STAGES OF PSYCHOTHERAPY FOR TRAUMA AND STRESSOR-RELATED DISORDERS

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Abstract

Psychotherapy technique should change as stages of treatment of stress response syndromes progress. Formulation helps clinicians determine what to do at each stage. This progression should allow for integration of modalities of therapy.

DSM-5 added a new category of Trauma and Stressor-Related Disorders. This framework now contains diagnostic criteria for Adjustment Disorder, Persistent Complex Bereavement Disorder, Acute Stress Disorder and Post-Traumatic Stress Disorder. These conditions share causation in exposure to a traumatic or stressful event as well as symptomatic responses of anhedonic, externalized angry, dysphoric and dissociative symptoms. Psychotherapy is the treatment of choice and many modalities have been developed (Horowitz, 2020; Aupperle, 2018; Hoge, Lee, & Castro, 2016). Clinicians need formulations that lead to individualized technique choices. Integrative approaches may be additive as patients go through stages of psychotherapy (Wampold, 2015).

Stages of Therapy

The first stage is **assessment**. Target symptoms may be selected. The next stage is often **support**. A therapist helps a patient form a therapeutic alliance and provides guidance about how to cope with current crises. An aim during support is to advance the patient's skills at expressing feelings without losing control.

As supportive techniques help a patient stabilize, the therapist adds techniques for an emotional **exploration of meaning**. The therapist may employ techniques for desensitization and distraction techniques to use for flashbacks (Foa, McLean, Zang, et al., 2018). A stage of **re-narration** follows. Information revision may lead towards rational appraisals of current, past and future stories. Traumatic events, especially earlier developmental adversities, effect identity and relationship schemas and these models may be updated and harmonized in a stage of re-schematization. In this stage, patient and therapist learn how to revise entrenched maladaptive roles and attitudes.

The final stage of termination prepares the patient for ending the consistently scheduled therapeutic alliance experiences. Table 1 summarizes these stages by emphasizing the activities for patient, therapist and the two in a therapeutic alliance.

(TABLE 1 about here)

Table 1: ***Common Stages in Psychotherapy***

Stage	Patient Activity	Therapist Activity	Therapeutic Relationship
Assessment	Reports events, symptoms, problems, and goals.	Obtains history, shares early formulations. Presents treatment options.	Agreement on initial frame.
Support	Expands story and focuses on coping with current stress.	Provides guidance on how to handle crises. Establishes safety for patient	Roles of a therapeutic partnership are defined.
Exploration of meanings	Expands on meaning to the self of the trauma and its sequelae.	Clarifies how emotions and ideas are linked.	Therapeutic alliance deepened by experience of safety.
Re-narration	Works on themes previously avoided.	Encourages tolerance of dysphoric emotional states. Helps the patient modify dysfunctional beliefs.	Negotiation of how to handle difficult moments.
Re-schematization	Plans how to restore a sense of self efficacy	Helps patient modify internal working models.	Expectations for the future are reappraised realistically.
Termination	Rehearses plans for how to cope with future problems.	Highlights the most helpful insights.	Emphasis on safe separation.

Personality features may increase the complexity of formulation and the length of treatment (Horowitz, 2011, 2016). When there are co-morbid personality disorders, every stage of therapy is affected. Even in the assessment stage, a therapeutic alliance is harder to form and may be challenged by transference and counter-transference attitudes and feelings. Therapeutic technique aims to teach safety in the alliance and help the patient learn to increase skills of self-regulation.

The issue of control of emotion leads therapists to face a technical choice at every stage of therapy. Trauma processing often involves a negotiation of a middle ground between two extremes of affect regulation. On the one hand, patients may be re-traumatized by re-experiencing alarming perceptual memories. On the other hand, patients preconsciously anticipate becoming flooded with emotion and may defend themselves by inhibition. Therapists aim at following a middle path between too much and too little emotional arousal of the patient. The configurational analysis (CA) method of formulation was developed to help a therapist navigate along this path.

CA is a sequential method with four components: 1) phenomena, 2) states of mind, 3) topics and defensive styles, and 4) configurations of self and relationship schemas (Horowitz, 2019). The first component, **phenomena**, is central to assessment. The patient and therapist identify symptoms, signs, and problems in living as targets for change. A specific phenomenon or a pattern of symptoms and behavioral dysfunction may occur only in some states of mind.

That is why the next analysis describes a patient's **states of mind**. A range of emotional regulation from under- to over-controlled is observed. State analysis provides some predictions of what may improve if certain techniques are employed and that leads to the guidance provided

as suggestions during the support stage of therapy. This converges with attention to what triggers shifts into distressing states.

Observing state shifts indicates unresolved emotional **topics**. Clarification of topics that trigger changes in emotional expression leads to techniques to advance cognitive processing during stages of exploring meaning and re-narration. The dilemma of patients in avoiding under-modulated emotional states (flooding) and inhibiting memory consolidation to prevent flooding is, when understood condusive to techniques to find a middle ground of working-through. This involves formulation of both current defensive obstacles and habitual defensive styles, as well as how to safely counteract them. This may involve dyadic regulation of emotion.

The fourth component of CA considers the dyad of self and other. This step infers a deeper layer of thought and emotion-organizing models; these models are the implicit contents of the patient's schemas for identity and relationships.

While deeper components of CA, such as inferring schemas for identity and relationship, may be tentatively described during assessment, an iterative process occurs as stages progress. Understanding increases. Early errors or ambiguities are very gradually clarified. Early predictions of what techniques might help are checked against observations. An updated formulation as stages progress is based on whether ongoing observations confirm or disconfirm the hypotheses.

Review of components of CA leads to **planning** of how and when to advance the stages. While each component may be considered at each stage, the assessment stage will emphasize attention to maladaptive phenomena such as symptoms, the support stage will emphasize states of emotional control and help the patient tolerate negative affects. That will allow more of an emphasis on clarifying and working on topics of concern in the exploration of meanings phase.

Then, in the re-narration and re-schematization stages the formulation of self and relationships will be augmented by consideration of developmental adversities and current traumatic memories. The therapist's aims deepen as formulation deepens over the course of therapy, as shown in Table 2. [Table 2 about here]

Table 2. Components of Configurational Analysis

Component	Purpose	Therapist's Aims
1. Phenomena	Select symptoms and problems.	Educate patient about symptom formation
2. States of mind	Describe states in which the symptoms and problems do and do not occur.	Counteract both flooding and excessive inhibition of expression. Teach affect tolerance and calming techniques.
3. Topics of concern	Describe topics that evoke problematic states. Describe how expression seems obscured by defenses.	Piece together dissociated fragments of memory. Clarify and challenge irrational beliefs and augment rational plans of action.
4. Identity and relationships	Infer roles and schemas of self and others for each recurrent state.	Modify maladaptive attitudes.
5. Therapy planning	Plan how to process topics and schemas so they do not lead to problematic phenomena and states.	Heighten the patient's sense of safety, emotional control and interpersonal skills.

Assessment and Support Stages

During the assessment and support stages, the therapist selects techniques to provide the patient with education and guidance. The goal is to improve coping and social functioning (Rothbaum, 2016). Advice on sleep, nutrition, exercise and connecting to support systems is given. Patients may learn calming techniques such as muscular relaxation, deep breathing, grounding as in body scans, mindfulness and gradated exposure to trigger situations (Foa, McLean, Zang, et al., 2018).

Statements by the therapist clarify the possible cause and consequence sequence in the patient's reaction to the stress. One useful technique is to validate and normalize the patient's fragmentary memory using a jigsaw puzzle metaphor. Jumbled pieces of recollection must be gradually reassembled (Clem and Schiller, 2016). Understanding segregation and dissociation of memories normalizes altered experiences and increases tolerance for distress.

Psychoeducation on the importance of accepting negative affects with continued self-care can reduce the patient's dread of what is next. Uncertainty feels less toxic when it is shared in dialogue and known to be a common human response to serious changes. The therapist may offer guidance on how to reduce loneliness and a sense of profound disconnection by increasing good social connections. Ways to actively engage family, friends, exercise and support groups are discussed. Such re-established belonging (even by remote media communications such as texts, online groups, phone or video) can help.

Assessment and supportive stages of psychotherapy include some state analysis. The therapist helps the patient understand how control of emotion and impulsivity varies from state to state. Describing apparent emotional control for *well-modulated, under-modulated, and over-modulated states* helps advance the therapist's individualized case formulations. Particular

emotional valences and qualities may be differentiated by degree of self regulation as when anger is expressed in a manageable mood or an explosive rage.

W*ell-modulated* states are preferable for optimum information processing and expressing emotions as connected to thoughts. The patient appears to be in self-command even when expressing distressing memories of stressor events. In well-modulated states, clinicians are likely to observe accord across the patient's verbal and non-verbal modes of expression. Over- and under-modulated states are shifts away from well-modulated states.

Under-modulated states include impulsive and relatively unregulated displays of feeling. If patients experience explosive entry into such states as rage, they may add distress from fear, shame or guilt about loss in self-control. In contrast, patients shifting into *over-modulated* states appear excessively restrained or rigid. They may display a poker face, pretend unfelt attitudes, or manifest what looks like detachment. The best progress in therapy is likely to be made in a well-modulated working state.

To stabilize well-modulated states, therapists may repeat what they heard and re-organize the sequence of ideas and expressions. This helps the patient slow down and clarify trains of thought.

A therapist need not intervene if patients shift into an over-modulated state as a means of giving themselves a temporary respite. If over-modulation of emotion is extended, the therapist may encourage patients to think about their reasons for shifting and explain the value of specifying emotional qualities. Saying "I am anxious," "I am depressed" is not the same as trying to understand what is felt. Stopping at a standard label may be a form of avoiding expression of particular feelings and attitudes.

Sharing observations of shift points can help patients reflect on themselves. Anticipating,

monitoring and moderating a potential shift into an undesirable state of mind can forestall it. A patient who is angry may express it quite differently in states of under-controlled righteous indignation, well-controlled expressed frustration, or over-controlled aloofness. When needed, the therapist can teach anger-management using a states of mind approach (Horowitz, 2019).

The Stages of Exploring Meanings and Re-narration

A therapist and patient may identify specific topics in a stage of exploring meanings. These are the themes that lead to emotional turmoil. Incompletely processed topics may include: "Why did this happen to me?" "Where is blame to be placed" and "Who failed to protect?"

Re-narration occurs as topics are explored (Herman, 1992). The therapist challenges dysfunctional beliefs and erroneous attributions of the meaning of events. The therapist can offer interpretations about perhaps erroneous beliefs that are used currently but are possibly entrenched maladaptive cognitions and expectations stemming from memories of adverse childhood events. Together, therapist and patient can use techniques of cognitive and emotional processing that develop shared, rational and present-day appraisals of meaning. Memory reconsolidation can occur as current events are understood in new ways, ones that may even modify unclear appraisals of what happened in earlier adversities (Riccio, Mullen, Bogart, 2006; Clem, Schiller, 2016).

Avoidance maneuvers such as using defensive mechanisms of denial, disavowal, repression and suppression may have inhibited the current development of rational new narratives. Obstacles to completing a train of thought such as inhibition of continuing attention can be pointed out in the present moment of their occurrence to the patient. Then the therapist can tactfully encourage more explicit talk about the previously unthinkable and previously warded-off content of ideas and emotional potentials. Realistic alternatives to dysfunctional

cognitions can be examined. Techniques that help reduce a patient's avoidances are summarized in Tables 3 and 4.

Table 3: Counteracting Avoidance of Ideational Specifics

Patient's Defensive Style	Therapist's Action
Selective inattention toward accurate discourse about the stressor events	Focus attention and provide verbal labels for chains of cause-and-effect sequences
Inhibitions of key emotion evoking ideas within topics of importance	Model explicit talking through repeated clarifications
Short-circuiting to erroneous conclusions.	Keep the topic open

Table 4: Counteracting Avoidance of Emotional Expression

Patient's Defensive Style	Therapist's Action
Excessively intellectualized.	Ask for feelings
Avoiding disclosure of emotion.	Ask about images and body sensations
Juggling meanings back and forth in a false binary.	Hold discussions on one valence of a topic and define a middle ground between binary polarizations
Endlessly ruminating.	Interpret desired, dreaded and tolerable "realistic" scenarios

Re-Schematization Stage

After successful progression through the stages of exploration of meanings and re-narration, a patient may recover equilibrium. Some patients, however, may continue to have dysfunctional interpersonal relationships that interfere with optimum recovery. If so, a stage of re-schematization may be needed. Now that post-traumatic effects are ameliorated, the patient can be helped to construct plans for better relationships and improve their social functioning in the present and near future (Herman,1992).

Schemas about oneself and others are not usually conscious; they are procedural rather than declarative knowledge. The therapist can help patients gain conscious awareness and reflect on explicit mental representations. Dysfunctional beliefs about themselves and others can be challenged. Especially after a traumatic loss of a significant other, a patient may need to change concepts about their identity and how they relate to other people, and perhaps also how they relate to communities and places. Old models of one's place in the world are outmoded, and adaptive, reality-appraising and accepting new ones need to be learned.

In addition, patients can harbor unrealistic ideas about the future now that past stressors have been partially processed. Through interactive dialogues in therapy, patients can be helped to elucidate their ideas about best case, worst case, and most realistic case scenarios. A configuration of wishful, fearful, and defensive stances used in an entrenched pattern of relationships can be illuminated.

The therapist labels dysfunctional ideas addressed at self and at others in contrast to more realistic appraisals of who did what, and when, with what intentions and consequences. Realistic appraisals of not reacting well during stressors lead to appropriate remorse and repair plans.

Excessive self-blaming, and devaluating routes to excessive guilt, shame and despair are repeatedly challenged as developmentally induced patterns that are not warranted in current adult functioning. Explicit interpretations can include elements of a role relationship model. (Horowitz,1991; Horowitz and Eells, 1993).

It may help to highlight the trusting role being learned within a therapeutic alliance as a corrective relational experience. Such reappraisal can change the patient's potential for establishing and maintaining safer and more compassionate interpersonal patterns of transaction. Making development-based beliefs explicit can lead to safety where danger was expected habitually (Silberschatz, 2017).

Patients functioning at lower levels of personality organization may need an extended stage of re-schematization. These patients, as discussed earlier in terms of personality disorder, may exhibit lower capacities for emotional control. Safety in dyadic regulation needs to be re-inforced gradually so that the patient can learn howto achieve adaptive re-schematizations. Such patients require more time, tact and parsing of statements by the therapist (Horowitz, 2016; Mullin and Hilsenroth, 2012; Lindfors, Knekt, Heinonen, et al., 2014). The therapist actively encourages patients to see themselves as agents of changing their understanding of what happened and what may happen next (Schauer, Neuner, Elbert, 2011; Greenberg, 2011).

When adverse childhood events have led to adult dysregulation of emotional expressions, self-states, and interpersonal behaviors, then a systematic effort to augment tolerance of dysphoria and amplify emotional control is indicated. Through an extended treatment, a continuous positive therapy relationship leads towards re-schematization of attachment models (Bowlby, 1969) and sustains attention to learning new skills (Linehan, 1993) as well as re-narrating the array of memories of adverse events (Herman, 1992).

Termination Stage

Rehearsals of new plans for transactional sequences can prepare the patient to enact improved interpersonal behaviors in the future. These plans can be highlighted again in the termination stage of therapy.

Conclusions

Each stage of psychotherapy for stress response syndromes has specific goals that both therapist and patient wish to accomplish, as shown in Table 5. Techniques to achieve these goals change as stages of therapy progress. The stage of assessment leads to clarity on what problems to address. The stage of support provides the patient with guidance for coping. As a sense of safety increases, the therapy enters a stage of exploring meanings to advance cognitive and emotional processing of stressor experiences. In the stage of re-narration, the patient and therapist consolidate memories by repeated appraisal of the effects of traumas and losses on the patient. In cases with dysfunctional personality issues. a long re-schematization stage may be needed before a stage of termination can be accomplished.

Table 5: Goals During Therapy

Stage	What Happens
Assessment	Patient increases knowledge of their symptomatic phenomena and feels validated
Support	Patient learns coping mechanisms and experiences therapist's empathy which augments their sense of self-worth
Exploration of Meaning	Patient thinks through trains of ideas and feelings without the previously anticipated shifts into states of emotional flooding
Re-narration	Patient changes a dire expectation of future loss and vulnerability and reconsolidates a life story
Re-schematization	Patient optimizes models of self in having more satisfying relationships
Termination	Patient plans to maintain adaptive changes in core beliefs and reconstructs plans for living well

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