Stress Response Syndromes

Character Style and Dynamic Psychotherapy

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Clinicians have gained considerable knowledge about psychopathology and treatment but this knowledge is poorly systematized and hard to transmit. One way to organize clinical knowledge is to circumscribe a limited area and describe within it the interactions between personality dispositions, states of disorder, and treatment techniques.

This report models such an approach by limiting disorder to stress response syndromes, personality to obsessional and hysterical neurotic styles, and treatment to focal dynamic psychotherapy. Within this domain, an information processing approach to working through conflicted ideas and feeling is developed. The result is a series of assertions about observable behavior and nuances of technique. Since these assertions are localized conceptually, they can be checked, revised, refuted, compared, or extended into other disorders, dispositions, and treatments.

Stress response syndromes are the topic, but the larger aim of this report is to test a model for organizing clinical knowledge. The model integrates variables that characterize current state, personal style, and treatment technique. To reduce information to a coherent level, particular categories along each dimension are designated. The interactions are then examined. Here, a particular domain is circumscribed by state in terms of stress response syndromes, disposition in terms of obsessional and hysterical personality, and by treatment in terms of focal psychodynamic psychotherapy. If this model works for circumscribing a domain and assembling assertions within it, then it can be used with other states, styles, and treatments. The resulting organization of clinical knowledge would allow a clear focus for resolution of disputes about observation and therapy.

RATIONALE FOR CHOICES

State: Stress Response Syndromes

Stress response syndromes have been chosen because the general symptomatic tendencies are well documented, observed across various populations, and usually change rapidly during psychotherapy. External stress events are usually clear and provide the therapist with a point of reference for consideration of other material.

Disposition: Hysterical and Obsessional Neurotic Styles

"Obsessional" and "hysterical" styles are classical typologies in dynamic psychology. Theorization about these styles is at the same level of abstraction as theories of stress, in that both stress response syndromes and obsessional and hysterical styles have been described in terms of potentially conscious cognitive and emotional processes. Information processing theory will thus provide a useful language.

Technique: Crisis-Oriented Psychodynamic Therapy

The goals of psychotherapy are infinite. Here they will be limited to conceptual and emotional working through of the stress response syndrome to a point of relative mastery, a state in which both denial and compulsive repetition are reduced or absent.

Nuances of techniques such as repetition, clarification, and interpretation will be focused on, since these maneuvers are on an information processing level of abstraction. The nature of the relationship between patient and therapist will also be examined, but the complexities of transference and resistance will not be discussed in detail.

The basic knowledge relevant to each choice will now be summarized and followed by development of their interactions.

The Natural Course of Stress Response Syndromes

Multiple meanings confound the use of the word "stress." In psychiatry, the central application is concerned with the stress event that triggers internal responses and evokes potentially disruptive quantities or qualities of information and energy. A prototype of a stress event is a highway accident and an elaboration of this prototype will be used to provide a concrete reference for what follows.

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Before developing this example, some reminders set the stage. Freud and Breuer[4] found that traumatic events were repressed and yet involuntarily repeated in the form of hysterical symptoms. While some "reminiscences" of their hysterical patients stemmed more from fantasy than from reality, the central observation of compulsive repetition of trauma was validated in many later clinical, field, and experimental studies.[5-8] A second common set of stress responses includes ideational denial and emotional numbing. These signs seem antithetical to intrusive repetitions and are regarded as a defensive response.[9-11] Tendencies to both intrusive repetition and denial-numbing occur in populations that vary in predisposition, after stressful events that vary in intensity and quality, and may occur simultaneously in a given person or in patterns of phasic alteration.

There is a common pattern to the progression of phases of stress response. With the onset of the stress event, especially if it is sudden and unanticipated, there may be emotional reactions such as crying out or a stunned uncomprehending daze. After these first emotional reactions and physical responses, there may be a period of comparative denial and numbing. Then an oscillatory period commonly emerges in which there are episodes of intrusive ideas or images, attacks of emotion, or compulsive behaviors alternating with continued denial, numbing, and other indications of efforts to ward off the implications of the new information. Finally, a phase of "working through" may occur in which there are less intrusive thoughts and less uncontrolled attacks of emotion with greater recognition, conceptualization, stability of mood, and acceptance of the meanings of the event.[11-13]

THEORY OF PSYCHIC TRAUMA

Freud's theories about trauma have two important aspects: the neurotic and energic definitions of traumatization. In early theory, a traumatic event was defined as such because it was followed by neurotic symptoms. To avoid circularity, a theoretical explanation of traumatization was necessary. The energic explanation defined as traumatic those events that led to excessive incursions of stimuli. In a series of energy metaphors, stimuli from the outer world were postulated to exceed a "stimulus barrier" or "protective shield." The ego tried to restore homeostasis by "discharging," "binding," or "abreacting" the energy. Energy, instinctual drives, and emotions were often conceptually blended together in this model.

While Freud repeated energy metaphors throughout his writings, he also conceptualized trauma in cognitive terms more compatible with contemporary psychodynamic models. As early as 1893 in his lecture "On the Psychical Mechanism of Hysterical Phenomena," he spoke of how one could deal with the affect of a psychic trauma by working it over associatively and producing contrasting ideas.[14] Also, implicit in his formulations of signal anxiety is the concept of ideational appraisal of events and their implications.[15]

The concept of information overload can be substituted for excitation or energy overload.[3,16] Information applies to ideas of inner and outer origin as well as to affects. The persons remain in a state of stress or are vulnerable to recurrent states of stress until this information is processed. It is the information that is both repressed and compulsively repeated until processing is relatively complete. Emotions, which play such an important part in stress response syndromes, are not seen as drive or excitation derivatives, but as responses to ideational incongruities and as motives for defense, control, and coping behavior. This view of the centrality of ideational processing is consistent with French's conceptualization of integrative fields[17] and the concept of emotion with ideational incongruities is concordant with cognitive formulations of emotion,[20] and cognitive-neurophysiological formulations.[21]

Prototypic Example

These generalizations will be given concrete reference in the form of a story. The story is intended as a prototype and will be elaborated in various ways as an exercise. That is, the story will allow a hypothetical constancy of events and problems but a variation in personality style. We shall imagine this story as if it happened to two persons, one with an hysterical neurotic style, the other with an obsessional style. Thus, similar response tendencies to the same stress event can be contrasted in terms of stylistic variations and the nuances of treatment applicable to these variations.

Harry is a 40-year-old truck dispatcher. He had worked his way up in a small trucking firm. One night he himself took a run because he was short-handed. The load was steel pipes carried in an old truck. This improper vehicle had armor between the load bed and the driver's side of the forward compartment but did not fully protect the passenger's side.

Late at night Harry passed an attractive and solitary girl hitchhiking on a lonely stretch of highway. Making an impulsive decision to violate the company rule against passengers of any sort, he picked her up on the grounds that she was a hippy who did not know any better and might be raped.

A short time later, a car veered across the divider line and entered his lane, threatening a head-on collision. He pulled over the shoulder of the road into an initially clear area, but crashed abruptly into a pile of gravel. The pipes shifted, penetrated the cab of the truck on the passenger's side, and impaled the girl. Harry crashed into the steering wheel and windshield and was briefly unconscious. He regained consciousness and was met with the grisly sight of his dead companion.

The highway patrol found no identification on the girl, the other car had driven on, 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 sat with him, found him anxious and dazed that night, talking episodically of the events in a fragmentary and incoherent way so that the story was not clear.

The next day he was released. Against his doctor's recommendations for rest and his wife's wishes, he returned to work. From then on, for several days, he continued his regular work as if nothing had happened. There was an immediate session with his superiors and with legal advisors. The result was that he was reprimanded for breaking the rule about passengers but also reassured that, otherwise, the accident was not his fault and he would not be held responsible. As it happened, the no passenger rule was frequently breached by other drivers, and this was well known throughout the group.

During this phase of relative denial and numbing, Harry thought about the accident from time to time but was surprised to find how little emotional effect it seemed to have. He was respon-

sible and well-ordered 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 in which mangled bodies appeared. He awoke in an anxiety attack. Throughout the following days, he had recurrent, intense, and intrusive images of the girl's body. These images together with ruminations about the girl were accompanied by anxiety attacks of growing severity. He developed a phobia about driving to and from work. His regular habits of weekend drinking increased to nightly use of growing quantities of alcohol. He had temper outbursts over minor frustrations, experienced difficulty concentrating at work and even while watching television.

Harry tried unsuccessfully to dispel his ruminations about feeling guilty for the accident. Worried over Harry's complaints of insomnia, irritability, and increased alcohol consumption, his doctor referred him for psychiatric treatment. This phase illustrates the period of compulsive repetition in waking and dreaming thought and emotion.

Harry was initially resistant, in psychiatric evaluation, to reporting the details of the accident. This resistance subsided relatively quickly and he reported recurrent intrusive images of the girl's body. During the subsequent course of psychotherapy, Harry worked through several complexes of ideas and feelings linked associatively to the accident and his intrusive images. The emergent conflictual themes included guilt over causing the girl's death, guilt over the sexual ideas he fantasied about her 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. To a mild extent, there was also a magical or primary process belief that the girl "caused" the accident by her hitchhiking, and associated anger with her, which then fed back into his various guilt feelings.

COMMENTS

Before continuing with those conflicts triggered by the accident, it is helpful to consider, at a theoretical level, the ideal route of conceptualization that Harry should follow. To reach a point of adaptation to this disaster, Harry should perceive the event correctly; translate these perceptions into clear meanings; relate these meanings to his enduring attitudes; decide on appropriate actions; and revise his memory, attitude, and belief systems to fit this new development in his life. During this information processing, Harry should not ward off implications of the event or relevant associations to the event. To do so would impair his capacity to understand and adapt to new realities.

Human thought does not follow this ideal course. The accident has many meanings sharply incongruent with Harry's previous world picture. The threat to himself, the possibility that he has done harm, the horrors of death and injury, and the fear of accusation by others seriously differ from his wishes for personal integrity, his current self-images, and his view of his life role. This dichotomy between new and old concepts arouses strong painful emotions that threaten to flood his awareness. To avoid such unbearable feelings, Harry limited the processes of elaborating both "real" and "fantasy" meanings of the stressful event.

Because of complex meanings and defensive motives that impede conceptualization, the traumatic perceptions are not rapidly processed and integrated. They are stored because they are too important to forget. The storage is in an active form of memory that, hypothetically, has a tendency toward repeated representation. This tendency triggers involuntary recollections until processing is completed. On completion, the stored images are erased from active memory.[3-8] (This memory is called "active" rather than "short-term" because of the extended duration of intrusive repetitions of stress-related perceptions.) The repetitions, however intrusive, can be adaptive when they provoke resumption of processing. They can be maladaptive when they distract from other tasks, elicit painful emotions, evoke fear of loss of mental control, and motivate pathological defenses.

Table 1.—Themes Activated by the Accident

Current Concept—Incongruent With—"Enduring" Concept		Emotion
A. Self as "aggressor"		
1. Relief that she and not he was the victim	Social morality	Guilt
2. Aggressive ideas about girl	Social morality	Guilt
3. Sexual ideas about girl	Social morality	Guilt
B. Self as "victim"		
1. Damage to her body could have happened to him	Invulnerable self	Fear
2. He broke rules	Responsibility to company	Fear (of accusations)
3. She instigated the situation by hitchhiking	He is innocent of any badness; the fault is outside	Anger

Defensive operations that oppose repetition can also be adaptive because they allow gradual assimilation rather than overwhelming recognition. Defense maneuvers can be maladaptive if they prevent assimilation, lead to unrealistic appraisals, perpetuate the stress response symptoms, or lead to other problems, such as Harry's alcoholism.

The six problematic themes of Harry's psychotherapy can now be reconsidered as ideational-emotional structures in schematic form. These themes will provide a concrete referent during the ensuing discussion of character style variations. In Table 1, each theme is represented as a match between a current concept and enduring concepts. Since there is an incongruity between the new and the old, the elicited emotion is also listed.

Three themes cluster under the general idea that Harry sees himself as an aggressor and the girl as a victim. For example, he felt relief that he was alive when someone "had to die." The recollection of this idea elicited guilt because it is discrepant with social morality. He also felt as if he were the aggressor who caused a victim to die because of his wish to live, a primitive concept that someone has to die, and a belief in the magical power of his thought. Similarly, his sexual ideas about the girl before the crash were recalled and were incongruent with his sense of sexual morality and marital fidelity. All three themes are associated with guilty feelings.

Three other themes center around an opposite conceptualization of himself, this time as a victim. Harry is appalled by the damage to the girl's body. It means his body could also be damaged. This forceful idea interferes with his usual denial of personal vulnerability, and is in-

consistent with wishes for invulnerability. The result is fear. Harry also conceives of himself as a victim when he recalls that he broke company rules by picking up a passenger. Since the breach resulted in a disaster, and is discrepant with his sense of what the company wants, he believes accusations would be justified and is frightened. "Harrys" with varying character styles would experience this same theme in different ways. A Harry with a paranoid style might project the accusation theme and suspect that others are now accusing him. He might use such externalizations to make himself feel enraged rather than guilty. If Harry had a hysterical style, he might have uncontrolled experiences of dread or anxiety without clear representation of the instigating ideas. Were he obsessional, Harry might ruminate about the rules; about whether they were right or wrong, whether he had or had not done his duty, about what he ought to do next, and on and on.

The last theme cited in Table 1 places Harry as a victim of the girl's aggression. His current ideas are that she made the disaster happen by appearing on the highway. This matches with his enduring concept of personal innocence in a way that evokes anger. These angry feelings are then represented as a current concept and responses occur to these concepts that again transform Harry's state. His felt experience of anger and his concept of the girl as aggressor do not mesh with his sense of reality. The accident was not her fault and so, as the state of ideas change, his emotional experience (or potential emotional experience) changes. He feels guilty for having irrational and hostile thoughts about her. With this switch from the feelings of victim to the feelings of aggressor, there has been a change in emotions from anger to guilt and, as diagrammed in Table 1, in state from B3 to A2.

All six themes might be activated by the accident. In "Harrys" of different neurotic character styles, some themes might be more important or conflictual than others. In a hysterical Harry, sexual guilt themes (A3) might predominate. In an obsessional Harry, aggression-guilt (A2), concern for duty (B2), and "self as an innocent victim" themes (B3) might predominate. Other themes, such as fear of body vulnerability (B1) and guilt over being a survivor (A1) seem to occur universally.[7,16]

Harry had a period in which there was relative denial and numbness for all the themes. Later, at various times after the accident, some themes were repressed and others emerged; eventually some were worked through so that they no longer aroused intense emotion or motivated defensive efforts. The first emergent themes were triggered by the nightmare of mangled bodies and the daytime recurrent unbidden images of the girl's body. The themes of bodily injury and survivor guilt (A1 and B1) were no longer completely warded off but rather occurred in an oscillatory fashion with periods of both intrusion and relatively successful inhibition. In psychotherapy, these intrusive themes required first attention. The other themes such as sexual guilt emerged later.

General Stratagems of Treatment for Stress Response Syndromes

At least two vectors effect stress response syndomes: the tendencies to repeated representation and the tendencies to inhibited representation to prevent disruptive emotions. The general rationale of treatment is to prevent either extreme denial, which might impede conceptual and emotional processing, or extreme intrusive-repetitiousness, which might cause panic states or secondary avoidance maneuvers. Various "schools" of therapy have evolved techniques for counteracting extremes of denials or repetitious states, and these are tabulated in Table 2.

Table 2.—Classification of Treatments for Stress Response Syndromes

Systems	States: Denial-Numbing Phase	States: Intrusive-Repetitive Phase
Change Controlling processes	Reduce controls Interpretation of defenses Hypnosis & narcohypnosis Suggestion Social pressure & evocative situations; eg, psychodrama Change attitudes that make controls necessary Uncovering interpretations	Supply controls externally Structure time & events for patient Take over ego functions, eg, organize information Reduce external demands & stimulus levels Rest Provide identification models, group membership, good leadership, orienting values Behavior modification with reward & punishment
Change Information processing	Encourage abreaction. Encourage: Association Speech Use of images rather than just words in recollection & fantasy Enactments, eg, role playing, psychodramas, art therapy Reconstructions (to prime memory & associations) Maintenance of environmental reminders	Work through & reorganize by clarifying & educative type interpretive work Reinforce contrasting ideas; eg, simple occupational therapy, moral persuasion Remove environmental reminders & triggers Suppress or dissociate thinking, eg, sedation, tranquilizers, meditation
Change Emotional processing	Encourage catharsis Supply objects & encourage emotional relationships (to counteract numbness)	Support Evoke other emotions, eg, benevolent environment Suppress emotions eg, sedation or tranquilizers Desensitization procedures Relaxation & biofeedback

Once extreme symptoms are reduced, the tendency to bring stress-related information to a point of completion. This "completion" can be defined, at the theoretical level, as a reduction of the discrepancy between current concepts and enduring schemata. The crucial feature is not discharge of pent-up excitation, as suggested by the terms "abreaction" and "catharsis," but processing of ideas. To complete the response cycle, either new information must

be reappraised or previous concepts must be modified to fit an altered life. Emotional responses will occur during this process when conflicts of meanings are fully considered.

Investigation, in focal psychodynamic treatment, includes examination of conflicts present before and heightened by the immediate situation, as well as the loaded meanings given to stressful events because of prior development experiences and fantasies. Conscious representation is encouraged because it promotes the solving of problems not resolved by automatic, out-of-awareness thought or dreaming. The communicative situation encourages representation and reexamination, and techniques of repetition, clarification, and interpretation enhance the on-going process.[22]

The state of stress imposed by a particular life event may impose a general regression in which developmentally primitive adaptive patterns will be noted, latent conflicts will be activated and more apparent, and increased demand for parental objects will affect all interpersonal relationships. These general regressive signs will subside without specific therapeutic attention, if the state of stress is reduced by working through the personal meanings of the particular life event.

The problem in therapy is to provide tolerable doses of awareness because knowledge of the discrepancies between desire and reality leads to painful emotional responses. On his own, the patient has warded off such knowledge to avoid pain and uncertainty. In therapy, while the affective responses are painful, they are held within bearable limits because the therapeutic relationship increases the patient's sense of safety.[23] In addition, the therapist actively and selectively counters defensive operations by various kinds of intervention. These interventions are, most commonly, clarification and interpretation of specific memories, fantasies, and impulse-defense configurations.

The aim of these techniques is completion of ideational and emotional processing and hence, resolution of stress state rather than extensive modification of character. However, persons of different character structure will manifest different types of resistance and transference during this process. The general techniques will be used with various nuances depending on these dispositional qualities of the patient. As illustration, hysterical and obsessional variations on these general themes will now be considered.

HYSTERICAL STYLE IN RESPONSE TO STRESS

Background

The concept of hysterical character was developed in the context of psychoanalytic studies of hysterical neuroses, even though these neuroses may occur in persons without hysterical character and persons with hysterical styles do not necessarily develop hysterical neurotic symptoms, even under stress. The discussion will briefly develop the "ideal" typology of hysterical style with the assumption that most persons will have only some of the traits and no person will fit the stereotype perfectly.

The main symptoms of hysterical neuroses are either conversion reactions or dissociative episodes.[24] Both symptom sets have been related to dynamically powerful but repressed ideas and emotions that would be intolerable if they gained conscious expression.[14-16] In classical analytic theory, the intolerable ideas are a wish for a symbolically incestuous love object. The desire is discrepant with moral standards and so elicits guilt and fear. To avoid these emotions, the ideational and emotional cluster is warded off from awareness by repression and denial. Because the forbidden ideas and feelings press for expression, there are continuous threats, occasional symbolic or direct breakthroughs, and a propensity for traumatization by relevant external situations. While later theorists have added the importance of strivings for dependency and attention ("oral" needs), rage over the frustration of these desires, and the fusion of these strivings with erotic meanings, the correlation of hysterical symptoms with efforts at repression has been unquestioned.[25-27]

Psychoanalysts view hysterical character as a configuration that either *predisposes* toward the development of conversion reactions, anxiety-attacks, and dissociative episodes, or exists as a *separate entity* with similar impulse-defense configurations but different behavioral manifestations. The hysterical character is viewed as typically histrionic, exhibitionistic, labile in mood, and prone to act out.

Because of a proclivity for acting out oedipal fantasies, clinical studies suggest that hysterical persons are more than usually susceptible to stress response syndromes after seductions, especially those that are sadomasochistic; after a loss of persons or of positions that provided direct or symbolic attention or love; after a loss or disfigurement of body parts or attributes used to attract others; and after events associated with guilt about personal activity. In addition, any event that activates strong emotions, such as erotic excitement, anger, anxiety, guilt, or shame, would be more than usually stressful, even though an hysteric might precipitate such experiences by his behavior patterns.

Clinical studies also indicate what kinds of responses may be more frequent in the hysteric during and after the external stress event. Under stress, the prototypical hysteric becomes emotional, impulsive, unstable, histrionic, and possibly disturbed in motor, perceptual, and interpretive functions.

Styles of thought, felt emotion, and subjective experience are of central relevance to the present theses and have been described by Shapiro.[28] He emphasized the importance of impressionism and repression as part of the hysterical style of cognition. That is, the prototypical hysteric 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 distractability and incapacity for persistent or intense concentration. The historical continuity of such perceptual and ideational styles leads to a relatively nonfactual world in which guiding schemata of self, objects, and environment have a flat, depthless quality.

Dwelling conceptually in this nonfactual world promotes the behavioral traits of hysterical romance, empha-

sis on fantasy meanings, and *la belle indifference*. For example, the prototypic hysteric 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 may remember his own emotional experiences unclearly and will regard them as if visited on him 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 of hysterical style is presented below.

Information Processing Style
Short-order patterns—observe in flow of thought and emotion on a topic
Global deployment of attention
Unclear or incomplete representations of ideas and feelings, possibly with lack of details or clear labels in communication; nonverbal communications not translated into words or conscious meanings
Only partial or unidirectional associational lines
Short circuit to apparent completion or problematic thoughts
Traits
Medium-order patterns—observe in interviews
Attenion-seeking behaviors, possibly including demands for attention, and/or the use of charm, vivacity, sex appeal, childlikeness
Fluid change in mood and emotion, possibly including break-throughs of feeling
Inconsistency of apparent attitudes
Interpersonal Relations
Long-order patterns—observe in a patient's history
Repetitive, impulsive, stereotyped interpersonal relationships often characterized by victim-aggressor, child-parent, and rescue or rape themes
"Cardboard" fantasies and self-object attitudes
Drifting but possibly dramatic lives with an existential sense that reality is not really real

Shapiro's formulations differ from clinical psychoanalytic opinion in terms of the stability of such patterns. Shapiro regards the patterns as relatively fixed, perhaps the result of constitutional predisposition and childhood experiences. Other analysts regard these patterns as more likely to occur during conflict. The following discussion will not contradict either position, since both allow us to assume a fixed base line of cognitive-emotional style and an intensification of such patterns during stress.

Controlling Thought and Emotion: Harry as "Hysteric"

Harry will now be considered as if he responded to stress and treatment in a typically hysterical manner. One of his six conflictual themes, as described earlier, will be used to clarify the hysterical mode of controlling thought and emotion. This theme concerns Harry's relief that he is alive when someone had to die (See A1, Table 1).

Considered in microgenetic form, Harry's perceptions of the dead girl's body and his own bodily sensations of being alive are matched with his fear of finding himself dead. The discrepancy between his perceptions and his fears leads to feelings of relief. The sense of relief is then represented as a conscious experience.

In the context of the girl's death, relief is incongruent with moral strictures. Harry believes that he should share the fate of others rather than have others absorb bad fate. This discrepancy between current and enduring concepts leads to guilt. Harry has low toleration for strong emotions and the danger of experiencing guilt motivates efforts to repress the representations that generate the emotions.

While repression helps Harry escape unpleasant ideas and emotions, it impedes information processing. Were it not for controlling efforts, Harry might think again of the girl's death, his relief, and his attitudes toward survival at her expense. He might realize that he was following unrealistic principles of thought, forgive himself for feeling relief, undertake some act of penance and remorse if he could not change his attitude, or reach some other resolution of the incongruity between the current concept with his enduring schemata.

If repression is *what* Harry accomplishes, one can go further in microanalysis to indicate *how* it is 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 girl's body are too powerful to ward off and, immediately after the accident, Harry might have behaved in an "uncontrolled" hysterical style. Later, when defensive capacity was relatively stronger, the active memory images can be inhibited, counteracting the tendency toward 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 can be inhibited.

Suppose this inhibition fails or is only partly successful. Warded off ideas are expressed in some modality of representation. In a secondary maneuver, the extended meanings of the ideas can still be avoided by inhibition of translation from initial modes to 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 image and word forms but not continue in development of obvious associational connections. The purpose would be avoidance of full conscious awareness of threatening meanings.

These controlling efforts are three typically hysterical forms of inhibition: avoidance of representation, avoidance of translation of threatening information from one mode of representation to another, and avoidance of automatic associational connections. If these efforts fail to ward off threatening concepts, there are additional methods. A fourth maneuver is the reversal of role from active to passive. Harry could avoid thinking about his own active thoughts by deploying attention to how other factors (fate, the girl, or the listener to his story) are involved. He could then change the attitude that he was 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 girl's activity in hitch-hiking, and of how she got herself

into the accident.

The fifth and last "hysterical" maneuver is alteration of state of consciousness. Metaphorically, if the hysteric cannot prevent an idea from gaining consciousness, he removes consciousness from the idea by changing the organization of thought and the sense of self. Harry used alcohol for this purpose, but no outside agents are necessary to enter a hypnoid state, with loss of reflective self-awareness. These five cognitive maneuvers can be listed as if they were a hierarchy of "rules" for the avoidance of unwanted ideas:

1. Avoid representation
2. Avoid intermodal translation
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: (1) alter hierarchies of wishes and fears; (2) blur realities and fantasies; (3) dissociate conflicting attitudes; and (4) alter the sense of self as instigator of thought and action.

The hysteric has further maneuvers, but these extend longer in time. Harry could manipulate situations so that some external person could be held responsible for his survival. This reduces the danger of a sense of guilty personal activity. In terms of 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 fantasied, which would make any act, or thought crime, their responsibility and not his.

Clarity in Therapeutic Interventions: An Important Nuance With Persons Who Have Hysterical Style

If the person of hysterical style enters psychotherapy because of stress response symptoms, the therapist will try to terminate the state of stress by helping him to complete the processing of the stress-related ideas and feelings. The 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 be useful to remove impediments to processing, but the main goal in the present 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 (as in Table 2) used with appropriate nuances.

These 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 noticeable effect on the hysteric who may respond with a startle reaction, surprise, laughter, or other emotional expressions. The same words uttered by the therapist mean something different from when they are thought or spoken by the hysteric himself; they are to be taken more seriously.

Additional meanings 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 meanings more clearly, hears new meanings as well, and the previously warded 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 by connection of causal sequences. At first, when Harry was vague about survivorship, but said "I guess I am 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 badly 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 to giving him permission by saying "You feel guilty over a thought that anyone would have in such a situation"; although this is, of course, sometimes necessary. As will be seen, *these simple everyday maneuvers are not as effective with persons of obsessional style.*

Other therapeutic maneuvers oriented toward helping the hysteric complete the processing of stressful events are equally commonplace. To avoid dwelling further on well-known aspects of psychotherapy, some maneuvers are listed in tabular form as applicable to specific facets of hysterical style (Table 3). Each maneuver listed has additional nuances. For example, with some hysterics, interpretations or clarifications should be very short and simple, delivered in a matter-of-fact tone that would serve to counter their vagueness, emotionality, and tendency to elaborate any therapist activity into a fantasy relationship.

Nuances of Relationship With the Hysterical Patient in a State of Stress

Hysterical persons have a low toleration for emotion, although they are touted for emotionality. 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 stressful event can be increased, then cognitive processing of that event can be resumed. The therapeutic relationship protects the patient from the dangers of internal conflict and potential loss of controls, and so operates to increase tolerance for warded off ideas and feelings. The therapist effects the patient's sense of this relationship by his or her activities or restraint. How this is typically done is also a nuance of technique.

After a stress event, the hysterical patient often manifests swings from rigid overcontrol to uncontrolled intrusions and emotional repetition. *During these swings, espe-*

cially at the beginning and with a desperate patient, the therapist may oscillate between closeness and distance within the boundaries that characterize a therapeutic relationship.

The hysteric 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.[25,26,29] During the period of imperative need, especially after a devastating stress event, the hysteric may need to experience warmth and human support from the therapist. Without it, the therapeutic relationship will fall apart, the patient may regress or develop further psychopathology. During this phase the therapist moves, in effect, closer to the patient: just close enough to provide necessary support and not so "close" as the patient *appears* to wish.

As the patient becomes more comfortable, he may begin to feel anxiety at the degree of intimacy in the therapeutic relationship because there may be a fear of being seduced or enthralled by the therapist. The therapist then moves back to a "cooler" or more "distant" stance.

The therapist thus oscillates to keep the patient within a zone of safety by sensitive modification of his manner of relating to the patient. Safety allows the patient to move in the direction of greater conceptual clarity.[30,31] Naturally, the therapist's manner includes his nonverbal and verbal cues. This is what the therapist *allows* himself to do in the context of his own real responses and qualities of being. This is *not* role playing. The therapist allows or inhibits his own response tendencies as elicited by the patient.

If the therapist does not oscillate in from a relatively *distant* position, and if the patient has urgent needs for stabilizing his self-concept through relational support, then the discrepancy between need and supply will be so painful that the patient will find it unendurable to expose problematic lines of thought. Inhibition would continue. If the therapist does not oscillate from a relatively *close* position, then conceptual processing will begin but transference issues will cloud working through the stress response syndrome. Neither clarity nor oscillation by the therapist may be a suitable nuance of technique with the obsessional.

OBSESSIVE STYLE IN RESPONSE TO STRESS

Background

Contemporary theory of obsessional style evolved from analysis of neurotic obsessions, compulsions, doubts, and irrational fears. Abraham[32] and Freud[33] believed the obsessional neuroses to be secondary to regressions to or fixations at the anal-sadistic phase of psychosexual development. The manifestations of the neuroses were seen as compromises between aggressive and sexual impulsive aims and defenses such as isolation, intellectualization, reaction formation, and undoing. Underneath a rational consciousness, ambivalent and magical thinking were noted to be prominent. Common conflicts were formed in the interaction of aggressive impulses and predispositions to rage, fears of assault, and harsh attitudes of morality and duty. These conflicts lead to coexistence and fluctuation of dominance and submission themes in interpersonal situations and fantasies.

Table 3.—Some "Defects" of the Hysterical Style and Their Counteractants in Therapy

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

Salzman[34] emphasized the obsessional's sense of being driven, his strivings for omniscience and control, and his concerns for the magical effects of unfriendly thoughts of both the self and others. Homosexual thoughts may also intrude, although often without homosexual behavior.

Vagueness seems less possible for the obsessional than the hysteric. Since they tend more toward acute awareness of ideas, staying with one position threatens to lead to unpleasant emotions. Seeing the self as dominant is associated with sadism to others and leads to guilt. Seeing the self as submissive is associated with weakness and fears of assaults; hence, this position evokes anxiety. Alternation between opposing poles, as in alternation between sadistic-dominance themes and homosexual-submissive themes, serves to undo the danger of remaining at either pole.[35,36]

To avoid stabilization at a single position and to accomplish the defense of undoing, obsessionals often use the cognitive operation of shifting from one aspect of a theme to an oppositional aspect and back again. The result is continuous change. At the expense of decision and decisiveness, the obsessional maintains a sense of control and avoids emotional threats.[37-39]

While the obsessional moves so rapidly that emotions do not gain full awareness, he or she cannot totally eliminate feelings. Some obsessionals have intrusions of feelings either in minor quasi-ideational form, as expressed in attacks of rage. Even when this occurs, however, the event can be undone by what Saltzman calls "verbal juggling." This process includes alterations of meaning, the use of formulas to arrive at attitudes or plans, shifts in valuation from over- to under-estimation, and, sometimes, the attribution of magical properties to word labels.

Shapiro[28] has described the narrowed focus of the mode of attention of the obsessional person, how it misses certain aspects of the world while it engages others in detail. Ideal flexibility of attention involves smooth shifts between sharply directed attention and more impressionistic

forms of cognition. The obsessional lacks such fluidity.

He also describes how the obsessional is driven in the course of his thought, emotion, and behavior by "shoulds" and "oughts" dictated by a sense of duty, by his fears of loss of control, and by his need to inhibit recognition of his "wants." In spite of his usual capacity for hard work, productivity, and "will power," the obsessional person may experience difficulty and discomfort when a decision is to be made. Instead of deciding on the basis of wishes and fears, the obsessional 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 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 a feeling of anxious self-doubt, a mood instigated by the absence of cognitive closure.

This discussion has focused on aspects of cognitive style. These are summarized below with common traits and patterns of behavior.

Information Processing Style

Short-order patterns—observe in flow of thought and emotion on a topic
- Detailed, sharp focus of attention on details
- Clear representation of ideas, meager representation of emotions
- May shift organization and implications of ideas rather than follow an associational line to conclusion, as directed by original intent or intrinsic meanings
- Avoid completion or decision of a given problem, instead switch back and forth between attitudes

Traits

Medium-order patterns—observe in interviews
- Doubt, worry, productivity and/or procrastination
- Single-minded, imperturbable, intellectualizer
- Tense, deliberate, unenthusiastic
- Rigid, ritualistic

Interpersonal Relations

Long-order patterns—observe in a patient's history
- Develop regimented, routine and continuous interpersonal relationships low in "life," vividness, or pleasure: often frustrating to "be" with
- Prone to dominance-submission themes
- Duty-filler, hard worker, seeks or makes strain and pressure, does what he "should" do rather than what he decides to do
- Experiences himself as remote from emotional connection with others, although feels committed to operating with others because of role or principles

Controlling Thought and Emotion: Harry as an "Obsessive"

Stressful events may so compel interest that there may be little difference in the initial registration and experience of persons with hysterical or obsessional style. But, short of extreme disasters, the obsessional person may remain behaviorally calm and emotionless in contrast to the emotional explosions of the hysteric. (This report demands such generalizations, but it should be noted that during some events, obsessionals may become quite emotional and hysterics may remain calm. The difference remains in the quality of the person's conscious experience. The hysterical person can have a "hysterical calm" because it is based on an inhibition of some aspects of potential knowledge, no emotion occurs because implications are not known. If and when the obsessional behaves emotionally, it may be experienced by him as a loss of control, one to be "undone" by retrospective shifts of meaning, rituals, apologies, or self-recriminations.)

After a stressful event, the obsessional and the hysteric may both exhibit similar general stress response tendencies, including phases of denial and intrusion. But they may differ in their stability in any given phase. The obsessional may be able to maintain the period of emotional numbing with greater stability, the hysteric may be able to tolerate phases of episodic intrusions with more apparent stability and less narcissistic injury.

During the oscillatory phase, when the uncompleted images and ideas of the current stressful concepts tend to repeated and intrusive representation, the hysteric is likely to inhibit representation to ward off these unwelcome mental contents. The obsessional may be precise and clear in describing the intrusive images, but may focus on details related to "duty," for example, and away from the simple emotion-evoking meanings of the gestalt of the image.

It is during the oscillatory phase of both intrusions and warding off maneuvers that styles stand out in starkest form. Instead of, or in addition to, repressive maneuvers as listed earlier, the obsessional responds to threatened repetitions with cognitive maneuvers such as shifting. By a shift to "something else," the obsessional is able to jam cognitive channels and prevent emergence of endurance of warded-off contents, or to so shift meanings as to stifle emotional arousal. That is, by shifting from topic to topic, or from one meaning to another meaning of the same topic, the emotion-arousing properties of one set of implications are averted.

Treating Harry: Modeled Here as an Obsessional Personality

In discussion of a hysterical Harry, the theme of survival guilt was used as an example. An obsessional Harry might share a tendency toward emergence of the same theme but react to this threat with a style characterized by shifting rather than vagueness and inhibition.

In psychotherapy, Harry begins to talk of the unbidden images of the girl's body. He associates now 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 (theme A1 in Table 1). Once 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.

Harry does not follow this idealized route because the potential of these emotional experiences is appraised as intolerable at a not fully conscious level of information

Table 4.—Some "Defects" of Obsessional Style and Their Counteractants in Therapy

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

able 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 introjects that might otherwise deflect thought.

Focusing on details is sometimes a partial deterrent to shifting in the obsessional, just as it may aid clarity with the hysteric. The nuances of focusing on details differ because the purposes differ. In general, the aim with the hysteric is to move from concrete, experiential information, such as images, toward more abstract or more extended meanings, such as word labels for activities and things. The aim with the obsessional is to move from abstract levels, where 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 utilizes the obsessional's predisposition to details but allows the therapist to specifically select them. Again, the nuance of asking for concrete details is part of the general aim of increasing conceptualization time.

In states where 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 girl's body, and then repeats in a single package the disparate attitudes that the patient oscillates between. For example, the therapist might tell Harry that the image of the girl'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, since simpler holding operations may be sufficient and the therapist can focus on a single theme.

These efforts by the therapist encroach on the habitual style of the patient. The patient may respond by minimizing or exaggerating the meaning of the intervention. The obsessional is especially vulnerable to threats to his sense of omniscience, especially after traumatic events. If the therapist holds him on a topic, the obsessional senses warded off ideas and feelings and develops uncertainties that cause his self-esteem to fall.

To protect the patient's self-esteem, the therapist uses another technical nuance. He 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. The obsessional patient can then credit himself with expressing these ideas and experiencing these feelings. The therapist with the hysterical person might, in contrast, interpret at such a moment, using a firm, short delivery, since a question might be followed by vagueness.

To the obsessional, incisive interpretations often mean that the therapist knows something he does not know. A transference bind over dominance and submission arises as the patient either rebels against the interpretation with stubborn denial, accepts it meekly without thinking about it, or both.

Timing is also important with obsessionals working through stress-activated themes. After experience with a given patient, the therapist intuitively knows when a shift is about to take place. At just that moment, or a trifle before, the therapist asks his question. This interrupts the shift and increases conceptual "time and space" on the topic about to be warded off. These technical nuances are put in a crude, broad context in Table 4.

Nuances of Relationship With Obsessional Patients in a State of Stress

The oscillation described as sometimes necessary with the hysterical style is not as advisable with the obsessional style. Instead, the therapist creates a safe situation for the patient by remaining stable within his own clear boundaries (eg, objectivity, compassion, understanding, concern for the truth, or whatever his own personal and professional traits are).

The patient learns the limits of the therapist within this frame. It gives him faith that the therapist will react neither harshly nor seductively. This trust increases *the patient's* breadth of oscillation. He can express more aggressive ideas, if he knows the therapist will neither submit, be injured, compete for dominance, or accuse him of evil. Harry could express more of his bodily worries when he knew the therapist would not himself feel guilty or overresponsible.

If the therapist changes with the obsessional's tests or needs, then the obsessional worries that he may be too powerful, too weak, or too "sick" for the therapist to handle. Also, the obsessional may use the situation to externalize warded off ideas or even defensive maneuvers. The therapist shifts, not he. This is not to say the obsessional does not, at times, need kindly support after disastrous external events. But his propensity for shifting makes changes in the degree of support more hazardous than a consistent attitude, whether kindly-supportive, neutral-tough, or otherwise.

processing. A switch is made to another ideational cycle in order to avoid the first one. The second cycle is also associatively related to the images of the girl's body. A common element in both ideational cycles allows a pivotal change and reduces awareness that the subtopic has changed.[40]

The pivot for the switch is the idea of bodily damage. In the second ideational cluster, the concept is that bodily damage could happen to him, perhaps at any future time, since it has now happened to her. Through the comparison with his wishes for invulnerability and his dread of vulnerability, fear is aroused (B1 in Table 1).

While fear is unpleasant and threatening as a potential experience, the switch allows movement away from the potential feelings of guilt (theme A1). When the second theme (B1) becomes too clear, fear might be consciously experienced. The procedure can be reversed with return to A1. Harry can oscillate in terms of conscious and communicative meanings between A1 and B1 without either set of dangerous ideas and emotions being fully experienced.

Harry need not limit switching operations to the two contexts for ideas about bodily damage. He can switch between any permutations of any themes. He can transform, reverse, or undo guilt with fear or anger.[41] He can see himself as victim, then aggressor, then victim, and so forth. These shifts dampen emotional responsivity but reduce cognitive processing of themes.

This does not imply that inhibition of representation will not be found in obsessional Harry or shifts of theme will be absent in hysterical Harry. Obsessional Harry will attempt inhibitions and use his shifts when inhibitory efforts fail. Hysterical Harry might shift from active to passive, as noted earlier, but timing and quality of the shifts would differ. Obsessional Harry would tend to shift more rapidly, with less vagueness at either pole. The shift could occur in midphrase, 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 obsessionals may be thwarted in their task. Suppose the therapist makes a clarifying intervention about A1, the survivor guilt theme. Obsessional Harry may have already shifted to B1, his fear of body injury, and thus hear the remarks in a noncongruent state. The clarification procedure may not work well because Harry was not unclear or vague in the first place, is not listening from the earlier position, and will undo the therapist's intervention by further shifts. An interpretation to the effect that Harry fears bodily damage as a retribution for his survivor relief and guilt would be premature since, at this point, he has not fully experienced either the fear or the guilt.

Holding to Context: Important Nuances With Persons Who Have Obsessive Character Style

Holding the obsessional to a topic or to a given context within a topic is equivalent to clarifying for the hysteric. *Metaphorically, the obsessional avoids conceptual time where the hysteric avoids conceptual space. The goal of holding is 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 begins with at least two current problems, such as the dual themes of A1 and B1 in Harry. When the patient is not shifting with extreme rapidity, the therapist may simply hold the patient to either one or the other theme.

The patient will not comply with this maneuver and the therapist must not confuse "holding" with "forcing." Ferenczi,[42] in an effort to speed up analysis, experimented with various ways to make the obsessional 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. During this technical maneuver his obsessional patients did experience emotions, they even had affective explosions, but the transference complications impeded rather than enhanced the therapy.

The therapist has to shift, even though he attempts to hold the patient to a topic. That is, the therapist shifts at a slower rate than the patient, like a dragging anchor that slows the process. This operation increases the progress of the patient 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 hysteric, in order to hold or slow the shift of an obsessional patient. But this use of the same maneuver is done with a different nuance. With the hysteric, the repetition heightens the meaning of what the patient is *now* saying. With the obsessional, the repetition goes back to what the patient was saying *before* the shift away from the context occurred. With the hysteric, the repetition may be short phases. With the obsessional, greater length may be necessary, in order to state the specific context that is being warded off. For example, if Harry is talking about bodily damage and shifts from a survivor guilt context to his fears of injury, then a repetition by the therapist has to link bodily damage specifically to the survivor guilt theme. With the hysteric, such wordy interventions might only diminish clarity.

At times, this more extensive repetition in the obsessional may include the technique of going back to the very beginning of an exchange, retracing the flow carefully, and indicating where extraneous or only vaguely relevant details were introduced by the patient. Reconstructions may add warded off details. This technique has been suggested for long-term character analysis,[31-34] during which defensive operations are interpreted so that the patient increases conscious control and diminishes unconscious restrictions on ideas and feelings. In shorter therapy, aimed at working through a stress, this extensive repetition is still useful, because, during the review by the therapist, the patient attends to the 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 toler-

Suppose the therapist becomes more kindly as Harry goes through a turbulent period of emotional expression of guilt over survival. Harry may experience this as an increase in the therapist's concern or worry for him. He might shift from the "little" suffering position that elicited the therapist's reaction, to a "big" position from which he looks 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 strong stubbornness to weak, vulnerable self-concepts. Within the context of this shift, the therapist comes to be experienced as hostile, demeaning, and demanding.

Unlike the hysteric, then, *the obsessional's shifts in role and attitude within the therapeutic situation are likely to be out of phase with changes in demeanor of the therapist.* The obsessional can chance further and more lucid swings in state when he senses the stability of the therapist.

Transference resistances will occur in spite of the therapist's effort to maintain a therapeutic relationship. The stability of the therapist will be exaggerated by the patient into an omniscience that he will continually test. When negative transferance 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. The hysteric may demand attention and halt progress to get it. The obsessional may take an oppositional stance not so much out of hostility or stubbornness, although such factors will be present, as out of a need to avoid the dangerous intimacy of agreement and cooperation. Since the therapist is not aiming at analysis of transference to effect character change, he need not interpret this process. Instead, with an obsessional patient in an oppositional stance, he may word his interventions to take advantage of the situation.

That is, interventions can be worded, when necessary, in an oppositional manner. Suppose Harry was talking about picking up the girl and the therapist knew he was predisposed to feeling guilty but was warding it off. With a hysterical Harry the therapist might say, "You feel badly about picking up the girl." With an obsessional and cooperative Harry he might say, "Could you be blaming yourself for picking up the girl?" With an oppositional obsessional stance, the therapist might say, "So you don't feel at all badly about picking up the girl." This kind of Harry may disagree and talk of his guilt feelings.

Provided the context is a basically stable therapeutic relationship, one in which the patient has an image of the therapist as objective, kindly, and firmly competent, the inflection need not be the sincere, neutral, firm tone helpful with hysterics. *Slight* sarcasm or *mild* humor may help the obsessional Harry assume a tough position while trying out his own tender ideas.[34]

By sternness, as implied in the above comments, the therapist may have the effect of "ordering" the obsessional to contemplate warded off ideas. This seeming unkindness is kind in that it removes responsibility from the patient and permits him to think the unthinkable. But this sternness, mild sarcasm, or slight humor has to remain a relatively consistent characteristic of the therapist.

This is not as difficult as it may sound, for *these nuances involve what the therapist allows himself to do or not do in natural response to the situation. They are not assumed or artificial roles or traits.* For some therapists, kindliness, openness, gentleness, and a nonjudgmental air are preferable nuances to any toughness, sternness, sarcasm, or honor and may accomplish the same purpose. These latter remarks are meant more as illustrations than assertions because it is here that we encounter that blurred border between the "science" and "art" of psychotherapy.

CONCLUSIONS

This report has taken a state of stress, considered the variations between two dispositional types within that state, and discussed the nuances of psychodynamic psychotherapy aimed at symptom relief. These dimensions, state, typology, and mode of treatment, define a frame of reference. Assertions have been made that are clearly positioned within this frame of reference. For example, stress response syndromes have been characterized by phases of denial and intrusion, hysterical persons have been described as using inhibition of representation to ward off intrusive and repetitive ideas and feelings, and clarity has been posited as an important nuance of their therapy. Obsessional persons were characterized by switching operations for the same purpose and holding operations were asserted to be important nuances of technique in their therapy.

Such assertions involve standard psychiatric knowledge. What is gained through this model is an organization for the systematic assemblage of such knowledge. With clear conceptual positionings of assertions, many of the arguments and divergencies that characterize psychiatry and psychology would fall away in favor of renewed empirical observation and formulation. The key is comparable rather than incongruous levels of abstraction.

To the extent that the model is worthwhile, the assertions here can be specifically challenged. General stress response tendencies may not follow the pathways defined, there may be better ways to typologize what was called "hysterical" and "obsessional," the nuances of focused psychodynamic psychotherapy described may be incomplete or inappropriate. A specific site of disagreement can be localized by following the same dimensions. For example, *an argument about a nuance of treatment would have to be connected with a specific kind of person, in an intrusive-repetitive phase after a stressful external event, involved in psychodynamic treatment aimed at relief of intrusions and resolution of the state of stress.*

While this type of model localizes conceptualization, it may be argued that it defines restrictively small areas. Within the general field of psychopathology and psychotherapy there would be multitudes of such areas. I believe that the field is so large that many specific subdivisions are indicated, and that knowledge will be accumulated and clarified by this method. The complexity is not overwhelming. The present model can be extended by keeping any two dimensions constant while extending the boundaries of the third. For example, extensions may involve

other variations of personality, other versions of pathological states, and other views of therapy.

Variations in typology would include narcissistic, schizoid, impulsive, and paranoid personalities. Each would be contrasted with hysterical and obsessional styles of response to stressful life events. Each would be considered in the context of brief dynamic therapy aimed at working through the life event and so central conceptual anchoring would be maintained.

Variations in state would include other formulations of the meaning of a crisis episode. For example, a contrasting view within the framework of brief psychodynamic therapy regards the life events as secondary in importance to enduring conflicts. The predominant state is seen as character patterns rather than phases of stress response. Separation from a lover would be seen as an occasion to work further on dependency-independency conflicts present for a long time.[43,44] Would the same nuances of treatment for varying styles apply in therapy oriented toward character conflicts?

Variations in treatment would maintain the set of stress response syndromes in certain common character types. Other technical approaches would provide contrasting points of view. For example, a behavior therapist would discuss treatment of such intrusive images as noted in Harry. He might advocate such approaches as systematic desensitization and implosion.[45] Learning theory hypotheses would be advanced equivalent to the repetition-until-completion tendency described in this paper. A rationale of treatment would be based on these hypotheses. Assertions would be advanced about how systematic desensitization and implosion work. The behavior therapist might assert that desensitization would be more suitable for hysterical styles because there is a progressive clarification of anxiety-provoking representations and a supportive patient-therapist relationship. He might prefer implosive techniques for obsessional styles, as this method can hold attention to a specific aspect of an ideational complex, provoke emotional response, and engage the patient in a "tough" appearing role-relationship.

These nuances of techniques within a behavior therapy point of view could then be contrasted with the assertions of the dynamic point of view, as well as with other technical possibilities. Nuances across schools might be developed. Hysterical vagueness might be seen as altered by any clarification technique such as role playing, psychodrama, transactional analysis, or gestalt therapy. Obsessional shifting of topics might be seen as altered by any holding technique such as systematic desensitization, implosion, or guided imagery techniques. Contrary assertions would, at least, be assembled at similar levels of abstraction. Disagreements could be resolved by further observation of given types of persons in a given state. In this way we might hope to pass beyond brand names as our professional disagreements become productive rather than schismatic.

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