life, and this was just. . . .

*J*: Another one, yeah.

*T*: . . . just another one to hit you. Of course, it had that kind of rippling effect in that it interfered with so many of your plans.

*J*: Yeah. It meant nothing in particular. My car, I hadn't paid for it; I was right in the middle of it. And that afternoon, I was supposed to go for planning for the summer. That particular day, I was doing a million matters of business, and none of them could be done . . . (*long pause*).

In an event-centered therapy, one may not wish to stray too far from what the patient is speaking of, but she calls her psychological reaction a depression and seems to recognize a recurrent pattern. The therapist believes this must be explored to understand her character, preexisting conflicts, and the meanings attached to this recent event. As she pours out a tale of losses, the therapist realizes the importance of accumulated stresses and the “last straw” effect in this case.

*T*: Okay. Well, tell me a little bit about some of the other depressions that you've had. What kind of things seem to trigger them?

*J*: I think most of the other ones were triggered by people dying, because I've watched my mother go into a depression when her mother died. That was when I was 5; I was just a kid, and I don't know what I was doing. I used to

throw tantrums, but I don't know what else I was doing. But when I was 12, she was ill, and she had been ill for years and died of cancer and that threw me. They had to take me to a doctor and start giving me vitamin shots to pull me back out because I was wasting away, losing too much weight. A few years after that, my favorite aunt died, and I went into another one. Shortly after that, one of my best friends died, and then I went into one again. One summer, in fact, I think it was the summer my aunt died, there was a dog we bought the year after my mother's death—and she always thought a dachshund would be a nice kind of dog because they're clean. So my sister helped find one and everything, convinced my father who was against it, and we bought a dachshund. It turned out that the dachshund was pedigreed, and he was overbred, and he had come out with a mean temperament. If a professional had been the breeder, he probably would have been destroyed because of his temperament, but it was a nonprofessional person who sold it to us, and he was like a one-man dog and we didn't know it. He could have been trained maybe to be a watchdog; otherwise, he should have been destroyed because he was mean. But we kept him for six years, and we had to do all kinds of things all over the house so that the family could protect people from him because he was moody and temperamental. He hurt people, and I got into all kinds of trouble because I was sitting for people at the time. I had to take a little girl to the emergency hospital and nearly landed in a lawsuit because her eye got scratched and all kinds of problems with him. But anyway, that summer he fell down the back stairs and dislocated his back and paralyzed himself from the shoulders back with some control of his internal organs. I had to take care of him 'cause I was the only one home, and I nursed him and nursed him and nursed him, and finally I was just getting really tired of it. My parents were going to be on vacation, and I said, "Is it okay with you if you'll take along the dog? I'm going to take two weeks off and visit a friend in Tahoe." They said fine. And I call, and they say everything is fine, and I came home and found that they had run out of painkillers and didn't know that pill was important and hadn't gotten any, and the dog had been in pain for eight days and just shaking with the pain. So I took him to the vet, and we had to have him destroyed. We had two dogs at the time—my other dog caught one of the infections that the dachshund had, and she had to be nursed back to health. After all that happened, after I went into a depression—it wasn't very long or very strong, because I had to do so many things right then and get back to school and stuff, but it seems they're all tied up with someone dying.

*T:* Losing something you like or are attached to?

*J:* Yeah. And then after that, there was—last summer was different. Last summer, I was taking courses; that's the last thing before you student nurse and go out. One of the people in the courses said, "I know you're really good" 'cause I was helping her out. She said, "I've got a job possibility for you," so

I went and followed it up and got the job, only the job was really something I wasn't quite ready for, and it threw me for a loop. I was tense because I had to learn how to deal with unusual patients and all of this as a semi-volunteer, possibly with money coming through and me in debt for a car that I had just bought, all at once. And so I got all upset, and Dr. Smith treated me then with tranquilizers, and I got through it and we had a glorious summer, no matter what (*laughter*). But about a week before the end of it, my mother's last surviving sister died of a brain tumor, and her daughter is a dwarf, who is slowly becoming—well, now I guess you'd call her a hermit. She's withdrawn from just about every living soul in the world. I happen to be one of the few people alive that she'll talk to. There are a handful of people: my sister, her sister, her brother, and a couple who she'll talk to on a very superficial level. I was trying to see if I could help her out, but of course, she wouldn't accept it. And also having lost my aunt, I went into another tailspin, but I came out of that one quick; it was short. I just got mad at the whole thing and said, "I've got to live for me and get out of this mess." Since that time, there's just been like little short things like the pressure of substituting. I'd get myself worked up in the morning waiting for that phone to ring and wouldn't be able to eat breakfast until after the phone rang, and I knew what the day was going to be. I was just waiting because at 6:00 A.M. when it could ring, I'd have to wait until 8:30 to know for sure whether it's going to ring. And then on three occasions, they called me for emergencies, so I really was never sure. So, I made it a policy that if it didn't ring by 8:30, I just left and I either did volunteer work or I did something else, 'cause it was driving me crazy to wait for the phone.

*T:* Well, you're a very strongly motivated person to get out and do things.

*J:* Yeah, well, I've had to.

*T:* It's related to what you've said; you've decided that you're going to survive. There are a number of messes in your family.

*J:* Definitely. Yeah. My mother taught me from the time I was very tiny, because my sister told me not too long ago that my mother had arthritis before I was born. And before she was ever pregnant with me, they told her that she shouldn't carry another child; it would hurt her too much, she had arthritis in her back. When I was very, very small, she would be in bed in the morning, and she would tell me how to do things. I would have to go and do them and then come back to her and see if they were done correctly. Instead of having her show me, she would just tell me, and I would have to go and do them, like getting ready for school in the morning, getting breakfast, and that kind of thing. So, I had to learn how to do things independently. Then, it got to the point where her arthritis would get worse, and she wouldn't be awake, and I wouldn't want to wake her, so I would do them all by myself, and if something new came up, I would sit down and think and see if I

could figure it out so I wouldn't have to wake her up. But the older I got, the arthritis got worse and then I don't know, something happened when I was about 8. It improved for a while, and she got out and got a job. And then we had to take on the whole thing about fixing dinner and buying food while she was out working. Then the cancer started, and she stopped work. Then she got really, really sick. Finally, because my father doesn't believe in hospitals, he insisted that she die at home, and she died at home from cancer and from all the complications from it.

*T:* Were you nursing her?

*J:* No, they wouldn't let me because I was the littlest. They had locked me out. That hurts sometimes (*crying*). They'd send me away, so I couldn't see her very much. Because she was so sick, they didn't want me to be scared, but it's scary not to know.

*T:* It can be harder than knowing the worst, sometimes.

*J:* I don't know. She finally died of dehydration, not from the cancer itself, but from what it caused.

*T:* I get the feeling that you never had a chance to say good-bye.

*J:* No. She said something once that sounded like good-bye, but they never told her she had cancer, and we knew for a while. She was smart and knew it. 'cause she was taking cobalt treatment, and anybody would know. But (*silence*) one time she did say something that was like good-bye. But that was months before she died. But I always have to—in my own family—I have to fight for the right to be treated my own age because I'm the littlest. My father wants me to be little and protected.

The accident made her ill and a stay-at-home like her mother. Later material will show that she has an ambivalent attachment toward her father in which they each can play either role: he babies her or she nurses him. Her progressive developmental strivings were leading to a healthy separation from this bond, with external sources of potential gratifications providing the enticements that would allow her to leave her father. The accident upset this forward movement and is a variegated type of loss, as later material will show.

*J:* I usually win, but it's always a big hassle. Like he didn't want me to go to the funeral. I told him—I was going to a parochial school at the time—I told him they're sending 100 school-age children my age to sing at her funeral, and they're my classmates. And if my classmates can go, there's no good reason why I can't go. He was convinced and I went. Had he left me out of the funeral, I don't think I would have believed that she had died.

*T:* Yes, I think you were quite right to have gone.

In hope of a rapid restabilization at her most progressive level, the therapist has decided to directly support her independence. He means this support also as a counter to the undercurrent of her potential dependent transference.



*J:* After that, after my father married Joan; she's fabulous; she came in, and we tried to make her fit and she tried to fit. It was a strain for a while, but it all worked out really beautiful. But then Dad began to drink more and more.

*T:* That's something more recent then?

*J:* Well, I can't remember how many years they've been married. He drank heavily after my mother died. My aunt, the one who's dead now, was trying to get all the kids placed somewhere else. They wanted to take me away from my house and place me with family or in an institution or something 'cause he was drinking too badly. But we proved to her that we were old enough to run a household whether he was well or not, and we did, 'cause he couldn't do anything. He was drinking really, really bad. And then, for a while, he sobered up, and he met Joan and he was well and healthy and doing all kinds of things. Like he's really handy around the house; he fixes everything, or he did. And it was then that she knew him when he was happy, a whole person. But not long after the marriage, he began to go to pieces again. And a couple of years ago, her son was in Vietnam, and he had a few more months before he came home from Vietnam, and we had a long time to wait before we could see my brother. So we planned a vacation 'cause she was getting so anxious for him to get home. We would drive to Arizona and visit my brother, and by the time we got home, it would be close to the time for her son to get home. Shortly after we left, they notified our household that her son was killed in action. My sister was the only one there, and she tried to notify us on the road and because it was a military matter, the highway patrol wouldn't help. We got all the way there, and my brother told my father on the phone and Joan collapsed, and we had to carry her to the car. He knew she was upset; she started saying all kinds of things against everybody.

She reports another loss. The therapist notes similarities but cannot be sure whether they are relevant. Joan saying things against everyone could have been like the second man's anger. In what follows, her father insists on sticking to the cars instead of going with Joan. Cars are very important to him. The therapist recalls that in the first hour, Jane spoke so proudly about taking care of the car, putting out flares, but does not yet know what to make of all this.

*J:* Then we got to the base, and my father wouldn't let us abandon what we were driving, which was a car with a trailer. I wanted to abandon the whole thing and take a jet home and comfort Joan, and he wouldn't let us do it. So my brother got an emergency leave, and we put my stepmother and brother on a plane, and they got to San Francisco, and they have lots of family and friends here to help them out. But then my father and I had to take the car and trailer back home. I knew how to drive; I had a license and I was experienced; more experienced than he realized because he doesn't hear me when I say things—he discounts what I say. But he wouldn't allow me to relieve him at the wheel.

*T:* He tried to drive it all himself?

*J*: He did. And finally, a gas station attendant took one look at him part way down and said, "Hey, you guys need a rest." My dad told him, "Yeah, we have to get home to a funeral, but I guess I do need a rest." One time, we tried to stop and find a motel, but we couldn't. But finally, a gas station attendant let us sleep in the back of the gas station. I could sleep, but he couldn't and he stayed so wound up; he was wide awake waiting for me to sleep so that I wouldn't fall apart. I woke up and I had to talk to him all the way to San Francisco 'cause I was so scared he would fall asleep at the wheel. He wouldn't let me relieve him at all, and he knew I could drive the car even with the trailer on it, 'cause I knew how to drive a car. I knew quite well; I had driven tractors and all kinds of things before that. But when we got to San Francisco and got home, he got sick all over the place and collapsed in a big heap; he had no control over his vomiting, diarrhea, and yelling and screaming, and he just fell to pieces.

An important memory contains cars, yelling, and falling apart. This memory was reactivated by her more current accident. Note how the patient is using the hour to go through an association that she may have been warding off in her own thoughts and that would be difficult to talk through with her family members.

*J*: And he won't allow any doctor to ever touch him, and we didn't have anything in the house that we could calm him with, except alcohol again. And there he went again on alcohol. From there until now, he's become an alcoholic, only he won't admit it and he won't accept any help of any kind, and he won't see a physician of any kind.

Note the implication that she is partly responsible for his resuming drinking by not driving, needing sleep, and giving him alcohol.

*J*: But, we went to the funeral, and it turned out that my stepbrother's wife had sent him a "Dear John" letter and he had volunteered for a dangerous mission and that's how he had gotten killed. Right after the funeral, she was living with another guy and getting the money from the government for him and buying a hot rod and just running all over. Joan was so upset that the household was just in a turmoil for months and months and months. She was bitter all the time. And even today, we all know that we can't say President Johnson in front of her or she'll become upset, and we can't say Vietnam in front of her or she'll become upset, or we can't say the name of the girl he married or see anybody drive a red sports car or any of that because she's still very upset about it. When things happen to make her upset, she sits and cries about her son who's gone, because her husband died and her son's gone and he was the last one of their family.

*T*: So, this kind of series of events you think might contribute to your vulnerability to getting depressed when an event happens? And there's another element in it that sounds like it's very important, which is your determination to survive and get out from under.

*J*: Be independent, is all I want. That's the one thing my family always hesitates about, always, is for me to try something. They're always holding me back, saying, "Well, are you sure, are you sure, are you sure?" I finally get myself convinced and I'm ready and confident, and they put all the doubt back in me.

*T*: Yeah, but you seem very successful when you do things. Like just moving out now; it seems like it's really an important step.

The patient has been crying at times during her telling of these stories. This expression of her feelings seems to have been a positive reaction for her. The therapist offers an appointment one week off to see how things are going then, implying by inflection that he expects them to go well.

## Third Session

Jane was to return for her next appointment on Monday. But she called sooner, on Friday, asking to be seen because she did not think she could get through the weekend. A brief appointment was scheduled for later the same day.

*T*: Well, what's up?

*J*: I'm getting all keyed up again.

*T*: Uh-huh.

*J*: And the thing that scared me really bad is in the pediatric ward. I've hit two patients. The first one was before; I hit an old man who kept touching me. And then it happened again this morning with a child. It's just terrible. But this kid kept picking at his bum. I couldn't get his attention because my voice keeps fading. My hearing is also shot. Doctors say I've got both eustachian tubes blocked, so when I get all frustrated and something is about to go, I overreact.

She goes on with details about the patients, crying at times and searching the therapist for his facial responses. He responds neutrally.

*T*: Yes.

*J*: And I'm physically getting myself tied up again. This morning I couldn't eat anything again (*spoken very slowly and deliberately*). I don't want to do that Saturday and Sunday and Monday. So when I left work, I decided that I'd call you and see if I could see you. The first time I saw you— after that I could eat again (*long pause*).

*T*: Yes. Why don't you just try and tell me whatever comes to you right now?

*J*: Well, I'm shaking (*there are tears in her eyes*).

*T*: Uh-huh; well, you're also crying, aren't you?

*J*: Yeah. Okay, this morning I told my doctor that I wouldn't take anything that had any depressants in it, 'cause I was scared of getting depressed again. And I have an infection, but he's treating it with antibiotics. He said, "If you won't take any depressants, will you use steam?" I've got an old vaporizer that

I used to use when I'd get these things before. I'm staying at my sister's with her husband in their flat. They put me in the spare room that's going to be the nursery in January when the baby is born. It's just an old flat, but the vaporizer last night was too strong and loosened all the dirt on the wall, and this morning there was just gobs of greasy dirt dripping down on the walls, all around. That's what I woke up to. Stupid stuff that's nobody's fault; just keeps happening, but when it does—

*T:* Did somebody blame you for that?

*J:* No, they kidded me about it, but they couldn't laugh about it because I was too tied up already and they knew it.

*T:* Yeah.

*J:* And then I woke up even before I saw the walls, with some of the paint which had been doing—and once I saw them, my stomach was out of control. I took stomach medicine that I'd been taking, and I got up and got dressed and went in, and they were having breakfast. I couldn't bring myself to eat anything because I just kept feeling so rotten. After they were gone, I was sick. Then I pulled myself together. My attorney wants me to write a diary, so I wrote an entry in the diary and left for work (*silence*). That's just today. Today's worse than yesterday which is worse than the day before.

*T:* You have an attorney?

Litigation is always a concern because compensation can be a secondary gain for continued suffering.

*J:* Yes, he's on vacation this week.

*T:* What is he going to be doing for you?

*J:* He's going to handle the medical costs of my accident.

*T:* Uh-huh.

*J:* But it's kind of ripped up; we don't know a lot of things yet. Because I was a substitute, we don't know if there's any way to collect compensation for loss of job.

*T:* Yes (*silence*).

*J:* Other things that keep bugging me is on my own ward I don't—can't think of things far enough ahead—can't plan ahead, so many things, I can see how they should go and can't make them go. Things turn my head in another direction and I can't get back fast enough.

*T:* Tell me more about your reaction with your patient.

Jane then gives a detailed description of how frustrating the child patient was to care for. She does not label her affect with words, but the therapist provides the label as the transcript continues.

*T:* You must have felt angry at him.

*J:* Yeah, repeatedly angry at him. But I have to watch it because he's so destructive of himself and won't let himself heal.

*T:* Yes, but right now, anger is especially hard for you to control because you're also angry at those people who. . . .

*J:* Yes, angry at the nurses who won't help enough.

The patient interrupts the therapist. He had intended to link her anger to the auto accident and to the various people who had blamed and deserted her. Deciding this link is probably correct and that she is warding it off by her interruption, he persists with his intent, feeling that she will be able to tolerate this confrontation.

*T:* Well, you're also susceptible to anger now because you haven't had a chance yet to work through and work out anger at the people who got you into the accident.

*J:* Yeah. Something happened yesterday that got me started off last night. There was a continuing education thing at the hospital. Yesterday's film was a thing on policemen and first aid. It was how a patrolman saw an accident happen and what happened after it. I really got upset during it, but I got myself all together before the lights went back on and helped clean up and everything. I've been having lunch with the ward clerk and went out to see a friend of mine in another ward and talked with her. She's going to try and help find me someplace to stay besides where I am. But that accident flashed back on me again last night during dinner. My sister and brother-in-law had been riding in their car. They witnessed an ambulance accident and right in the middle of dinner, they were telling me about it. They didn't know it, but I couldn't take it and I just stopped eating and right then, I began to get sick. And I don't want to make my sister any more upset, so I just slipped away. They know I don't have any appetite anyway, and they weren't very upset.

Jane's intrusive episodes are now very apparent. Although intrusive signs were present before as bad dreams, the earlier interviews basically represented a denial phase. In the first interview, she was in an unstable denial state with loss of concentration, bodily symptoms, anxiety, and tension. In the second interview, the denial phase was more stable. Now, by the third interview, it appears that ideational repetition has become more prominent and is contributing to her discomfort.

*T:* But you didn't want them to know that their talking about the ambulance triggered the memory?

*J:* Yeah.

*T:* Were you ashamed to let them know, or you thought it would hurt their feelings?

*J:* No, my sister is pregnant with her first child, and we were very, very scared that she would lose it and she wouldn't let us tell anybody for weeks. She's just—I don't want to upset her that much either, because she was upset already about it, worrying about it.

*T:* Yeah. But last night they were talking about this ambulance, and then you began—

*J:* Thinking about the morning I reacted in my own accident. And then I stopped eating and (*silence*) and later—

*T:* And you were feeling frightened when this happened?

*J:* Yeah.

*T:* In fact, very frightened.

*J:* But I couldn't really say anything because I was also afraid to get her upset.

*T:* Yes (*silence*). Well, that may have been a trigger to your reaction today, you know.

*J:* It acted like a trigger.

*T:* Do you know that this is the sort of thing that happens after accidents?

*J:* I figured it would, but I never heard it said.

*T:* Yes. People often go through a period when they put things out of mind. Then they come back, especially if there is something that hasn't been worked through about it. For you, there are a number of things that haven't been worked through. You're frightened. Even though you don't rationally think so, part of your mind thinks that it might just happen again.

This is essentially a supportive remark aimed at reducing her fear of her symptoms and at sharing an understanding of what is going on.

*J:* Well, it was the kind of accident that could happen again and again because, I was saying, that it was the other man's fault, and I had no way to get out of the way. But I have to commute now because—the only arrangement I had before was riding with my sister-in-law, and I reached the breaking point with that. I can't ride with her anymore because I get just as scared watching her drive as not going at all. I'm better when I'm in control of the car.

*T:* Yes, I'm not surprised to hear that.

*J:* But even like coming over here. A couple of times I checked the mirrors and ahead in merging traffic, and I look, and there's somebody too close behind me, and I have no idea how they can get that close unless they're coming up too fast, which is what happened before.

*T:* Yes, so there is this constant expectancy below the surface that is frightening you. And the other thing I think that will need some working on is your anger. You feel very bad about having it, and you're trying to do things, like with your sister, by not even letting her know that this reminded you of your accident.

*J:* That's why I want to stay with somebody else besides her.

*T:* Are you sure she's so delicate?

This is an indirect challenge focused against what the therapist intuitively is her own defective or vulnerable self-image. The remark, at an unconscious level, may be received as "maybe you are not so delicate and can see yourself once again as a capable, grown woman."

*J*: Well, she was a few months ago, and she tells me she's not now. But it's hard to believe.

*T*: Well, for her to know what you're going through might not injure her in any way. You might just let her know what you're going through.

A therapist ordinarily does not give direct suggestions, even in brief therapy. But in this instance he does, because he believes that less inhibited communication with her sister may help her to work through the meanings of the accident more rapidly. As with his previous statement about the delicacy of her sister, this comment has an indirect meaning: "You can take knowing what is happening and also let others know how you have responded."

*J*: The thing is that she's a personnel worker for the phone company, and she's getting people like me all the time and she's always saying she works because she has to. I don't want her to be pressured at home, too. But she really should stay out of that job; it's not doing her any good.

*T*: Well, we have to stop now. We can continue on Monday at the time we scheduled. So see you then.

*J*: Okay, at 3:00 o'clock.

## Fourth Session

Jane reported feeling gradually better over the weekend, but she was still shaky and awoke early. At the beginning of the hour, she and the therapist again reviewed her reaction to the movie on accidents and her intrusive thoughts about her own accident. She then talked about wanting to avoid discussing the accident because she was afraid that if she did get into it again, she would become upset and not do well at work. The therapist was inclined to deal directly with the accident memory. He wanted to work the memory through to the point that she would not be upset by reminders. The hour proceeded with the following discussion of whether or not to focus further on the accident:

*T*: Yes, that's the decision we have to make now. Should we do that [not dwell on it now], while you try and get through, or—sooner or later, I think it has to be talked out.

*J*: I know it does, because it scares me when it happens.

*T*: Yes. So I think your intuition might be best. My intuition doesn't say for sure, so let's go on yours. You decide whether we talk about it now or make another appointment and talk more about it.

*J*: It's kind of weird because it's hanging over my head if I don't do it. And then I might just start thinking that way and go round and round again.

*T*: Well, I wonder if you're not in enough control so that we could do a little bit, kind of a small dose, and then just stop.

*J*: Okay.

*T*: Want to try that? Let's say you can stop any time you want.

*J*: Okay.

*T*: Okay? So I'd like you to do this feeling as relaxed in your body as you can. Why don't you try and just see if you can't really relax yourself, okay? Then we can spend a little time talking about it.

The suggestion to relax is used because the therapist believes it will be helpful with this particular person. Other patients tense up with a directive to relax. The implication is that she will be able to talk about the accident with the therapist without getting too frightened. In what follows, the therapist continues talking until he feels the patient is in a mental set in which she can recall and yet retain a sense of control.

*T*: Okay. Here's what we're going to do and all we're going to do. We're going to go back to the accident and have you remember a little bit of it and just see what springs to mind from it, and perhaps it will be something that will make you reexperience some of those emotions. As it happens, you'll try and keep relaxing, and we'll try and talk about the ideas and feelings as they come to you. You'll try and keep putting the feelings into words, and I'll try and understand them as best I can. We don't have to do a big chunk of it today; we can do a portion. That way, you'll learn it's safe. I think it might help to put it all in your control, keeping it from coming back when you don't want it to. Does it seem reasonable to you? Any questions? Okay, let's just go back to the accident. One thing that struck me about it was that man who came out yelling at you.

*J*: Yeah, he was the second guy.

*T*: Yes, I thought maybe that was upsetting you, especially upsetting. Was that so?

*J*: I could feel myself just going out of awareness when he was doing it. I mean, just slipping into shock or whatever it is; just the more he yelled, the farther away from him I got until I finally just yelled at him, "You're not leaving the scene of this accident until I get your name!" So he threw his license at me and left anyway. But that was a long, long time because that collision was a half hour after the first collision.

*T*: Now, try and just go back and remember what he said, and let's just see what comes to you.

*J*: His thing was how he had appointments to keep, and I couldn't hear a lot of it. He sees the wreck and yelled and screamed, and then he turned to us. But to us, he just says, "I have to go find a phone as fast as I can." And it turned out that he was in very much the same situation as I was in: he works in a hospital the same as I.

*T*: He was going to work?



*J*: Uh-huh. He wasn't a nurse, he was a student lab technician. But it's hardly any different. He had the same need to be on time that I had. But then he stomped away from the scene, and I don't even know where he went because you couldn't see in the fog. I was mad because I had stuck to the scene of the accident, and I wanted to see a doctor because my back was hurting, and he stomped away right away! We had the policeman; we could have settled it, and I could have been on my way if he had stuck around. And I was standing around shaking and hurting, and he was gone.

*T*: And what's this; he threw the license—

*J*: Threw it at me.

*T*: At you?

*J*: Because I was the one that protested.

*T*: And where did it hit you?

*J*: I think I caught it.

*T*: And then what happened to his license? He drove off without his license?

*J*: No, he couldn't drive his car; his car was demolished. He walked away fast from the scene, but you couldn't see more than twenty feet in the fog, and he went to a phone, which I should have done long before that. But since my neck hurt and I knew I was numb every place else, I was afraid to walk as far as it was to a phone. I didn't know how badly I was hurt.

*T*: And you never saw him again?

*J*: No, he came back. In fact, a few minutes later, the policeman had his report and stuff together. I got confused then, and I gave him the other man's license instead of my own because he wanted a license. And then I left to phone Zone City to tell them I couldn't come. By then, they had already talked to me about an ambulance, and I told them I didn't think I needed one. So I called my brother-in-law to come and take me to a doctor.

*T*: But this other man came back?

*J*: Well, I missed him somehow. I'm not sure if he came back by the time I came back.

*T*: And did you have any more to do with him?

*J*: Yeah. We climbed into the back of a patrol car to fill out all the forms because it was really cold and he kept borrowing pens and being obnoxious to everybody. He had to ask his questions whether you were in the middle of saying something or not, and this kind of thing. I was the last one to finish the report because I had the two collisions to report.

*T*: How was he obnoxious to you?

*J*: It was just his general attitude, I would suppose. His standard behavior. Instead of asking for anything politely, he would just demand it. Like if another officer asked a question about the tow cars—I called for a 3-A truck because I know 3-As come faster and I'm personally in 3-A, even though my Dad's not. So

they had three different trucking companies, two trucking companies coming. A tow truck arrived, and he assumed automatically that it was his. And I listened and understood that it had to be mine. But he butted in already, and I couldn't outspoke him; I had to wait until he was finished and then explain it to them that it was my tow truck. Every time there was a question, he was right there for himself

*T:* So you feel he was being selfish?

*J:* Yeah.

*T:* And his selfishness was hurting you worse.

*J:* This was the wrong time to be selfish. He should have been—like the police officers; there were two of them there, let them direct it. And before that, when they weren't there and they weren't in charge, he didn't take any effort to lead it, you know, like direct the traffic or put out the flares or that kind of thing. But when somebody else was there, he would compete with them—just standing in our way.

*T:* So, he was obstructing your getting help?

*J:* I wanted to get out of there as fast as I could and find out why my neck hurt so bad.

*T:* Let's try and go back then. We know a lot more about your neck now than then, but let's go back then; let's see if we can reconstruct your thoughts about your neck.

*J:* Right after the collision, I was numb and in a few seconds, the only feeling I had was my neck on the right side and in my shoulder. And it hurt; I couldn't feel anything else at all. Then the driver in front came back 'cause he could see I was just dazed and looked straight ahead. He had seen through his mirror my car hit. He came back and said, "Are you okay?" And I said, "No." He said, "How bad?" I said, "I think it's only my neck, but I'm not sure." Then I waited and I could tell that the rest of me was okay. I felt okay.

*T:* What thoughts were going through your mind?

*J:* Well, I know that if you're hurt and you get into shock far enough, you can be badly hurt and not know it and walk around with it. That's what was going on in my mind. It just feels like my neck, but I'm not sure.

*T:* So you were thinking that you might be badly hurt and you might not know it, and you might walk around and hurt yourself more.

*J:* Uh-huh. But then, I looked at the situation and I thought if I don't move this car from where it is right now, somebody is bound to collide into it again. So I got out of the car anyway and got into the back of the car and gave them some flares to pass out. Then I looked at the situation and said to the other man that I think we'd better move our cars because we're at the top of a grade by a red light on a really foggy morning and it's going to be a ten-car pileup if we don't. So I moved into a safety zone near an island, and he moved all the way off to the shoulder. I left my car running with the lights on so that people could see it.

*T:* Could we go just a little way in your imagination and imagine what didn't happen, but what you might have thought might happen? Which would be that you would walk around and your neck would get hurt worse. Just imagine—

*J:* My neck or my back?

*T:* Yeah, imagine that. What would you imagine would happen?

*J:* Well, I've had back trouble before, and when it got bad enough, I was told not to move until it relaxed. And I would imagine that I would get paralyzed.

*T:* Where would you be paralyzed?

Because of the patient's neck pain, other somatic complaints, and her mother's severe illnesses, the therapist wishes to explore for cognitive elements of somatic localization that occurred at the time of the accident.

*J:* I don't know.

*T:* Your legs?

*J:* Well, before it would have been my legs, but I don't know about this one.

*T:* What was the back trouble before?

*J:* I have one leg shorter than the other, and I repeatedly strained muscles because of the imbalance, so it's been different muscles getting strained. One time I did it real good, strained it on the job and had to stay still for a while until it eased up.

*T:* And if you didn't, you might get paralyzed?

*J:* No, just that it would stay, the pain.

*T:* The paralyzed idea was during the accident?

*J:* Yeah.

*T:* Okay. Any other thoughts about your body, anything you can remember? Try and go back in your mind to the accident.

*J:* Well, after the accident, after the first collision when we were waiting, we were sitting in his car, I got double vision. But that's not unusual for me; I have a muscle problem in my left eye. I wondered about it, because I didn't think my head had gotten hurt.

*T:* But it might mean that you had a head injury?

*J:* Right.

*T:* At least, that was your thought then?

*J:* Yeah, but I get double vision under stress, no matter what's causing it. Can't think of anything else.

*T:* So, you were worried then that you might be—your back might be broken or something and you might get paralyzed if you moved. And then you were running around putting out flares.

*J:* Well, nobody else would do this kind of thing; nobody else was thinking. You know, I'd ask a question, and there wouldn't be a response because they couldn't think of an answer for it.

*T:* Well, maybe you felt that they were fools. You had to risk yourself because they were so foolish.

From listening to her vocal intonations, the therapist has a growing conviction that she is struggling between impulses to express rage and a need to inhibit such expressions. He is attempting to provoke a clear expression of ideas that might lead to anger as well as ideas that might be threatening, were she fully aware of them. At this point he is trying out certain labels with her and, more importantly, encouraging continued expression by actively receiving her communications and not being critical. In a sense, he has just said, "It would be all right with me if at the time of the accident you thought the people around you were fools or were afraid they would think you were a fool. I'd like you to freely tell me that sort of thing, even if you feel badly about it." As it happens, the label of fool does not exactly hit on a central ideational complex, but the feedback from the therapist sets up a dialogue that promotes fuller expression.

*J:* Well, I had to save myself anyway, because they weren't going to move their car, his car. Nobody else wanted to—like—like direct the trucks that were bearing down. You know, I said, "Well listen, I've got a flashlight in the glove box with a red cap on it; if you swing it, they can see it and get around us." Nobody wanted to do it and my arm was stiffening up and I was about to stand out and do it because I—

*T:* What do you mean, "No one wanted to do it." Who was that?

*J:* Well, the man in front of us who had stopped and the man who had hit me.

*T:* Why didn't they want to do it?

*J:* One man was ready to leave for work because he said nobody is really badly hurt. And the man behind me had to leave to telephone his place of business to tell them he wouldn't be coming in. And nobody was around who wasn't busy.

*T:* So you were just left. Were you all alone?

*J:* Yeah. I was sitting in the car of the man that hit me because his was in a better position by then.

*T:* So you were kind of left alone with no one to take care of you?

*J:* Yeah, but then I could sit up straight and I knew that if I didn't do anything, nothing horrible was going to happen to me like that.

*T:* Did you feel it was unfair, though?

*J:* Yeah, and I asked him to make a phone call for me and he came back and said, "Oh, I forgot."

*T:* He forgot?

*J:* Yeah.

*T:* That must have made you angry.

*J:* I don't know if I felt angry. I felt like desperate—like how can I make that dumb phone call.

*T:* Yeah, but you'd been left out again. Do you remember that moment, when he came back and said he forgot?

*J*: Kind of; he was back in the car again.

*T*: Now you seem pretty relaxed talking about all of this. Any side thoughts?

*J*: No.

*T*: How are you feeling right now?

*J*: A little bit tense.

*T*: A bit tense? Where is the tension?

*J*: It's all over.

*T*: Yeah, describe it, though.

*J*: I wouldn't know how.

*T*: Is it in your muscles?

*J*: Yeah.

*T*: Do your muscles feel tight? Okay, try and relax them. Does my asking you about it make you more nervous?

*J*: About relaxing?

*T*: Yeah.

*J*: Well, it's just that that's the one thing that everybody is telling me to do.

*T*: Everyone tells you to relax?

*J*: Yeah. You can't exactly do it without knowing how.

*T*: Have you ever learned how?

*J*: I don't know. I guess I did a little bit. I used to take yoga for a while, but I can't relax myself when my mind isn't relaxed.

*T*: Well, let's see if we can find where the tension is in your mind right now. What are you doing now? What are you paying attention to?

*J*: The back of my head.

*T*: Uh-huh (*long silence*). Well, one way to find out about such tension, for us to use right here, would be for you to say whatever comes to your mind now.

*J*: I'm getting scared; I'm not wanting to talk anymore.

*T*: Yes. What would happen if you were to go on talking? Do you think you'd get more scared?

*J*: I don't know. This is the same way I feel when I wake up, feeling sick.

*T*: Uh-huh. Is it a scare that something is going to happen?

*J*: I think it's more that something is not going to happen that should happen.

*T*: Uh-huh. That would mean that there'd be no help for you?

*J*: Yeah.

*T*: Okay. What do you think should happen?

*J*: I don't know.

*T*: You know, the idea of no help for you runs through a lot of this. Nobody being able to help you; your family not being a help to you; the other drivers not helping you; maybe my not helping you.

This labeling of her sense of not being helped seems to make her feel safer, and she continues with considerable additional material, without responses from the therapist.

*J*: Something else: When I made the phone call, a male operator came on the line, and I didn't recognize the voice as an operator's and I thought it was Bob, which is my brother-in-law, and so I spoke to him as if he were, and then we figured each other out. We were both mixed up. He took the message wrong, too. Then I told him the number, and he connected me so fast that I didn't recognize the change in voice. And so when Bob answered, my message was all confused. I know it made him upset, but the more I said anything, the more confused I got and I couldn't get it straight.

So, it turns out that after he had hung up, he didn't know how badly I was hurt, so he called my sister at work, and all he told her was that Jane's been in an accident and I'm going to pick her up. I'll call you later.

After the accident when we were trying to arrange a doctor and stuff, he told me about it, about her being notified. And I said, "Aren't you going to call her back?" He said, "No, we'll wait and see how you are." When I got to the doctor's office, he had two other emergencies ahead of me, and so I waited in the waiting room for an hour and a half and then I waited in an examining room for fifteen minutes, and then when he saw me, he sent me to X-ray. The doctor in charge of X-ray had to look at the X-rays that were taken.

And it wasn't until after all of that, that my brother-in-law told my sister. She had been sitting there all morning not knowing, just knowing that I was in an accident. That bothers me because there have been other accidents in the family. There was one when my stepbrother died in Vietnam and my sister was the only person in San Francisco, so when the call came through, she knew and we were on our way to Arizona. Nobody would notify us because it was a military matter, and the highway patrol wouldn't stop us so we had to get all the way there where my brother was and he had to tell us. It was just her sitting there again, waiting and not knowing.

*T*: So that happened to her with your accident.

*J*: Yeah.

*T*: That's upsetting for your sister?

*J*: It's upsetting for both of us because after that I was in Arizona with my father and we put everybody else on a jet; my brother got emergency leave, and my father refused to let the car sit and go back with his wife. He insisted that we drive back to San Francisco. And I had a driver's license and was perfectly capable of driving, but because there was a trailer on the car, he didn't trust my driving and he wouldn't allow me to drive.

Here is a retelling of the story of the trip with her father, discussed in an earlier interview. The timing in this hour and her general demeanor indicate the importance of her father in the associations to the accident.

*J*: So for the whole trip back, I really was tired and very, very worried, so I kept tuning in radio stations and talking so that he wouldn't fall asleep. And he wouldn't

pull over and he wouldn't rest until finally I convinced him that we needed to stop, and we stopped in a town full of motels and all of them were closed for the night. So we had to go on or sleep at the side of the road and he refused to do that. Finally, a gas station attendant let us sleep in the back of the station, but he didn't sleep all night; he only did it for me, and I barely slept and then had to get up again.

*T:* How do you know he didn't sleep?

*J:* He told me he didn't and he'd been sick. He had vomited all over the trailer. He told me he hadn't slept at all. I told him I was in better shape to drive, but he wouldn't let me.

*T:* That still bothers you?

*J:* (*indignantly*) He still doesn't believe I can drive. He won't ride in the car if I'm driving.

Here is an important meaning of her accident. Her father has criticized her driving. Right after the first collision, one association would be something like "Oh, no, my father will say this is all my fault!" This thought would already be on her mind when the second collision occurred and the driver of that car angrily screamed at her. In a larger sense, she anticipates that her accident will give her father reason to say that not only can she not drive well, but also she is not an effective, grown-up woman and must remain his dependent and subordinate little girl. She anticipates his rage and depreciation of her. Responding to this prophecy, she is hurt by him and angry at him. The various rejections and desertions she experiences from other persons involved in the accident and its aftermath serve to justify these feelings. Frustration, sorrow, and anger are also activated by the disruption in her life plan.

Rage at her father cannot be expressed or experienced directly because that would make her feel guilty. She already feels bad at not having rescued her father from his alcoholism relapse after the long drive following her stepbrother's death. This is part of a general ambivalent attachment to her father. Though these formulations are oversimplified and incomplete, they represent the therapist's working hypotheses at this point in therapy. He follows her statement with an exploratory question relating her father to the recent accident.

*T:* He thought that if you drove, you might have an accident?

*J:* Uh-huh. Any car that I've bought, he's never stepped foot in.

*T:* And now you've had an accident.

*J:* Uh-huh.

*T:* Maybe you were worried right at the accident about what your father would say. There you'd gone and had an accident, even if it wasn't your fault at all.

*J:* Yeah! Later that day, I let my brother tell my father; I didn't want to tell him.

*T:* Why didn't you?

*J:* Because if I talked to him on the phone, we don't get along very well at all; but if I talked to him on the phone, I would probably get upset enough for him

to worry that I was hurt more than I was—just because it's so hard. He doesn't usually hear my voice; he's deaf in one ear and hard of hearing in the other one. He usually—I either shout or he reads my lips. And on the phone, it's impossible with two of us, but it's always a strain for me to talk to him. But on this occasion, I just said, I can't do it at all. Somebody else has to do it.

Her initial response here is probably partly defensive in function. Other evidence suggests that she was primarily afraid of her father raging at her. But she seems to undo that fear by saying that he will worry unduly about her: "I would probably get upset enough for him to worry that I was hurt." This also suggests another defensive operation. If people present signs of physical harm, then one shows concern and does not blame them. She goes on to imply a complaint about her father's neglect: "He doesn't visually hear my voice." After these remarks about her father, she then expresses her own anxiety over confrontation with him: "It's always a strain. . . . I just said I can't do it." The therapist chooses to focus on this self-experience.

*T:* Were you concerned about what your father would say?

*J:* Well, I didn't want him to come walking home from the bus stop and see the car all smashed up.

*T:* Yes, what would he have thought if he had seen the car all smashed up?

*J:* He would have wondered where in the world I was, what had happened.

Once again, she presents a worried and concerned image of her father rather than that of the enraged accuser. She continues along this line.

*J:* I didn't think he should do that. I would rather that he be told on the phone than when he comes home—

*T:* Well, he would think that you'd been in an accident.

*J:* Yeah. Well, one time before, I messed up the front end of a car, and he went on for hours about "why didn't you tell me." So I knew I had to tell him, otherwise we'd go through that again.

Here is the associative meaning to the man yelling angrily at her. The important and, as yet, undisclosed detail that the car damaged in the current accident belonged to her father follows after the therapist clarifies that the car she dented earlier also belonged to her father.

*T:* Was that his car?

*J:* Yeah, these were both his cars. Because I had sold my car a few months ago.

*T:* Oh, so this was his car in the accident?

*J:* Yeah.

*T:* And the new car you bought was going to be yours?

*J:* Uh-huh (*very softly*). I sold my car when it started giving me trouble.

*T:* Yes. So maybe you felt badly that it was your father's car that was damaged.

*J:* Yeah. We never agree on that car anyway. He won't keep it up (*very angrily*)! He won't, like, put the tires on soon enough when they're wearing out or



get stuff done that needs being done. It's always run down. And like he rebuilt the engine and put it back in; he didn't put the transmission back in straight so when you start it, you have to know how to force it into drive to get it started. I usually get frustrated with the engine; you have to sit and wait and then get it started. I am—every time I get into the car, I'd get mad if I couldn't happen to get it started right away because of the way he fixed it; only halfway.

T: Yeah.

J: He did that to the exhaust system, too. It sounded horrible to drive. They'd give you three clamps; he'd put one clamp on and put the tailpipe on, and it would rattle all over the place. It'd get a hole in it and was worn out.

T: Yeah, he really didn't take very good care of the car.

J: He took as little care as he could. He insisted that no work be done that needed being paid for. He had to do the work.

T: But then he bawled you out when you got in an accident?

J: Yeah.

T: What did he say to you that other time?

J: That was the car before this. That was my fault because I had a sinus infection and was all run down.

Once again, physical illness is presented as a way to avert blame.

J: I had a choice of public transportation and getting on the medicine and not being able to drive 'cause it makes me drowsy. So, I decided to drive and not take the medicine, but I got too tired anyway and I missed a turn in the parking lot and hit a cement wall at a low speed and punched in the front end on one side. So we all knew it was all my fault, but he refused to accuse anybody. He just went wandering around junkyards trying to find a replacement for the front end of the car, and he never found one.

T: Huh. What did he say to you though?

J: Well, by the time that he saw me, I was upset enough and my face was swollen enough that he didn't want to say anything. I loosened my front teeth, and I couldn't talk by the time he saw me, 'cause my whole face was swollen.

T: But he was angry?

J: He didn't show anger or anything; he just stomps away and gets a drink because he's an alcoholic, but he doesn't say anything.

It is possibly relevant that she uses the same word, *stomping*, to describe her father as she did to describe the driver of the second car that hit her car, because this accident is a repetition of the earlier accident. Because she is physically hurt, she does not receive the direct brunt of her father's anger but, instead, is made to feel guilty that she has hurt him and caused his drinking.

T: But did you feel worried about how he would react before he reacted?

J: Yeah.

T: Were you very concerned in your mind?

*J*: But then he doesn't really react; he runs away from it.

*T*: But beforehand, you were worrying about how he would react?

The therapist is clinging to the topic of her father's reaction and trying to clarify her feelings about her father's potential or actual anger toward her.

*J*: Yeah.

*T*: I wonder if you had any thoughts about your father right during this current accident?

*J*: I don't remember thinking about him. I do remember thinking, "Well, at least this car is gone now; nobody can drive it; he'll be forced to get rid of it." And it turns out he's not; he's taking money for it and says he's going to put it back together again. Since then, when we got it home, he made me drive it one afternoon. I told him that the doctor told me to leave the collar on and if I needed to drive, to only go a short distance and take the collar off to drive so I'd be able to turn my head. I said I didn't feel like turning my head enough to drive that day, but he insisted.

She is talking about how her father hurts her. The role-relationship model is that of one person hurting another, and she can place herself in either position. She is afraid both of her accusations that he hurts her and of the possibility that he will accuse her of hurting him. Her communication is devoted to obtaining a verdict from the therapist that she is "not guilty," has been hurt more than enough, and deserves tender attention. She may also want the therapist to be angry at her father. This would be anger on her behalf, and she could avoid guilt. She continues with evidence that her father gave her a bad car.

*J*: So I drove it and I'd been complaining about the car down-shifting suddenly on lulls 'cause the transmission still needed work. It took a really good hill to do it, and there weren't any near the house, so I took it to the best hill nearby and it didn't do it. He still doesn't believe me, and he's not going to work on that part of it. But what used to happen was if I took it to work in Zone City, it doesn't have enough speed to make merging easy, so I would go wandering freeway to freeway in a way that I wouldn't need to merge so much. I would get onto highways that weren't freeways. And one of them was Pickwood Drive, which is really steep, and up near the top of it, the car would downshift suddenly and then shift back up and just jerk really, really bad. He had never experienced it because he doesn't drive at all like I drive. I kept telling him that it would happen and that it needed something so that it wouldn't happen, but he wouldn't fix it. So that's why he wanted me to drive it. He said there's nothing wrong with the car. The whole tail end of the car now is out of alignment; it doesn't even travel on a straight line anymore, but according to him, there's nothing wrong with the car anymore. He's going to drive it that way. But every time his job makes him travel, because his job changes, he takes the other car.

Throughout these sections, she is expressing anger at her father, as shown by her tone of voice and her nonverbal communications.

*T:* Which other car, the new one?

*J:* There's another car that he owns.

*T:* He owns two, a better one and this clunkier one?

*J:* Yeah.

*T:* And you got to drive the clunkier one?

*J:* I was not allowed to drive the better one.

*T:* Why not?

*J:* He didn't want me to.

*T:* He wasn't using it at the time; he was taking the bus.

*J:* That's right.

*T:* So why doesn't he want you to use it? Is the idea that you'd get in an accident?

*J:* I'll do something to it. I'll scratch it in a parking lot or whatever. That one was special; this one is the one that I was allowed to use. It was the one I had driven before that, anyway.

*T:* But you resented it.

*J:* I hate that car to begin with! And every time I had car trouble, they'd tell me it's just because you don't like the car and are not willing to put up with it. I said, "Why can't you get me in the situation where I can get another car and I could put up with that." Like I'd wear the battery out trying to start it, and I couldn't keep the transmission in drive long enough to get it started.

*T:* Okay; well, it seems to me that we were able to talk about the accident, and it wasn't too dangerous to talk about here, so we might go on and schedule another appointment to do that a little bit more.

*J:* Okay.

*T:* Does it seem reasonable to you to do that?

*J:* Yeah.

*T:* Okay. How about next Monday at this time?

*J:* I can make it any time; I'm out of work by then. My job ends Friday.

*T:* Okay, let's make it 3:00 next Monday.

## Fifth Session

During the fifth session, Jane indicated that she felt she was back to normal. Her physical symptoms were much improved. She was sleeping and eating well and no longer felt tense and anxious. She did not have intrusive episodes or moments of intense irritability, though she still had some pain in her neck and in her hip joints. She felt that things were going smoothly for her. Three topics occupied the session: her relationships with her father, her mother, and her therapist.

During the week she had begun a dispute with her father that, because of her assertiveness, was resolved to the satisfaction of both of them. Her father wanted her to sign a release so that the payment for damage to his car could be obtained from the insurance company of the other driver. She refused to do this, pointing out that the medical liability was as yet undetermined. She consulted her attorney, who backed up her position. Her father became pleased that someone more responsible than he or she was looking into it. She felt relief at living out of the house, as her father drank heavily during their discussions. She had resolved her guilty feelings over living with her sister by making maternity clothes for her.

The therapist felt that the restoration of Jane's equilibrium was the result of many factors. Time had passed; there had been some working-through in the therapy; and with this, her improvement might have been motivated by a desire to reduce the need to explore the relationship with her father. The presence of unresolved conflicts and ambivalent attachments would not, however, indicate the continuation of a brief therapy aimed at restoring a balance disrupted by a stressful life event. She had moved out of her home environment and was continuing her work; she could pursue her life plan. The therapist continued the interview by asking about the status of memories about the accident in order to see whether there were further intrusive episodes. This would be an additional sector of information relevant to a decision about termination.

*T:* Any memories come to you about the accident?

*J:* Today's weather reminds me of it: looks the same.

*T:* But have there been any other events, like the conversation with your sister that triggered it?

*J:* No. I've been feeling people being more sympathetic because—even though, like I've had to miss some days at the hospital; one of the other aides came up to me and said that her mother had had the same thing. Only she said that her mother had to have special shoes made, and I kind of smiled and said, "I'm wearing special shoes, too." Other things—we had a ward party and people came and talked to me and stuff.

She went on to talk of how her body was feeling better, though she was afraid that any tension might make her stiffen up again. The therapist offered a kind of summing up of one aspect of what had happened:

*T:* One of the psychological problems for you was that the accident let you know in a way that your body was vulnerable to injury. When you didn't get better rapidly, you got frightened that your body was even more vulnerable.

*J:* It made me think of something. My mother used to have arthritis in her back and stay in bed in the mornings. I found myself doing the same thing, just like her. I was staying in bed because it was the most comfortable place to be. I didn't want to get up and move and walk around. I just kept thinking of all the

things I was doing then and that she was doing that when she hurt from arthritis in her back.

*T:* Yes. She kept on going also?

As before, this is an implicit encouragement and support of her attempt at independence.

*J:* Yeah, until she had cancer and she died of cancer.

The therapist believes that one function of this remark is to test him for a transference potential. If he feels sorry for her and gives her attention for being sick, then she may be tempted to adopt that role more durably in order to obtain the gratification of sympathy. The therapist believes Jane is indirectly asking whether she really has to get better. He wants to give her the support of saying “yes,” which he does with a repetition of the same type of remark he made when he said, “She kept on going.”

*T:* So you feel kind of brave at times?

*J:* Sometimes, but sometimes I feel dreadful because I know, uh—she used to send us away when she was feeling bad so that she could rest. I can’t send my responsibilities away.

*T:* Okay. Now, have you had any other thoughts, you know, since we talked a week ago, about getting upset because of the accident? Have any other explanations for that occurred to you?

*J:* I think it was a huge disappointment that stopped me from everything I was trying to do. It was at a time when I was trying to plan moving out of the house and getting a permanent job and just changing everything around me. And all of a sudden, I was frozen where I didn’t want to be.

The remaining part of the hour dealt with the idea of termination and the possibility of a transfer to long-term therapy if she wished to explore further her vulnerability to depressions after losses and/or dependency-independency issues of personality. Because she did not express feelings about the separation other than gratitude, the therapist asked her directly:

*T:* Well, maybe you’ll be sad not to see me anymore?

*J:* I think so (*pause*). Yeah (*pause*). That’s been happening this month to everyone I’m around, though. Well, one friend who took me out to dinner really doesn’t want to see me. It’s happening all around me. I’m beginning to get used to it. The patients, you get to know them and they leave. It’s okay.

She later entered a personality-development type of psychotherapy and continued to see another therapist for forty sessions. By the onset of that therapy, she had essentially recovered from all symptoms related to the immediate stress event. The physical symptoms that had gone into remission remained absent and the residual pains in her neck and hips improved by the end of one month. An exception to this marked improvement was continued difficulty with her eyes, a symptom corrected by a new prescription for glasses. The central issue of the

therapy was loss and neglect with the attendant fear of not getting enough care in her relationships with other people, though she kept her angry reactions to frustrations in tight check. These themes were worked on in regard to medical treatment for the eye symptoms, legal manipulations to recover medical costs after the accident, relationships with her family members, and the transference.

## Discussion

Had it not been for the accident, Jane may have continued her progress toward independence. By establishing social and professional ties, she may have been able to continue her development throughout her young adulthood. If not beset by stress and the disruption of interpersonal relationships due to her neurotic potential, she probably would not have sought treatment. At a crucial time, however, the accident activated unresolved conflicts involving her own bodily integrity, degree of dependency, and the validity of what might be called her character trait of excessive "self-righteousness."

Her concept of bodily integrity was related to her mother and other relatives who had severe bodily misfortunes. She herself had a slight leg deformity and a tendency, when stressed, to a disruption in optic focusing that was also apparently based on a mild congenital anomaly. She was the baby of the family and was raised during a period when her mother was not a help to her. Thus, she had a special vulnerability to feeling a defective identity and body image. The physical trauma and fears of even greater injury forced on her awareness by the accident reinforced her defective self-concept as it conflicted with more recently developing womanly and intact self-concepts. Such an accident can threaten the sense of invulnerability of all persons, but Jane had a less stable adult self-organization to use to master this threat. Working it through on her own was impossible, and the therapist supported her more competent self-concepts by encouraging her continued efforts to work and cope.

The ambivalent ties with her father were rapidly conceptualized by the therapist in establishing a formulation and plan for the therapy. This rapidity carries more risks of error than do the more temperate inferences possible in a long-term therapy in which more associations, memories, and fantasies are gradually accumulated. Basically, it seemed as if a variety of factors had combined to develop and emphasize a self-schema as "hurt, little, and in need," one that conflicted with her developmental progress toward a more mature self-concept.

Jane's mother had been too ill to provide complete maternal care or even a stable identity model. She might have turned to her father for love. She conceptualized herself as "little and in need" and her father as taking care of her. But at times, she probably felt insufficiently cared for and had a role-relationship model

in which she was “little and in need” and her father was neglectful. Rage at her father stemmed from this latter version.

Because of such rage, she also developed a role-relationship model of herself as destructive in her relationship with her father. In conflict with her ideals and morals, this role relationship generated a tendency to feel guilty if she were placed in the role of hurting her father. To avoid guilt, to gain the stronger role for herself, and quite likely also to replace her mother, she often conceptualized herself in the caretaking role and her father in the role of being in need. Later material supported these formulations. Her father turned to her for care at various times, but he also rejected her when she assumed a caretaking role. During her adolescence, he fostered her regression to a preadolescent stage of life and rejected her efforts to care for him. He belittled her attempts at this and, in general, undermined her efforts to gain a sense of womanly competency.

The accident heightened the ambivalence between them. “Cars” and “accidents” were already part of this as a theme because of the previous dented fender, the long, traumatic drive he refused to share with her, and his reluctance to let her drive the “good” car. As soon as the accident happened, she knew that blame would enter the picture. Her father would blame her and she would blame him for blaming her and for giving her a bad car. The second man, who yelled angrily at her, became a symbolic father image for her and gave the ambivalent role fantasy a terrifying reality.

The accident thus became an event that produced fear over her bodily integrity, rage and sorrow over the loss of her plans for independence, and anger and guilt, entangled with a wish to remain attached to her father. Perhaps the most important conflict was that of dependency and independency wishes. The bodily symptoms gave her an excuse to resume dependency and yet led to the frustration of not being taken care of properly. The bodily symptoms also could punish her for her aggressive feelings toward her family. Working through the stress event meant processing these themes. She had to reassure herself, by reexamining the current reality that her body could still work and was not under continuing threat. She had to consider the possibilities for resumed dependencies and ties to her father (or father substitutes such as her doctor) and reject them. She had to reexamine her work and living situation and continue toward independence. She had to evaluate the accident and decide that it was just an accident, that the angry man was just a nasty stranger who behaved badly, and that it was over.

The therapist fostered this working-through process by providing support while encouraging continued efforts toward independence. The various themes were not interpreted at a deeper level. Rather, there was an effort to process the details and immediate associations to the accident so that reality could be clarified and separated from fantasy elaborations. The major theme of dependency-independency surfaced in the transference as a tension between an “I don’t want

any help; I can do it myself' attitude, presented largely through her resistant demeanor, and a subsurface clamor for excessive worry and concern by the therapist. This was countered with a steady insistence on working on the immediate meanings of the stress event. That is, the therapist did not appear worried about the patient's guilt driven by her remaining symptoms, or neglectful in offering her help and sympathy.

## Summary

Jane drove her father's second, poorly cared-for car to a job that she hoped would enable her to gain her independence. She was rear-ended on a foggy day. The man who drove into her was so polite that she could not be angry with him, but a second car piled into her already-damaged vehicle as it stood by the roadside. That driver, a man, exploded angrily at her. This seemed to induce a dissociative state of shock. Later she had difficulty obtaining medical attention. She then felt that her family neglected her by turning a postaccident visit (to check up on her) into a party that ignored her condition.

She developed progressively debilitating symptoms combining somatic and psychological signs. She had neck and hip pains, eye difficulties, nausea, upper-respiratory infections, and sleep disturbances. She was also affected by dazedness, difficulty concentrating, irritability, intrusive and repetitive thoughts, and episodes of anxiety. Her brief psychotherapy began when she was in an unstably defended denial phase in regard to conscious ideas, and then entered an intrusive phase.

When viewed retrospectively, the accident can be seen as an activator of unresolved conflicts. Before the accident, these conflicts caused episodes of what might be a depressive disorder, not severe enough as yet to motivate her to seek psychotherapy. Rather, she was moving forward in her psychological and sociological development. After a turbulent childhood and adolescence, she had successfully completed school and training and was about to engage in a career that would allow her to separate from her family and, especially, to diminish the ambivalent ties binding her to her father. The therapy enabled her to continue this forward course on her own even after the termination of treatment.





## CHAPTER 14

# Visual Shock and the Compulsion to Look

*With Erik Gann*

A young man is walking down a Chicago street when a woman jumps to her death from a window high above him and her body smashes into the pavement just behind him. He turns to find her mangled corpse in plain view, her brains spattered on the cement and on him. Stunned, he has a compelling impulse to stare at the woman's remains. Simultaneously, as he continues looking at the body, he feels an equally disturbing sense of transgression.

Experience of this event did not result in a stress response syndrome of sufficient intensity to motivate this man to seek consultation. Instead, other events led to an interview two years later and provided an opportunity to see what happened to such a memory, independent of treatment issues. The result is an illustration of (1) the enduring intrusion of images from traumatic perceptions; (2) the interaction of the repetition tendency with aims to inhibit such intrusions and pangs of emotion; and (3) the compulsion to look at stressful scenes, even though it conflicts with social taboos against doing so.

Daniel, the young man, had been interviewed by a physician as part of the admission procedures for a medical school in Chicago. During the interview, he described the incident as it had occurred two years earlier in Chicago. A young Latin-American secretary working for the same firm as he did threw herself from a window in the building, landing very close to him as he passed on foot below her. The memory of this event was still vivid in his mind. He often found himself talking about it or thinking about it. He had never sought psychiatric help, however, for the recurrent disturbing memories or for any other problems. The physician was impressed with the intensity and peremptory emergence of this memory during the entrance interview. She suggested, and he agreed to, an interview with a psychiatrist who had a research interest in this type of situation.

During the interview, it became apparent that this event had had several ramifications for Daniel. First, he had been immediately thrust into the midst of several universal responses and conflicts. He had found it imperative to look, to discover what was going on, and to attempt to comprehend the meaning of what were highly unusual and disturbing visual perceptions. There seems to be a quasi-instinctual need to look at such things; for example, the uncanny fascination of observing accident victims, looking at executions, and watching horror films. In addition, he became aware of his concern about the woman who was essentially unknown to him. This appears to have been connected to a common response of identifying with the victim. Finally, another conflict was aroused: the survivor's guilt. These universal conflicts became infused with his own personal conflicts.

After an initial agreement concerning the exploratory and investigative nature of the interview, Daniel was asked to tell the incident in any way he wished. He responded as follows:

I've talked about this a lot (*pause*). I was very upset when it happened (*pause*). A woman jumped out of a ten-story building; she landed next to me. I don't really remember. I didn't see her. She landed about ten feet away from me. I don't remember any sounds except the blood rushing in my ears, which I guess didn't happen 'til I turned around and saw what happened. She was lying on the ground with her head facing me. There was a big hole in the top of her head (*pause*). My first reaction was that she had fallen down, that she had tripped on the sidewalk or had a heart attack. My first reaction was what could I do to help her? You know, what's the smartest thing to do—cover her up with a blanket, give her artificial respiration? That was my immediate thought, even though I saw that there was nothing in her head . . . just a big, empty hole (*pause*). I stood and stared for quite a long time. I remember one of my thoughts was that I shouldn't be looking at that, but for some morbid reason, I wanted to look at it and kept staring at it. Then I noticed her brains were all over the sidewalk. Some was on me too, and that upset me. Initially, people just walked by . . . (*pause*) that really upset me too. Nobody stopped, and I started crying. I walked closer and looked more (*long pause*). I noticed her right leg was split open. She was wearing big black boots about up to here (*gestures to his calf*), and her right leg was split open through the boot, and the next thing I remember was that people started to gather around. I walked off quite a good distance and then stared again, again for a while; I don't know how long. It seemed that what happened was that everything stopped, and I couldn't hear anything except the blood in my ears. I wasn't aware of anything going on except this one scene with nothing moving, and

then I turned around and stared again, and the same thing happened, and then I left. I got on the bus and kind of looked at people; I'd been in Chicago about eight months then. It was starting to bother me because people were so unfriendly there. And I looked at them (on the bus) like, well, at least now, be friendly; at least now, open up, but I didn't say anything to anybody.

He then added that all this did not hit him at that time, and at first, talking about it did not affect him very much; he just forgot about it. However, not long after the incident, talking about it made him nervous, and in fact, the phone conversation to set the appointment had also left him feeling nervous.

One aspect of the scene that still bothered him was an image of a passerby stepping on a piece of her brains. He stated, "That still bothers me. I don't think I've accepted that. It upsets me when it comes into my head; I immediately shove that out of my mind. I say, 'How could that have happened' and then say, 'Okay, that happened; forget about it.'"

At this point, still early in the interview, Daniel spontaneously reported a dream he had had approximately two weeks before (between the medical school interview and this one). He was reminded of it in this context only because his girlfriend, an aspiring psychologist, told him that it was related to the suicide incident.

I saw a man get killed in a car accident in the dream. Something that I flash on when I see, picture what happened, was that hole in her head (the woman in the stressful event). That was empty, and in this accident, the man had his legs cut off, but I could see all the way up into his body cavity and it was all scooped out. I could see all his bones and everything; it was as if the legs were part of the actual body cavity.

At this point, he paused and remained silent for a minute or two. The psychiatrist asked if that was the whole dream and he replied, "Yeah; there's more detail, but I don't know if you want to hear the whole thing." When interest was indicated, he proceeded.

I was walking over an overpass; there had been an accident. There were police around and I saw the man lying there, and he looked kind of plastic, like he had black, plastic hair, very smooth olive skin but looked like he was android or plastic. He had a shaft in his chest; it looked like a metal shaft had gone into his chest and had broken off about there, (gesturing). And blood, kind of, on his chest. And when I walked by, I noticed that his legs were cut open; of course, I just saw a cross section of his legs, the muscles and the bone, and then it turned into the part where it was all hollow. And I could see his spinal—his

backbone and his rib cage, but it was covered with—you ever see the inside of a fish? It's kind of silvery, a silvery coating? Well, it (the man's backbone) was all covered with that kind of silvery coating. And then the man started squirming and blood started gushing out of his mouth and would kind of cover his face and run off very smoothly, and I could kind of put myself in his position, and I knew he was in a great deal of pain, and I knew he was saying to himself, "I just wish this would be over." And I knew he knew it would be over very soon.

He continued immediately by reporting that his girlfriend had said that the dream was probably related to his having observed a similar occurrence. When asked for his thoughts about this comment, he replied, "It (his girlfriend's statement) didn't click with me; I don't think it (the dream) had anything to do with it (the stressful event), but it might. I've never had a dream like that before, where I've seen somebody actually in the process of dying. And when I saw the woman jump out of the window, it was about two years ago—so I think that was a pretty long time ago. The dream doesn't bother me, though when I had it, I just said, 'Okay, you've had this dream.'"

The remainder of the interview focused on the immediate and long-range impact of the event. Daniel reported that the time spent in Chicago came during a period in his life when he was somewhat depressed and lonely. He was struck by the city and its inhabitants as being indifferent, cold, and uncaring. The woman's suicide was "the last straw" for him, and he decided to leave for the West after that.

Immediately after observing the body and the ensuing scene, Daniel had gone home. While on the bus, he caught himself staring intently at a young woman across the aisle and became "self-conscious" and felt he "shouldn't have been staring" at her. For the next several days, he felt numb and somewhat withdrawn and then began noticing a need to tell people about it. There followed a period of intrusive thoughts about the accident, which he kept trying to push out of his mind. After approximately a month, he would not think about the event unless something brought it to mind.

Daniel became essentially free from intrusive images of the scene, unless he heard specific topics mentioned that triggered a series of images. He would then feel compelled to review this set of images in his mind and would often feel the need to describe the whole memory to someone. He was aware that hearing of an incident in which someone was hurt or mutilated or hearing anything concerning Chicago would initiate this conscious and compulsive repetition of the imagery. However, hearing about death, suicide, or accidents in general would not have the same effect.

When his memory was triggered by one of these cues, Daniel would envision the following sequence: first, an image of the woman lying on the ground

with the hole in her head; then he would see "her face, which was flattened because she landed on the back of her head." This was followed by an image of the leg, "split, with no blood in there either, and white"; and finally he would see "a piece of brain on the sidewalk, and I remember thinking, it must be a part of her medulla because of the convolutions." The images would make him "nervous" and "depressed" because they were "close" to him and occasionally evoked his own vague thoughts of suicide. (Although Daniel experienced episodes of mild depression, he never seriously entertained suicidal notions, nor did this depression ever interfere with his functioning.)

Over the two-year period, Daniel felt that he had achieved some conscious control over reexperiencing the imagery at any given moment. That is, he could choose either to push the thought out of his mind or to think about it, and, inevitably, to recreate the above cycle of images.

In general, Daniel had not noticed the onset of any other symptoms since the event. He was not aware of any other intrusive imagery or any difficulties with sleeping, eating, or sexual functions. The only behavioral disturbance he remarked upon was his reactions after talking about the incident, when he would invariably feel "spaced out . . . my mind just goes out of focus . . . feel emotionally like being about to faint; conscious, but as if there are no stimuli coming in." This feeling would persist for about 30 minutes after having described the scene and the unbidden images, and he reported having felt this sense of dissociation during this interview.

In addition, he reported two other significant consequences of his experience. The first involved driving past an automobile accident about six weeks after the stressful event. He saw a man on the side of the road holding his bleeding head in his hands. He then noticed that the top of the car was smashed in and that there was a baby crib in the back seat. Upon observing the crib, he suddenly became upset and began to fantasize about the baby or the man's wife being trapped in the car. Then he was struck by the thought that "it was unnecessarily morbid to fantasize about it and I should stop." Whereupon, he consciously and with difficulty, forced himself to cease thinking about this episode.

The second consequence was an extended fantasy, a story that he had evolved over time about the suicide victim and her reasons for killing herself. She had many children and was working hard to support them. The children were too much to handle, and her husband had left her. She felt alone, alienated from her children, and as if she were fighting the whole world alone. This was too much for her, and so she killed herself.

In fact, Daniel did not know her and knew none of this to be necessarily true, but he told me, "I had to give myself an understandable reason why she'd do that."

In the final minutes of the hour, Daniel spoke of his fears about this interview. He found that he was more nervous discussing the incident in this instance

than at any time in over a year. He was worried that the psychiatrist would notice something that was bothering him but that he was unaware of and would not care to admit, such as the idea that the incident had affected him more than he thought it had.

The psychiatrist observed aloud that Daniel had been able to continue his life with a minimum of disturbances, despite the occasionally troubling thoughts. He offered him a chance to return to talk about it and to be treated briefly for help with the recurrent distressing visual images. Daniel thanked the psychiatrist and said he would call if the need arose.

## Discussion

From his own subjective memory report, one can reconstruct the behavioral and ideational contents of Daniel's immediate response to this terrible scene. Perhaps it would be best to begin by placing the whole stress event in the context of this lonely period in his life when he was mildly depressed. A manifestation of that mood was his thought that one is not cared for in Chicago. In this frame of mind, he had an incredible experience.

Suddenly "something" made him turn around as he walked along the street. He reports not remembering any sounds except "the blood rushing in my ears." One must surmise that he heard the awful sound of the impact of the body, which probably would have resulted in an explosive noise. But Daniel either repressed this entirely or else did not record the initial impressions in memory. He was then presented with an awful sight—a dead, mutilated, female body with a gaping, empty hole in her cranium. The shock of this visual perception may have eroded preliminary codings of the auditory percepts. Next he was aware of a thought—"she has fallen down (perhaps), has tripped on the sidewalk, or has had a heart attack." He wondered what he should do to help her and yet was aware of the irrationality of these thoughts while observing simultaneously "that nothing was in her head." His mind rapidly appraised alternatives along multiple lines of associations. He tried to disavow the terrible finality of bodily destruction but concluded by recognizing its reality.

He was frozen into a state of staring. Then after a moment, he became acutely uncomfortable with his awareness that he was staring, and he thought, "I shouldn't be looking at that." Then he found himself caught in a conflict; he "shouldn't" look, "but for some morbid reason, I wanted to look at it and kept staring at it." A large part of what followed, according to Daniel's description, involved both his looking and what he saw.

One source of disturbance stemmed from the incongruity between Daniel's ordinary schema of how bodies should look and the way this particular body

looked. Bodies are supposed to be intact, shaped in an ordinary manner, and the insides invisible. But this body was misshapen, and the insides were visible. In order to resolve this incongruity, he instinctively needed more information, and his eyes were glued to the body by an automatic tendency to obtain that information. In addition to this automatic tendency, there may have been psychodynamic factors such as a body schema developed around fearsome but unconscious castration fantasies.

The compulsion to look is thus an adaptation function based on a need to find out about any possible danger in novel situations. But self-awareness gives new meanings to automatically instigated staring. Daniel felt that looking was socially taboo. Customarily, eyes are averted from dead bodies, corpses are covered up as rapidly as possible, and children are protected from them. He thus felt guilty for having looked and wanted social confirmation of his act. Since the event, he relived the horror of looking, the compulsion to look, the aim never to look at such things again, and the wish for social sanctions.

Another problem with the scene was his observation that other potential onlookers were not looking, an aspect of the general tendency to deny threat. People walked by, stepping on pieces of the brain, and, incredibly enough, disregarding the body. These other people, then, represented the opposite, or mirror, response: the need to not look. For Daniel, cognitive and emotional processing of the event included not only appraisal of the meaning of the woman's body but also understanding, integrating, and accepting his own immediate responses and those of other persons who, in a sense, socialized his reactions.

While riding the bus, he caught himself reenacting what had just occurred as he stared with tears in his eyes at the young woman opposite him. Perhaps he was identifying with the dead woman as he thought, "Well, at least, now, be friendly" (to him). He was also asking, nonverbally, if looking was all right.

Despite his identifying with the dead woman's plight as being depressed in Chicago, there was probably a counter theme of relief that it was she who died and not he, that she was mutilated and he was intact. This thought could only serve to reinforce his sense of guilt.

By this time, Daniel was already manifesting a stress response syndrome. Over the next several days, he forgot about it but felt vaguely depressed. This represented an initial period of denial and numbing, which soon began to alternate with a need to tell what happened. He also began to experience intrusive imagery and was most aware of this when exposed to one of the trigger stimuli, like hearing a set of words or seeing events such as the automobile accident. In general, he was preoccupied with the presence of the memory of the event and with his efforts to prevent it from coming to mind. He was also trying to ward off the guilt, fear, and depression associated with this memory, and one would imagine it was the discomfort of these potential emotions that prompted him



to try actively to suppress the images. But two years later, he still had intrusive images of the event after certain specific triggers, such as the word *Chicago*.

## The Meaning of the Interview and the Dream

Daniel's dream occurred some time after the medical school interview, at which he had somewhat impulsively told his story and while he was anticipating the interview reported here. It occurred probably as these stimuli activated the aspects of the memories that were not worked through and represented a continued ideational cycle responsive to the stress event. His decision to follow the medical interviewer's suggestion and to come for the interview with a psychiatrist may also have included a covert wish to continue with and complete the cycle of thought initiated by the stressful perceptions. He continued to deny, however, that he was bothered very much at this point by the memory of the event. Accordingly, he did not view the dream as connected to this memory or to the recurrent, disturbing, intrusive imagery he still experienced. Instead, his girlfriend suggested it, and he found that the suggestion "didn't click." He maintained his denial despite his report of an association in the initial part of the dream presentation that confirmed his feeling that the dream was related to the stress memory. He associated the man's exposed body cavity with the hole in the woman's head. However, after adding more detail in the second part of the dream, he told of his disagreeing with his girlfriend's interpretation.

It will be helpful to examine briefly the form and content of the interview in this context. Daniel began with a description of the stress event. He emphasized the impact on him of the woman's empty cranium, the brains splattered about, and his own behavior, looking and staring—first at the body and then later at people on the bus. He immediately presented the disturbing conflict as his desire to look and his guilt about doing so.

Soon afterwards he mentioned having had the dream and offered a description, concentrating on the part concerning the body cavity that was "all scooped out" and the association to the woman's empty cranium. Then he stopped and was silent. The interviewer asked whether that was the whole dream, and he replied, "There's more detail in it, but I don't know if you want to hear the whole thing."

He was really asking if the interviewer could stand hearing more detail, as the interview process was a reliving of some aspects of the stress situation with the externalization of some of his quandaries to the therapist. He presented the distressing images to the interviewer in a forceful way and watched his response. If the interviewer preserved his equanimity, then, by identification, Daniel too could remain unperturbed. If the interviewer did not criticize or reprimand him

for staring, then the compulsive looking would be made socially acceptable. If the interviewer expressed his own wish to see and know more, then Daniel could feel less guilty about looking.

Several references have been made linking his dream to the stressful event. What is the evidence for this? A connection between the man's body cavity in the dream and the woman's cranial cavity in the perception has already been mentioned. The view is reversed, from above and downwards to below and upwards. Daniel said the man in the dream had been in an accident, a term he used during the interview to refer to the woman's fall. The man's legs had been severed, and the bones could be seen, an image similar to what he had received when looking at the woman with her leg split open.

After learning that the interviewer wanted to hear the details, Daniel reported the second part of the dream: "The man looked kind of plastic, like he had black, plastic hair ... looked android or plastic." The woman had worn black (patent leather or plastic) boots, probably had dark hair, and her face, flattened from the impact, may have looked "android" or unreal and plastic. The man had "very smooth olive skin"; the woman was Latin American. In this second telling, Daniel again described the man's legs as "cut open. . . . I saw a cross section of his legs, the muscles and bone." This is an even stronger suggestion of his image of the woman's leg "split open." He saw the man's "spinal—his backbone." He had described a part of the woman's brain as being quite identifiable as her "medulla." The "silvery coating . . . like the inside of a fish" in the dream is probably associated with the luminescent quality of the meninges, which he might have observed on the brain parts. Finally, in the dream, he spoke of putting "myself in his position." The woman has become a man in the dream, as her suicide was "very close to home" for him. The dream's manifest content contained images derived from the original stress event and occurred in expectation of reliving the event in the forthcoming interview.

To recapitulate, two years after a frightening experience, images of that experience continued to have an intrusive quality, emerging despite suppressive efforts when there were certain associational triggers. In addition, there was a continued need to retell the story while both awake and asleep. Even the process of the interview itself had aspects of reenactment. This is by no means an unusual story and illustrates the endurance and intensity of a response to stressful events in a normal person.



## CHAPTER 15

# Suicide of a Parent

*With Frederick Parris*

Margaret, a 25-year-old Chinese-American woman, illustrates denial, the resumption of mourning during psychotherapy, and the communicative problems imposed by a style in which isolation and undoing are prominent.

She telephoned the outpatient clinic for an “evaluation of depression” because of suicidal thoughts during a period shortly after her mother committed suicide and because she feared that she might do as her mother did. She was referred to the stress clinic, and an appointment was made. She phoned and canceled this appointment, explaining that she was feeling much better. Contact was renewed several weeks later when Margaret called again, saying she had been feeling better but now wanted help.

## First Session

She presented herself as composed, unemotional, controlled, intelligent, and personable. As part of obtaining informed consent, she signed a statement containing the words “Research on Stress Response Syndromes.” She began the first session by commenting on this phrase.

M: Margaret

T: Therapist

*M:* It is important to, uh, to study that, and I think the greatest impact has of course, been on my father.

She was referring to her mother’s suicide.

*M:* And ah, I read a research study recently in the paper that said that sudden deaths are extremely hard to get over for a spouse, for him, and after they’ve

been married for 33 years and were very, very close in the relationship, so it affects me most when I'm with him but when I—whereas I'm living my own life out here, and I was living my own life when she died, although we were very close (*pause*).

She said again that her father is the one most affected by her mother's suicide. As is often the case, the first minutes of therapy indicate a character trait of the patient. She used alternative facts ("he is upset") as a way to ward off threatening facts ("I am upset"). She went on to say how days could pass without thinking of it, before disclosing her own distress.

*M:* So I was just thinking recently that sometimes I'm, I'm pretty sure I, I go whole days without thinking about it—and I'm feeling the more direct problems that I'm confronting, you know in my work, which is difficult. I was standing talking on the phone at work yesterday, and there was this girl behind me who was cracking up, saying to her girl friend she felt like committing suicide, and you know, everything was going wrong. And all the machines weren't working, and you know, I was identifying very strongly because that happened to me a couple weeks ago.

Her identification with one who commits or might commit suicide was held in the therapist's mind as a possible key issue. Later on, on questioning, she had no intentions or plans for self-harm. The "universal" stress response theme of fear of merger with a victim is here colored by another "universal" theme, identification with the parent of the same sex.

*M:* 'Cause all the machines I wanted to use weren't working, or I was doing really stupid mistakes. And ah, it was just before Easter and I had to get something done and, and I was just starting to shake, I was just so uptight, and so when I first called here I, ah, was in a very, uh, very bad situation, you know, emotionally, I just didn't know what was going on, and I was, I was feeling suicidal and ah, just, for the first time in my life that I just couldn't cope with the things that were happening to me. And I couldn't cope with my own feelings, and I was just, I felt like I was getting out of control. And when I started realizing what I was doing to myself and to the people around me, notably to the guy I'm living with, um, I realized I had to get a grip on myself, and I have been, I don't feel like I'm freaking out that much anymore. Sometimes I feel, this is why I didn't follow up too closely after I called, I called and, and ah very, very urgent at the time and then, you know, then I got a grip on myself and ah, I, I couldn't really make up my mind whether or not I should come ah, or whether I was getting back on the road, and I didn't have to worry too much any more and still feel alternately one way or the other. Sometimes I feel fine, I feel sane, and sometimes I still feel that ah, I need new perspectives and I really need somebody to um, help, you know put my head right back where it should be, you know. I don't know if I've ever, my head has ever been where it should be. So, um, it,

it's also hard. I got kind of nervous this morning when you first saw me because I suddenly tried to put all my problems together, and sometimes I feel I can talk about them very coherently, and I like to, and then it comes out to somebody, whoever I happen to be with at the moment, and then, there, I was just afraid this morning on account I wouldn't be able to talk and I wouldn't be able to put anything together. So, I don't know if I can (*pause*). But I guess it's also hard for me just to sit here and keep talking without any sort of direction, I suppose. So (*laughs*) do you have any advice for me?

Margaret became diffused and repetitive at an abstract level over the issue of whether or not she was all right.

The therapist asked her to go on with whatever she felt most distressed about. She talked of her current love relationship with Ned but quickly shifted the topic to her work in photography. She graduated from college with a major in literature and then decided to leave her home in suburban New York for California. She got a very promising job in movie production. It required that she plan her own original work in addition to carrying out certain editing-room routines. For the first time in her life Margaret felt that she had embarked on a satisfying and fulfilling career, but she had difficulty concentrating in the darkened editing room. She retraced her history in order to illustrate her feelings during earlier periods, continuing as follows:

*M*: You know, I really hated myself all through high school. I thought I was ugly and nobody liked me and I went through all these very unstable things, um, that I started getting over finally when I went to New York State and um, I had a couple of relationships and I met a girl who is now very, very close to me. I'm very close to Alice, and we lived together for about a year and a half and have been friends for nearly three years now. And then after I graduated as a lit major, um, I worked for a year as a secretary in Central Bookstore which was, it was fun, it was nice, but I felt I wasn't doing anything with my life, and I wanted to do something more creative and interesting. So I came out here because a friend had this movie studio that was really moving, and then, um, my father, who is a computer designer, he was working for General Labs in New Jersey, and he was pressured into taking a big important job which would mean moving to Philadelphia for two years, and my mother said absolutely no, I won't go, I'd die sooner. You know, she's a very strong-willed, independent person, and, ah, that upset me a whole lot, like (*laughs*) my God, my parents are splitting up after 29 years, and there was no way my father could get out of it, so, um, my mother would go back and forth. She finally decided to go with him, but she was going to stay home in New York for the summer, and, ah, then she killed herself; it was just as sudden as that. You know, it's very, in a way it's very like her because she wasn't a person to make a big show of trying to ah commit suicide. You know, just she did it (*laughing*).

Margaret's laughter was not simply nervousness; it was a way of undoing and averting negative emotional responses. She later revealed that her mother was strongly committed to her own career as a freelance illustrator and had earned substantial sums for many years. For a period immediately preceding her suicide, she had received an unusual number of rejections in competitive circumstances and was not earning any money. Her mother loved their home, friends, and community. She hated Philadelphia and the idea of tagging along with her husband and was sure that he would have a second and fatal heart attack from the enormous pressures of the new job to which he had committed himself.

*M:* —you know just a total shock to everybody, and so I stayed with my father for a month. Just every day, just trying to see him through every day, and, ah, then I spent the next month seeing him and going, arranging things in New York and, and, ah, relaxing and then going down to Philadelphia, and, and then I came out here, ah, about five and a half months ago, um, and started work. I was going to work full time, but I didn't, I'm working part time instead. I'm working two days a week, taking some courses, um, and that's about it. I don't know if it's given you any insights. It's been a, you know, I feel it's been a pretty normal middle-class existence, and, ah, up till now I feel I've been coping with everything fairly well (*pause*). So I don't think it's anything unusual; I don't even think my problems are anything unusual, and you said it was, um, it was good I realized that it was all going on inside my head, and I do know that. I don't feel that the world is doing anything to me. Um, I feel that the way I see life is that I can sort of make it whatever I want to, I know that whatever I'm doing with my life is totally up here (*pause*). So I don't know where to go from here.

Margaret was in a denial phase. After her mother's death she devoted herself to her father's grief, and then she continued with her plans. She was having difficulty at work and with her boyfriend, though she played down these problems in order to maintain her sense of esteem. At this point she was not experiencing sadness over the loss of her mother, although the need to ward off such responses may have contributed to her problems at work and with Ned.

The therapist then asked a series of questions exploring for signs of depression, suicidal potential, and any abnormalities in her current mental status. When no material of consequence emerged, he requested more details on her present interpersonal relationships. She responded by telling of her difficulties with Ned, her periodic feeling of jealousy, and her worries about losing him. The therapist sensed, because of clues in the flow of her remarks, that it was she who wished to leave Ned but that for some reason she felt bad about this and could not acknowledge it. But he did not verbalize this, and she continued to describe how Ned moved in with her.

*M:* Just after Ned and I started getting a little, very, very slightly involved, um he was, he was forced to move out of his apartment, and, ah, so

in a moment of rashness, you know, of generosity, I said, well, you know, stay with me if you can't find any other place to stay, as a temporary thing. That's how (*laughs*), that's how it started. It was really weird, and for a long time, for about a month, I guess, I said, ah, you'll just have to find your own place as soon as you find a job and can pay for it. And he was saying after a while, after we'd been living together for a couple of weeks, he was saying, "No, I want to keep living with you," and I said, "No, I don't want that. I want to live by myself." Um, and so finally, you know, we worked out things to the point where I decided, after about a month and a half or something, that if, if we found different living quarters our relationship, which had built to a certain point, that point would just be thrown out the window because it wasn't the kind of thing that could survive on, ah, two totally separate, um, things. It would be a regression, if we lived in different places; it would be putting our relationship on a lower level, which neither of us thought it would survive. So I decided I wanted to continue with it rather than just completely throw it out. And that's why we got a larger apartment and moved about two months ago.

*T:* And that's about the time you began to become jealous, had fantasies, and worried?

*M:* Well, it was also the sort of time when I stopped being in control of the situation, because as long as Ned was saying, "I want you," and I'm saying, "Well I'm not sure," you know, I was more in control, and as he was always the one who was making the efforts to, to adapt to my needs and wants and I needed more time by myself. And, ah, once I, once I, you know, sort of made a turnaround and said, "I want you," then sort of like the balance shifted, and, ah, he became, he wanted to become more in control. I've always, I, I, you know, always resist him being in control, you know, and I said I'm the one who's suddenly having to make all the adjustments. I want it to be 50-50, and, ah, that's when it started, um, resisting the security of, the security of the relationship, and, and sort of subconsciously trying to dump on it, and that was when we moved. So now, now I, I sort of resent feeling that I'm the one who has to make most of the adaptations and most of the changes. You know, because he's, he's still, he says, "Well that's the way I am you know. If you don't like it, that's too bad."

*T:* How do you feel about having to make the changes? Are you feeling very frightened that if you don't, you'll lose him?

The therapist was aware of the parallel between Margaret and her mother. Both were threatened by lowered controls, possible loss of a man, and a loss by moving. He groped for this connection and her possible identification with her mother in what follows.

*M:* Yeah (*pause*).



*T:* I'm struck also—I'm trying to tie this in with the "Why now" question I have in my mind. You came West involved with yourself. Everything was going fine. You had your independence, but for some reason things have regressed.

*M:* Mm-hmh.

*T:* Perhaps you feel now the way you did back in high school, that you doubt your own value.

*M:* No, not, God forbid if I could ever doubt that again. No, I still have a basic sense of my own value and my own worth, and, and the person I am. I still have, you know, about 300 percent more self-confidence, down basically than I, than I, did, then, um.

*T:* What I was really driving toward was closing the circuit. I was wondering if your mother's death had any effects on you. Here was this case where *she* wanted to retain some control, in a sense of not having to make the move, was forced into a corner, and as you said, "She wouldn't make the move even if it killed her," and that's apparently how it occurred. Would you identify with this part, or would you prefer to—

*M:* Ah, I respect her a lot, and ah, ah, I respect, you know, the, the strength that she always had and the independence and the, the person that she was. You know, she was just a really beautiful person, and, ah, I suppose the fact that I had to come to terms with her suicide, the fact that she deliberately took her life in the sense that I respect her so much. You know, so I've got to respect what she did, you know.

Margaret did not quite connect with the therapist's communication about identification. Instead she reacted as if the therapist had suggested that she might feel critical of or angry at her mother for committing suicide. She was protesting too much about how wonderful her mother was and how much she respected her. She not only was avoiding negative feelings, but she also was avoiding them by stating opposite ones. This was a characteristic style for her, akin to the switching described in Chapter 10. She did this so emphatically and repetitiously, while seeming ill at ease, that the therapist approached it in a very gingerly manner.

*T:* In fact you almost had to respect what she did, so as not to interfere with your image of her as a . . .

*M:* Mm-hmh.

*T:* Not to place a value on suicide, but you had it in your mind as respecting her suicide because if you didn't respect that, you would have to question the image. . . .

*M:* Yeah. Also, um, like she couldn't, you know, I can see how after decades of living with one man and loving him and having a very close, good relationship that they did, she couldn't turn around and say, "I'm leaving you." You know that. I don't see how any person could really do that.

Hence she also could not break up with Ned, although later in therapy she felt able to do so. One reason for coming to therapy was her conflict over how to terminate an unsatisfactory but close relationship.

*M:* Whereas knowing how much she hated Philadelphia and the pressure-cooker existence, that and the fact that she, she was also very sure that my father, you know, was going to die of a heart attack because he almost did five years ago. And put in a similar situation, she was positive he was going to drop dead anyway, once he did that, once he moved, um. So having made that decision, and she, she also felt that he betrayed her by doing this when he knew that she, she would hate moving so much. But I respected that fact that she wanted to retain her independence and, and that it was hurting her pride to have to follow somebody else. You know, like just to be an appendage to my father, um (*pause*). So she, she wrote in her note, you know, to my father, "You did what you have to do. I'm doing what I have to do." And uh, I, you know, I've never, I haven't thought of suicide at all since I was about 16 years old. And you know, the fact that, you know, my mother's, you know, doing it brought it to my attention so much and having to respect the fact. Like I, I'm, I'm almost positive that's why it seems like an alternative to me now. Um—although I'm, I'm, I'm pretty positive that I wouldn't do it. Because I, I don't think that I could face hurting my father that much. I mean, I wouldn't have to face it, obviously, but um, I just don't think I could. You know, knowing, how much it hurt him for her to die. You know, I just feel it would be another blow that he couldn't bear.

*T:* I wonder if what makes it even triply hard for you, as sad as you feel just trying to respect and love your mother, is the fact that she did hurt your father very much in the final analysis.

This was a fairly direct interpretation of her hostile thoughts toward her mother and of a warded-off hostile component in her reaction to her mother's suicide.

*M:* No. I know she was a very selfish person, and I knew that when she was alive, and I knew it when she was dead. Um, it was a selfish thing to do, you know, and she was a very self-centered person, and she, I knew, I always knew that (*pause*). So I don't respect her for being so, you know, that self-centered, you know. I certainly don't blame my father, either (*pause*).

The therapist inferred here an unspoken thought, "I don't blame my mother" before she said, "I don't blame my father either." This was a sequence of undoing: "I don't respect her (I do blame her). (I don't blame her), (I blame father), I don't blame my father." She ended by denying the impact of her mother's death.

*M:* But I do feel that I've come to terms with, you know, with her death about as much as I ever will. I don't feel that it's, it's really disturbing me so much now, you know, emotionally, except that there are situations that I find myself in now that I, I just say (*laughing*) you know "I wish you were here." You

know, because she, you know, she was always a great support for me. She was somebody who really, really did believe in me and always said so. And she always tried to put some backbone into me, you know, and she really did. I absorbed a lot of things from her. When I was in a situation where I'd say, "Oh mommy I like this guy, and he won't ask me out," and she'd say, "Well go ask him out. What are you waiting for?" You know, she was a very aggressive person, and she, she pounded that into me. Um, and she was, she was an extremely proud person, and she pounded that into me as much as she could too (*pause*).

T: Okay. We're going to have to end for today.

## Second Session

Margaret came in expressing ambivalence about her need for therapy. She denied any relationship between her problems and what had happened to her mother and said that she had come back only because she felt obligated to discuss whether or not she needed therapy. She did not like the way the therapist just listened to her and offered nothing of himself. In various ways, she asked for more support and direction. However, in doing so she became provocative and accusatory. The therapist felt that she was testing him to see whether he would collapse (have a heart attack as her father did), become angry and wish to be rid of her, or approach her more intimately and socially (which would frighten her), or try to control her. But he continued with the same concerned, tactful, and objective professional manner as in the first interview. She announced that she was going on a visit to see her father for a few days.

## Third Session

Margaret dealt superficially and unemotionally with the visit to her father. She felt that she was much better and believed that her fears of being flooded were related to "a period of identity problems in adolescence." She gave additional history, including a suicidal gesture as an adolescent when depressed. She was agreeable and intellectual during the hour, using undoing, negation, and disavowal to avoid anxiety.

## Fourth Session

Margaret spoke of an episode of sadness that occurred while she was developing her own pictures in the darkroom at work. She had taken these pictures dur-

ing a recent visit home and had also brought back a picture of her mother that she had found there. She talked longingly of missing a girlfriend, but to avoid intensifying her sad feelings, she switched to discussing both difficulties and successes with her editing work, focusing on mechanical issues. In summarizing her remarks over the hour, the therapist mentioned an idea she had spoken of earlier in the hour, about going home to be closer to old friends of hers and her mother.

She responded that introspection on such ideas made her “massively oversensitive to any little thing.” She related this oversensitivity to Ned and continued as follows:

*M:* . . . like, um—even if, if I feel, ah, I feel affectionate toward Ned and he just doesn’t happen to feel that way at that moment, it just sends me, I mean, right to the bottom, or just looking, you know, at a picture of my mother will just send me into a fit of crying, and this doesn’t happen normally. But things that don’t normally upset me do, things that I just can’t, I can’t deal with them rationally. I can’t shrug them off, and I feel—in a way I feel a huge loss of self-esteem—whereas on the other hand, if somebody said, “Do you like yourself?”—I would say “yes.” It’s just one of, one of the main characteristics of my depression is just feeling unable to cope with the complexities and the demands of life and the future and making a living and achieving something or accomplishing something. It just seems too complicated and too difficult, and the whole thought of it just appalls me.

*T:* It’s only a hunch, but I would think some of those feelings come to mind when you look at a picture of your mother and have some realization of her loss and talent.

The therapist noted the defensive maneuver of abstract generalization, attention to peripheral details, and expansion to issues too large to contemplate, such as “the complexities and the demands of life and the future.” By giving this interpretation, he tried to hold her to a topic she had brought up and was also warding off.

*M:* Well, one of my, one of my strongest fantasies, or actually I have very, very few fantasies that, that I wish, but one of the things that has been recurring since she died is wishing that I’m little again—very little—you know like about 5 years old. And I brought back from the East two pictures, one was of my mother when she was in college, and one was of me when I was 5 years old, and I’m, I’m planning to put them together in a frame because that is my strongest fear (*a slip of the tongue*), ahh, fantasy, you know, I want to go back to the time that everything was taken care of for me and I didn’t have to worry about finances and supporting myself and, and, ah, trying to accomplish something in life. Although I suppose you know, the little things I was going to try and survive were just as traumatic as the things I, I might go through now. But that’s, that’s how I feel. You know, it’s not so much that I hate myself, I hate myself, but a feeling of just being unable to cope with all these things because I, I think that

the self-esteem, and the, ah, the feeling I like myself, or I wouldn't be anybody else, um, I think that those feelings are very solid in myself I don't question them, I, I feel in that sense, I always feel very together. . . .

She was switching from her wish to be little and dependent, an idea that made her feel too infantile, self-critical, and controlled, to assertions that she liked herself. When this undoing operation restored a sense of safety, she could resume her self-critical statements.

*M:* . . . But my main, the the main characteristic of my depression is just I hate to get up. I hate to face each day. I hate to—um, I feel that every single day is a struggle, and I never want to wake up in the morning, or when I wake up, I never want to get up. I just dread every day. And that's, those are, that's the massive feeling that my depression consists of. And, ah, I relate this to the pressure that has been put on me by my father to succeed—it's not that he's pressuring me. . . .

She was using her characteristic switching maneuver again. She switched to describing her father and was also using the topic of her father to switch away from ideas and feelings related to her mother. As will be seen, the "mother" topic will return.

*M:* . . . but (*sighs*) he wants me to, you know, for my own sake, be, because he knows, or he's instilled in me, I suppose, the need to feel that I'm accomplishing something in life. But at the same time I've gone through four years of liberal arts college, and movies are such an overloaded market that it's very difficult, and you have to be extremely aggressive to be able to succeed, and ah, much as I want, I still have these ambiguous feelings. I have tremendous fear of not being able to. And ah, it's just really, that is, that is another thing that's very, very difficult for me to cope with. And you know, when I got these feelings from him, my mother was always the person I was able to go to. She wanted the same things from me, but she, she didn't express them in a pressurized way. She expressed them in a much more sympathetic way that I could identify with, and I've, you know, I always turned to her. And in the years when I was closest to her, I was farthest from my father.

*T:* When were those years?

The therapist, sensing she was about to switch away from the train of thought involving her mother, tried to hold her to this topic by asking a relevant question about her mother.

*M:* Oh, my college years and, and, ah, up until she died—well after I'd left home. She was, ah—um, I feel a lot of sympathy for her, because she, I don't think she was a very good (*pause*) mother. . . .

This "I feel a lot of sympathy" was a kind of premonitory undoing of the angry feelings that were incipient and emerged clearly in her voice when she subsequently spoke of her mother's terrible temper. Both feelings were really present.

*M:* . . . She didn't want to be really (a mother). My father told me this after she died. Especially when both my sister and me were little. She hated having two little kids around, and, I mean, she loved us, but I remember she had the

worst temper, you know, she used to—I remember when she grabbed me by my hair and shook me like that. Um, I mean she never beat me or, you know, anything like that but she, you know, she had a terrible temper. And this died away very, very much after I left home. And she and my sister, ah, my sister was very unstable and really hated my mother for years even after she went to college, and ah, I don't think their relationship ever really got close, even after that. But after I left home, very quickly I started growing back closer to my parents, and, and my mother always, um (*pause*), she, she always needed me, and I, I understood that, you know, without ever really talking about it. And you know, sort of a feeling she really wanted me to have all the freedom that I could possibly have, even though she needed me, and she wanted me to be near, you know, on vacations and stuff like that. You know, and she urged me to move to California, even though you know, she would've much rather had me (*pause*) closer (*pause*).

The therapist tried to hold her to this topic with another question, but she deflected to other topics until the end of the hour.

## Fifth through Seventh Sessions

The next two hours, the fifth and sixth sessions, dealt with ordinary matters at work and with Ned and avoided mention of her mother. In the seventh hour Margaret talked in a general way about everyday work frustrations. She then told of how strongly she had felt that she had to get away from Ned and be with a girlfriend, not to “sob on her shoulder but to get her energy.” She “accepted it with equanimity” when the girlfriend was too tired to have her come over. She immediately returned to work topics and expressed righteous anger with her boss. She then criticized her editing machine for being defective and talked abstractly about artistic tasks. One purpose of discussing the boss and the equipment was to show that she was not at fault or to blame for her anger.

She then talked, dejectedly, of eventually showing her film work. The therapist said that she might be asking if it were all right to show not her work but her feelings, for he could sense that she was depressed. She said she was sad that she had only her work to attest to her worth, and she was uncertain about it. She came close to tears at the end of the hour, but the cause was unclear, concealed by intellectualized generalizations.

## Eighth Session

Margaret began the next session by saying that she had been feeling unstable for the last two days. She had been reluctant to do darkroom work because

she was afraid she would be unable to focus her thoughts while there. The first half of the interview was occupied with a long soliloquy about the uncertainty of her future plans and her ambivalence toward accepting financial support from her father. When the therapist attempted to focus her attention on the unstable feeling, she deflected toward continuing these generalizations and abstract ruminations. But she then went on to mention her mother, as illustrated in the following transition:

*M*: . . . Ah, like last night I got terribly depressed about what I was saying, and I was going through one of my sort of panics, and this time I said, "I'm not going to run over to anybody," and in a way I didn't want to, I wanted to just figure it out. And I couldn't. I mean, I just couldn't figure out why I was feeling so completely down. I knew when it started though, and, and I have an absolute progression of what happened because I'd been sort of down for two days. It all started with a thought of my mother, and, ah, I mean everything was fine. I was feeling really good one evening, and Ned and I were just sitting around talking and a song of Joni Mitchell's came on the radio, and all of a sudden I flashed back to this conversation I had with my mother about Joni Mitchell about two or three years ago, a long time ago, when, um, my mother was just saying, "Oh, it's just her publicity people that say she writes and sings and plays the guitar and she does everything." I said, "Mother, cut it out, she really does." And my mother said, "Oh." You know, she was, she was just thinking I was being naive. And I flashed on that, and I got really depressed and into my own thoughts and I sat down and I wrote a long letter to this woman back East, who, um, was my mother's closest friend, and who's like, you know, another mother to me. I just haven't, I haven't been writing letters lately, but I wrote her a long letter, and (*sighs*) it was just, you know, I just went into the bedroom and, and sort of sat and thought for a long time. I was, I was feeling down but not, not really terribly bad. I was just thinking and I wanted to be by myself (*sighs*), and I was still down with the flu, and I was sick of being sick and, ah, and so on. And the next day, the next evening, a couple of friends of Ned's came over. I've talked to you about the problem I have of relating to his friends, and this is his friend Tom, who's a total freak, and Tom's, a woman that he lives with. I mean it's a really weird situation; she's a call girl.

*T*: Can I ask you what the letter was like that you wrote to the friend of your mother?

Although the associations may possibly be relevant, the therapist noted the reference to her ambivalence about her mother, and so he chose to help Margaret hold onto that aspect of the topic, that is, the issue of missing her mother, feeling frustrated, and wishing for a substitute mother. If Margaret were on her own, as she would be alone at home, she would probably not continue to develop this idea because it evoked painful feelings.

*M:* Oh, yeah, um (*pause*). I wanted to explain to her, you know, what was going on between Ned and me because I'd talked to her about it when I was back East. What I mainly, what I expressed right away, was the fact that I needed, um (*pause*), ah, somebody sort of to function as my mother, and, you know, she is the closest to me. But she doesn't have the background in my life, and the, the things that you always go through with your parents (*sounds like she is about to cry*).

*T:* I asked you that very directly because I think you're experiencing a lot of feeling right here and now.

*M:* (*Long pause, sighs*). I just don't know if I can really talk about it (*almost crying, sniffs long pause*).

*T:* What sort of thoughts are you having?

*M:* I'm not really having any thoughts. I'm just trying to pull myself back together again so that I can talk. You know, it's like I said, I don't want to come in here and break down, you know, although you said that does serve a purpose (*cries*). Um, I really want to use these sessions very constructively for my head (*sniffs*). But we are getting very close to my emotions recently, because I've noticed this several times when I've come in here and started talking, just talking, you know, but not about my mother, not about anything, but I feel like crying, and it's not as hard, I mean it's not hard to hold back, but, but I feel that I'm very close to my emotions (*sighs, pause, sniffs*).

*T:* I think that there's something very constructive going on, expressing emotions here.

This patient had been warding off crying, not only because her sadness is painful, but also because she believes it is humiliating to give way to her emotions. The therapist said this to counter her humiliation.

*M:* (*Pause*) um, it's not that I've been holding back. The emotions that I'm feeling are reactions to what I'm saying, um. Thoughts of my mother have been very much with me. Well, one way of showing this is a photograph I wanted to make, a self-portrait for my father. What I chose to do (*sighs*), was use time exposure on my camera, you know, you can set it, and about ten seconds later it goes off so you have a chance to get into a pose or something, do it by yourself. So I chose to try to take a picture of myself studying myself in the mirror and in the mirror are two pictures; the two pictures that I mentioned once to you very briefly before: one of my mother and one of myself when I was little, and the one of my mother when she was about, say, 20. And to show that I'm looking at myself very strongly these days and that these two pictures are, um, well, pictures of the little girl, I mean myself as the little girl because that's, as I've said before, that's sort of almost how I wish that I were, was, and the picture of my mother, and it's an old picture. She'd, she just didn't like to have her picture taken so we have very few pictures of her that are recent and of those my father has them. My father's coming this weekend, by the way. . . .



She was expressing the thought “I miss my Mommy, I wish I were a little girl with her again.” She modulated the rate of the idea’s emergence by using other thoughts. In effect, these thoughts partially filled cognitive channels so that the previously warded-off thought could not rush out all at once and overwhelm her sense of control. The other thoughts, such as “my father’s coming,” might also have been antidotes to her compelling sense of loss. She continued talking about her father, using his sadness as a vehicle to externalize her own similar feelings, identifying with both his feelings and his capacity to cope with them and savoring the continued attachment. Note that she will say that she warded off ideas of her mother for father’s sake.

*M:* . . . So, I’m hoping that we, as always I’m hoping that we’ll, we’ll just enjoy each other’s company and not (*sighs*), um, bring too many old ghosts back in. Um, this past week was their anni, their wedding anniversary, and ah, I was afraid my father was going to be really down, so I called him up, and he was, he had friends over for dinner, which really made me happy, he wasn’t by himself and depressed. He had been very depressed lately. I knew that, but he was really pleased and touched that I had remembered and that I had called and that made me really happy, and we’re both looking forward to seeing each other. But, um, when we’re together, I try to keep as far away from any mention and thoughts of my mother as possible because it (*sighs*) amplifies the feelings so much when the two of us are together. I mean I can talk about my mother, and I can cry about my mother in front of Ned or you or any one of my friends. . . .

As far as the therapist knew, this was the first time she had cried. To reduce her embarrassment she declared that she was comfortable with crying and did it all the time.

*M:* . . . But with my father, his pain is just so great and so is my own that we just increase each other’s feelings. So with him, I just try to avoid every mention of her, every thought, and whether this is good or bad I don’t know. . . .

One reason that she might feel bad is that she might have been predisposed to feeling guilt over an oedipal victory. She now had her father and excluded (mention of) her mother. This would be only one factor in an overdetermined behavior pattern.

*M:* . . . (*Sniffs, pause*). There are, there is this one lady, ah, Marion, who is my mother’s closest friend. I’ve known her all my life. She has a daughter who’s a year younger than I am, and (*pause*) you know, it’s like back home. I have a lot of people who, who want to function as my special friends and parents, and they do, but she’s, she’s very much the closest . . . (*pause, cries, clears throat*).

Stabilized by discussing her father and perhaps growing anxious about this topic, she returned to her wish to attach herself to a woman friend as a mother replacement. The woman could not replace her mother; she must give up her mother, and so her sadness came out again.

*M:* . . . But what I feel that she has been, she's missing in her role with me (*cries*) is, you know, all the things that are, that go between a mother and a daughter when they're growing up. All the little problems, all the, you know, the ado—especially adolescence, which has got to be the worst period of anyone's life, but all the things that, you know, I went through with my own mother, and I have never experienced with Marion (*pause*). So one of, I expressed that in my letter to her, saying that I wanted, that there were questions that I wanted to ask my mother about her experiences in life that I had never had a chance to or had never run up against and ah . . . (*sniffs, pause*).

*T:* What sort of questions would those be?

*M:* Well they're mainly, ah, with regard to, ah, her marriage. Like I know that my parents went through difficult times, and I, I wanted to know how much do you, should you go, I mean it's crazy, nobody can tell you this, but I wanted to know from my mother's experience (*sighs*) how do you, how long do you hold on to a relationship when it's not good? How hard do you work for it? How, like, like Ned said to me once that there are going to be times in our relationship when we'll hate the sight of each other, you know, and, and trying to show that that's, you know, that if you really, that a relationship will go through good times and bad times—and the bad times will be awfully bad, but if you can hold on, I mean, the relationship will be very much strengthened, and this is something that my mother had also said to me. She'd, when we'd discussed the relative merits of marriage you know, I've said, you know, what am I supposed to push marriage for, you know, for nothing (*said rapidly and vehemently*).

Margaret continued talking in generalities about one person hurting another. She then recalled a family scene in which she had said she did not want to have children. Her mother took her side, but her father was horrified. She went on to talk of her parents' ambivalence toward each other. The therapist summarized by saying that she was talking about expressions of both tender and angry feelings between persons and added that she too may have angry feelings that cannot now be shared with her mother. She denied this:

*M:* Um, not so much share feelings with her because I always did, and I always did tell her how much I loved her. But I think (*sighs*), when my mother died, I must have been the only person on earth who didn't have guilt feelings, who didn't say "If only I had done this" or, um, I had no feelings that I could have prevented or, or, ah, I don't know, just plain guilt that, that she had done it, she had committed suicide, and I still don't have any. I don't have any feelings that I wish that I had said that I loved her because, you know, I did. I said it many, many times you know, starting I remember even years ago. Must have been when I was just about 17 or 18 and, and, ah, either just off to college, or about to go off to college, I said, I remember very distinctly saying to her, that she had given me so much love and understanding and it was the kind of love and understanding that you

can't give back. I mean, I can't turn to her and say, "Now, you know anytime you want advice, come to me," but it was some, something that I could, that I had learned and could hand on to somebody else. And, ah, even way earlier than that I remember when I was about probably 12 or 13, I had said something meaning to be funny, and it was actually very malicious. I said, she was, no I, I must have been about 14, 'cause I remember the house we were living in, and it's one of my really clearest memories (*cries*). She was, she was doing the laundry and I was sitting at the table and she was singing and I said, "Mother have you ever listened to yourself sing?" and she said "No," and I said, "Well you're lucky," and I was just, it was a stupid joke, and years, I remember, for years later, I always said if there was one thing that I could call back in my life it was that, because it started her crying. I had made my mother cry, and I was just, I, I apologized, I said I'm sorry, I didn't mean it that way; that was really stupid.

Margaret continued with memories of her mother and then spoke of wanting to talk to her father about her mother but being afraid to do so. Finally she talked again of longing to see her mother's friend Marion and of being envious of Ned, who could still call up his mother whenever he had a problem. At the end of the hour she gestured to the box of tissues and said, "Do you always keep these by the chair?" The therapist suggested that she was asking him to say that it was all right with him that she cried during the hour, and it was all right.

## Remaining Sessions

This stress-oriented treatment continued for seven more sessions. The above session marked the beginning of Margaret's open mourning for her mother. Her grief process was marked by her loving attachment as well as her resentment and fear of overidentifying with her mother. She had a model of her mother that she had never before clearly conceptualized; she saw her mother as superficially strong and powerful but weak underneath. Mother's refusal to move with her father, for example, was seen as a sign of strength in her first conscious thoughts, but the mother was avoiding ideas that it was weak to have to commit suicide. Her mother was dependent on her father and could not live independently from him. But the attachment was ambivalent and unsatisfactory; clearly her mother did not feel fulfilled by the marriage or by the children or by her creative work.

## Summary

Margaret was afraid that she was too much like her mother. Her relationship with Ned was a psychological parallel for the relationship between her parents. Like

her mother, Margaret believed she could not give up Ned because she would then drown in a sense of abandonment. On the other hand, she feared marrying Ned because he was self-centered and in some ways unstable, and she did not love him enough. As Margaret could deal more authentically with her separation and independence from her mother, while also accepting the painful reality of the loss then she could risk separation from Ned. She engineered this separation and tolerated it well, while using the therapist as an interim relationship.

In the therapy she also worked through her feelings of being neglected by her father, especially when she heard of his plans to remarry a younger woman who was about Margaret's age. Rage at all abandoning figures, including the therapist, with whom termination was impending, was an important topic for working through in the therapy, in which she continued to use her style of switching topics or attitudes toward the same topic. The therapist's awareness of this defensive style allowed him to help her temper's use, that is, to use it when her emotions were too threatening at a given moment or to not use it and stay with a topic when her emotions were anticipated to remain within tolerable limits.



## CHAPTER 16

# Suicide of a Friend

*With Robert Hammer*

Tim is a 31-year-old single man whose friend committed suicide shortly after a plea for help. During the weeks that followed, Tim felt so haunted by his dead friend that he was motivated to seek treatment. He was unable to sleep, was afraid of the dark, and had startle reactions and unbidden images. During a brief psychotherapy treatment these symptoms were relieved. The suicide of his friend was also linked associatively with the death of his father several years earlier. When the therapist established a situation of safety through a tactful maintenance of Tim's self-esteem, it initiated a mourning process that had not begun at the time of the father's death.

Jack was Tim's friend and in some ways his leader for several years. His was the role of a man who knows women and is successful at work. Then for about a year while each was involved in other activities, they seldom met. Recently, Jack had called Tim, and they had spent a long evening together. Jack spoke of feeling depressed and meaningless. He asked Tim to spend more time with him and hinted at moving in with Tim. Tim inwardly recoiled. He was aware of a strong feeling that he did not want to be sucked in. He did not want to rescue Jack; they had not been that close recently. But on the surface he presented a friendly demeanor and tried to cheer Jack throughout the evening.

A few days later, Tim received a telephone call from Carol, a woman who was a close friend of Jack's and a person Tim had recently dated. Carol was worried. Jack was missing and had left a note that suggested a possible suicide. Once again Tim was concerned but did not want to become involved. Over the next four days Tim periodically felt anxious that Jack might be playing some type of trick to get back at him for not being more concerned. Then on the fifth day Carol called again to say that Jack had shot himself and that his body had been found in some nearby hills.

Carol asked Tim to join some friends in a funeral service. Feeling pressured, he refused but then felt that he had acted in an aloof and callous manner. Within days he developed insomnia, a phobia of the dark, and intrusive thoughts about Jack that at times were so vivid that he could feel his presence as a menace within the room. Below is the opening of the first interview in which he described some of these symptoms.

## First Session

*Tim:* A friend of mine shot sh-shot and killed himself; I don't know, about ten days ago; since that time I was afraid of the dark and I'd keep a light on. At first it took me forever to get to sleep; I kept, I'd keep wanting to open my eyes to look around to see if anyone were around in the apartment. I experienced periods during the day when I was frightened, felt very empty, extremely alone (*pause*); every time I drive by the hills I hate to look in the direction to where I think he was when he shot himself (*pause*). I don't even want to know the specifics, but I have general information about it (*pause*). His body was taken to a funeral home which happens to be very near where I live. Every time I go by there I hate to. I just get very uncomfortable, and (*pause*) I don't like dealing with a woman whom he was involved with, who I happen to work with somewhat now. I felt like she was going to suck me into this thing, into a funeral and extend it, and that was very upsetting. I had a talk with her last night about how I don't want to have anything else to do with her whatsoever (*pause*), and then on top of that, I started thinking about my own life and how I'm not happy with it. I dislike it, how I want to change certain things in it (*pause*), how I'm lonely, want to get closer to somebody, thinking about having a family, and having a job that I would like to put energy into (*pause*), but mainly right now I just want to get rid of all these feelings about him (*pause*). I can't stand it, it's hard for me to, he crops up when I'm alone all the time. . . .

*T (therapist):* You mean sort of intrudes on your mind?

*Tim:* Yeah, this morning, washing my face, I have soap in my eyes, with my eyes closed, I keep thinking all of a sudden somebody is going to touch my arm, and there's no one in the apartment (*pause*). I don't know why I freak out on that; I just force myself to finish washing my face, and then I open my eyes and I'm okay, look around; it's daylight, and everything's fine. . . .

*T:* How have you been sleeping lately?

*Tim:* I was sleeping a little better—at first I had all the lights in the apartment on; now I'm down to one in the living room which I'm very much aware of from my bedroom. Until last night I was definitely sleeping much better each night. I wasn't feeling much. I was better, and then I had this confrontation

with this mutual friend, this woman, and that upset me and I felt nervous in my stomach, and it was hard for me to get to sleep. It makes me a little angry, the whole thing, that it should bother me.

*T:* It makes you angry.

*Tim:* Angry. I figure the way to get rid of the stress, for me, is to start doing things I want to do that make me happy and to stop sitting around on my ass 'cause then I just think about him. But I feel I move like a snail toward things I want to do.

During the beginning of the first hour, the therapist noted that Tim in his display of earnestness seemed pronounced and displayed a kind of charm that invited smiles, nods of agreement, and reassurances. There were unusually frequent requests for the therapist's interpretations and personal responses, all of which would have been premature or inappropriate. The therapist thus found it necessary to make some effort not to react with either faint warmth or a withdrawal from the patient.

Tim had obtained psychotherapy on several previous occasions. He had entered both individual and group treatment after his father's death several years before, when he had felt not so much sad as empty, alienated, and aimless. These therapies had focused on his difficulties in maintaining intimate attachments with both men and women. Since developing the intrusive images of Jack, Tim had already gone to a gestalt therapy group. There he had worked on these symptoms, and he described it during the interview.

*Tim:* I took a gestalt therapy group which I haven't found helpful. I wanted more personal attention.

*T:* You wanted what?

*Tim:* I wanted more personal attention. This thing was so stressful for me; I felt that I had to get on it now and work on it closely, work on improving my life closely with somebody, and I felt that it wasn't going to happen at the gestalt therapy.

*T:* Have you been able to talk about this in the gestalt therapy?

*Tim:* I talked about it yesterday. I had Jack on a pillow, you know, this guy on a pillow, and I yelled at him. I said: "I don't want to think about you anymore. I want to get on to living." Did that whole thing. And I didn't get what I wanted out of there. I was leaving, and one of the senior consultants there, I went up to him and I had wanted to ask him for a hug, but I hadn't been able to in the group, well, he said, that was fine, he would give me a hug afterward, anyway. And then he said, you know—he didn't know what to say. And I interpreted that to mean that he couldn't offer me any help about this thing. And that was, I didn't like that; I felt lonely. I felt like saying (*angrily*): "Hasn't anyone died in your life or something, and haven't you had to work it through? Can't you even tell me that?" I didn't say that, though.



Tim criticized the gestalt therapist for behavior he felt bad about in his own relationship with Jack. “He couldn’t offer me any help.” Tim also seemed to denigrate the gestalt therapy in order to win the approval of the present therapist, to whom he related rapidly and superficially. Tim appeared ready to idealize the present therapist as a shaman who would exorcise Jack’s ghost and diminish Jack as a person with the power to hurt him.

Tim watched the therapist intently. If he talked about his problems to an extent that might be embarrassing, he would then switch to another version of the story that put him in a better light. In telling of his relationship with Jack, Tim spoke alternately of caring and not caring, as if trying to move from a blameworthy to a praiseworthy position. The danger of an uncaring and strong self-concept was that he would in that role-relationship model feel criticism of self for hurting or using others. The danger in a role-relationship model of self as responsibly caring was the associated sense of weakness and personal vulnerability. The therapist did not comment on these shifting self-concepts. He concentrated instead on trying to develop a shared model of the sequence of events and a therapeutic alliance in which his role would be defined as giving neither blame nor praise but, rather, clarification of what had happened and was happening now.

Later during the first hour, the therapist was surprised by Tim’s expression of intense anger toward Carol and the gestalt therapist. In essence, Tim regarded Jack’s death and its aftermath as an imposition on him, which had weakened him by depleting his energies. This imposition was personified by others who made demands on him or did not contribute to his well-being. He was especially intense in his anger with Carol, who he felt was trying to “milk Jack’s death for all it was worth” and to “move in on him” in doing so. He minimized all of his own questionable attitudes and displayed Carol in a bad light.

## Second Session

The second hour can be summarized as one of transference testing. Tim reported feeling much better. His phobia of the dark had improved, and he could sleep with fewer lights on in the house. This was followed by a eulogy about Jack’s good qualities. He then attempted to engage the therapist in sweeping theoretical reviews of his current life problems and to communicate a nonspecific readiness for an “in-depth” approach. His wish to please the therapist was clearly apparent but, because of his vulnerability to shame, was not interpreted. Instead the therapist diligently leaned toward a continued reconstruction of the stressful event, Tim’s state before it happened, and the sequence of subsequent events. His benevolent non-reaction to the patient’s provocations for expressions of

closeness seemed to be reassuring. Tim then went on to review his life history, commenting on various patterns and meanings he connected by himself.

### Third Session

In the third hour Tim seemed to be dejected and closer to the therapist, and again solicited sympathy. He described general feelings of fear and helplessness and gradually related these to an identification with Jack. The next associations led to Tim's first discussion of his father, who had died of cancer some years previously, and from whom Tim had inherited some money. His mother had tried to get closer to him and also felt that she should have a greater portion of the money from his father's will. He felt that his mother was trying to suck him in and was being selfish, the therapist linked this feeling to Tim's reactions to Carol as trying to suck him in after Jack's death.

### Fourth Session

During the fourth hour Tim was more defensive than he had been throughout the first three hours. He maintained an aloof, overmodulated state of mind. Even in such a state, however, he gave useful information. He talked glibly about his conflicted attitudes toward women. He enjoyed fantasies replete with sadistic but harmless play. But in his actual relationships with women, he tended to be so submissive that he felt they soon lost interest in him. There was a certain exhibitionistic quality about his stories of sexual relationships, as if he were saying pointedly that he was heterosexual rather than homosexual. The therapist accepted these demonstrations at face value and did not interpret them. Rather, he worked to maintain a steady and nondirective interest in Tim in order to stabilize his self-esteem and gain empathy for what might be going on beneath the defensive surface.

### Fifth Session

A few weeks had now passed since Jack committed suicide. Carol called to invite Tim to join several friends at the site of the death, where they would have a final farewell ceremony for Jack. But Tim was determined not to go and tried to make other plans for that day, of a concrete and defiantly pleasurable nature. In this, the fifth hour, Tim spoke with some pressure of how he wanted to avoid thinking of Jack because it "would drive me crazy." The therapist sensed that it

was necessary to ask him what this meant. Tim, with embarrassment bordering on a sense of deep humiliation, reported that although he had said he was feeling better, he had still been having recurrent intrusive images of Jack. Though he could not describe this quite as directly as it is stated here, he had not talked about these intrusions because he was afraid the therapist would withdraw from him because he had not improved rapidly enough.

In the intrusive images Tim saw Jack, still alive and bleeding from his wound, having second thoughts and crying out for help. The therapist quietly said, "Jack felt alone." Tim then related "alone" to how he himself felt alone and talked of his own suicidal ruminations and his identification with Jack. He then worked on the association to himself of "having second thoughts." He had second thoughts that he should have been more willing to reestablish his closeness to Jack and thereby prevent Jack's need for such a desperate escape from loneliness. This line of thought was repeated throughout subsequent therapy sessions, and as Tim reviewed his acts and decisions, he confirmed for himself that though he did feel guilty, he was not responsible for rescuing either Jack or Carol.

As he returned to the idea of suicide and whether or not persons should be rescued, Tim revealed for the first time that his father had contemplated suicide and had entered therapy. Tim had felt then the way he had felt with Jack, that he should give more affection to his father but did not want to drain himself. He used the treatment as an excuse; he did not have to get close to his father because it might interfere, in some nebulous way, with the therapeutic process. His father had, at this time, tried to get closer to Tim, but in a needy rather than paternal way. This abortive effort at intimacy or, as Tim experienced it, at using him, had been repeated after the diagnosis of cancer.

In more normal times, the father had treated Tim imperiously. A successful businessman, he regarded Tim as an appendage rather than a successor whom he might groom to take on adult work. Tim thus had been placed in a need-fear dilemma. He felt dependent on his father and lonely without his love, but whenever he got close to him, he felt used.

## Sixth Session

At the sixth session, Tim reported feeling more depressed. After the last hour he had felt like talking with his mother. In a long telephone conversation with her, he had had both positive and negative feelings. His mother seemed to make herself more available to him and wanted more contact, but he was uneasy about becoming closer to her and the possibility of being used. The similarity of his images of his mother and Carol and his fears of being "sucked in" were worked on. Although he feared being used, he also had bad self-images when he backed off from people.

He then spoke of feeling bad when he approached women. He felt as if he was “taking them over.” The emotions of these “strong” images were isolated; he did not feel virile and competitive, only vaguely disturbed over issues of right and wrong. Avoidance of the imagined blame in the therapist’s eyes seemed to Tim to be an important motive for how the information about these meanings was processed. For example, he readily changed the designation of attributes, sometimes labeling the one in need as himself and other times as Carol. The therapist’s interventions were to clarify his own emotions and attitudes about having the experience.

Tim became uncomfortable talking of his mother and Carol and, as he showed avoidance, began to discuss sports. He described his enthusiasm and vitality while playing ball. He imagined that the therapist was “a fellow jock” who empathized with this and felt warm and close. The therapist asked if this reminded him of anyone. He then spoke of how he and his father had played ball and of how it was the only time of sharing between them. He entered an undermodulated crying state, which became more modulated. He spoke of continuing with sports as some kind of celebration of his father’s memory.

## Seventh Session

The following hour was characterized initially by flat affect and his aloof, overmodulated state of mind. Tim talked vaguely of current work and dating problems. The therapist commented that he “seemed to have more difficulty getting started this hour” and asked in a kindly way if they might reflect on it together to see why this might be. With hesitation, Tim entered a shimmering state with both signs of earnest expressivity and warding-off behaviors. In this state he reported that he was having “difficulty thinking about his father.” This acquisition of the therapist’s word usage (*difficulty*) was noteworthy. The implicit shield of certification seemed to enable him to contemplate warded-off ideas without feeling like a bad person for having them.

He went on to say that he had stopped thinking about his father when he was alone. As he spoke, Tim checked the therapist with penetrating glances to see whether he felt that such avoidance was acceptable or blameworthy. When he seemed reassured that the therapist was not angry with him, he expressed anger with his father. He questioned the need to let himself feel sad; his father did not deserve his positive and sad feelings because he had given Tim so little during his life. Tim should be selfish too, a person who needs no one. The same held true for Jack. Tim was angry that he had been made to feel as though he should be a rescuer. He did not know how to be of help to anyone else and did not want to be expected to try.

## Remaining Sessions

In the nine ensuing hours, Tim and his therapist worked through his fear of being “sucked in,” his anger, and his fear of retaliation for neglecting Jack. A mourning process had been initiated. As part of this process they worked on his feelings toward his father and his father’s death, as well as on the symbolic connections between his father and Jack and between Carol and his mother. The process in relation to his father can be summarized as follows.

## Discussion

During Tim’s mourning process, the threat of injury to his self-concept was prominent in the themes that were warded off and in the transference attitudes that were activated by approaching these themes. Rage at neglect was the central theme, and it had to be viewed in terms of self-experience as both the neglected person and the person to blame for the neglect. Tim placed himself in both roles in relation to Jack and his father.

When Tim saw his father as healthy and powerful and when he saw Jack as the masterful leader, he felt anger at their lack of interest in him. When he saw his father and Jack as in need, Tim felt withdrawn and even found them repugnantly weak. He then feared that they would in turn be angry with him. If he were to care for and help others then he feared that he would be drained, lose independence, and be doomed to serve the identity of another. By dying, his father and Jack seemed to confirm to Tim that he was at fault.

His problem was warding off this blame. He expected the rage of others in the form of either angry demands on him or revenge for neglect. This fearful expectancy was represented in the intrusive images of Jack who had, symbolically, come back to haunt or assault him.

As Tim recalled and related memories of being with his father during his terminal illness, he realized that he felt bad that he had not been more giving to his father, just as he regretted not being more supportive of Jack. But this awareness emerged in stages. He softened the potential injury to his self-esteem by first presenting material about how others were to be blamed. By implication he was then not to blame, or not completely to blame. For example, he explained to the therapist that the reason he had not told his dying father that he loved him was because his mother had told him not to do so. Her rationale was that if he told his father that he loved him, it would be an unusual event, and so his father would then realize that he must be terminally ill.

As he spoke of his regret for not telling his father of his feelings, he expressed rage at his mother. He pointed out to the therapist that she was also to blame for making his father uncomfortable when, because she was worried about money, she would not provide luxuries for the hospital room. Only when he was further along in the working-through process could he acknowledge that as a person in his late twenties, he was independent enough to decide for himself what to say or to do for his father and that his holding back was related to his own discomfort with his closeness to his father and his fear of his father's illness.

As Tim dealt with the issues of himself as self-centered and related this to his mother's and father's selfishness, he experienced the therapist in such roles. He felt that the therapist would be critical and angry with him for neglecting the therapy and at times tested the therapist for this countertransference potential.

At the height of this transference, Tim usually regarded the therapist's interpretations as reprimands rather than insights. He would feel more aloof from the therapist when he thought the therapist was enthralled with the theory that Tim's reaction to Jack's death was connected with his reaction to his father's death. Tim could then disavow that such feelings were his own by believing that he was manipulating the therapist as he continued the theme only in order to make the therapist happy. If he did not feel praised for such continuation, then he would feel that the therapist was angry with him. During this period, he felt that he and the therapist were each, in some way, neglecting the other. Rage would be vaguely in the air, never fully attached to either person.

It was necessary for the therapist to avoid direct interpretation of the externalization of blame during the period when Tim's defense to preserve his self-esteem was paramount. A premature comment that Tim blamed his mother for what he blamed in himself would have been taken as a slur, as Tim was not yet ready to tolerate the experience of bad attributes in himself. He first had to contemplate the idea of blame for neglect at a distance, to see whether it was safe. Then, gradually the attribution could move from others to himself.

Although the therapist avoided overly direct interpretations, he did encourage this working-through process. For example, when Tim talked about not saying that he loved his father, the therapist helped clarify which persons communicated what ideas, what his mother said about not telling his father, what Tim felt like saying but did not say, what he said to his mother, what he said to his father, and so on.

With such work Tim made contradictory statements. When he felt too bad about not expressing affection, he said that he had shown his father that he cared. But when he felt less threatened, he said that he had not expressed himself to his father. A tactful approach meant avoiding confronting Tim with contradictions but, rather, encouraging a gradual movement along a train of thought that he had been inhibiting and distorting.

With this rudimentary outline of some themes, it is possible to put them into a sequence of thought. Some of the principal concurrent defensive operations are indicated below in parentheses.

- My father (and Jack) is a powerful man. He does not do enough for me; I like him but I hate him for that (ambivalence of attitude).
- I would like to be powerful like my father (and Jack); then I would not need him.
- I will model myself after him while watching out for the danger of being used by him or being sucked in by him.
- He (father, Jack) is not omnipotent; he can feel pain, weakness, and death.
- I must move further away from him (father, Jack) to avoid contamination with death or extreme need. I am afraid it is too late; the same thing may happen to me.
- By moving further away, I did not save him (father and Jack) or even help him during his suffering (need to experience remorse).
- Jack, like my father, will be enraged and get back at me (projection).
- These images and my feeling that he is present are either evidence he is out to get me or show I am weak and going crazy.
- But I am not to blame. I refuse to believe I should have done more. People are wrong to expect anything of me. I refuse to think any more about this (denial, suppression, disavowal).
- It is not true that I moved away from Jack or my father (slides meanings to alter the story).
- Even if it is true, then others did it too, more than me. They are to blame (externalization).
- Even though others moved away and bear their responsibility, I am responsible that I moved away from him (father, Jack).
- Although I did not do all that I might have, I am still not a terrible person. My neglect did not directly kill them.
- I miss my father and am sad that it was not better between us.
- I am sorry that he (father, Jack) died; I wish I had done more. But even though I did not do as much as I would have liked, it is not true that they are now enraged at me.
- Even though it is true that I felt an inner rage that my father did not do more for me, that rage did not kill him (or Jack). So I do not have to bear total responsibility for his death (father, Jack).

As indicated by the later items in this condensed ideational line, Tim began to grieve not only for the father he had lost but also for an ideal father he had never had. As one example of this mourning process, he had a kind of restitutorial

fantasy in which he was a surgeon operating on his father and saving his life. This fantasy condensed many feelings: his anger (cutting open his father), his rescue wishes (saving him), his need to be strong and admirable (the brilliant surgeon), and his need to be omnipotent against death.

Tim's symptoms were relieved. With the cessation of intrusive images of Jack entering or being present in his apartment, he was able to go to bed with the lights off and to sleep through the night. His anxiety attacks stopped, and he felt confident that he had worked through the stress event. He had shown a readiness to deal with his character problems and a wish to advance from his less-than-optimal pre-stress level of character development. For these personality problems, long-term psychotherapy was recommended as a possible future choice for him to make.





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# About the Author

Dr. Mardi Horowitz was awarded the Lifetime Achievement Award by the International Society for Traumatic Stress Studies, and also the Foundation's Fund Research prize by the American Psychiatric Association for the first edition of *Stress Response Syndromes*; this book led the criteria for PTSD (in *DSM-3*, published in 1980). This work, in its successive and highly acclaimed editions provided an effective and evidence based psychotherapeutic approach. In addition, basic understanding of mental processes was enhanced by the author's emotional information assimilation model.

The author is a Distinguished Professor of Psychiatry at the University of California at San Francisco, President of the San Francisco Center for Psychoanalysis and Past-President of the Society for Psychotherapy Research. Dr. Horowitz's books include *A Course in Happiness*, *Grieving as Well as Possible*, *Understanding Psychotherapy Change*, *Person Schemas and Maladaptive Interpersonal Patterns*, *Personality Styles and Brief Psychotherapy*, *Cognitive Psychodynamics*, and *Formulation as a Basis for Planning Psychotherapy Treatment*.

## Other books by Mardi Horowitz, M.D.

*Image Formation and Cognition*

*Image Formation and Psychotherapy, 3rd edition*

*Psychosocial Function in Epilepsy*

*Hysterical Personality Style and the Histrionic Personality Disorder*

*States of Mind: Configurational Analysis of Individual Personality*

*Personality Styles and Brief Psychotherapy* (with Marmar, Krupnick, Wilner, Kalreider, and Wallerstein)

*Psychodynamics and Cognition*

*Introduction to Psychodynamics*

*Nuances of Technique in Dynamic Psychotherapy*

*Person Schemas and Maladaptive Interpersonal Patterns*

*Psychic Structure and Change in Psychoanalysis* (with Kernberg and Weinshel)

*Formulation as a Basis for Planning Psychotherapy Treatment*

*Cognitive Psychodynamics*

*Essential Papers on Post Traumatic Stress Disorder*

*Understanding Psychotherapy Change*

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*Assessment Based Treatment of PTSD*