A MODEL FOR ABREACTION WITH MPD AND OTHER DISSOCIATIVE DISORDERS

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ABSTRACT

:1 carted ltur! model for rrbreactine murk with uttthifile / 1(1snttrlli/ i and ollierrlissocirrtire dfsoaalers isfiresented. 7/ tecontext and fi ocrs.s of abreaction are described. The model ı nt ndeslIte/ ollonting CO npotterrIs: Providing safety and Jaratecliart (/1refialaliotet *eliciting dissorirrlerl aspects of the lrcorutrt (identification); (11(1' nut) rig the fixation point in existential crisis of the Irrttono (resolution),; creating rt gestu11 mills the dissociated aspects within* ruled *(SSgSI /1//C 5(1171//a (rlo/ ni7latiurll; 71/i arr'rrin !bc/1(Uien1117ra11,,h the)elltrrt of an internal locus of crrrtlrnl, restoration of rout/•trout ronsciousna'S5* owl *)iienmr, and assimilation of idctttitt (o/tfiliralivu}.*

INTRODUCTION

Dissociation is born of ovetsvhchning trauma. Stn-ivre s of severe trauma who have utilized dissociative defenses may have disturbances and interruptions of identity, consciousness, and/or tremor)' (American Psychiatric ,association. 1987). The therapeutic task with such individuals is to reassociate disrI.tpted memory patterns, to restore a continuity of consciousness, and to assimilate the patient 's identity into a unified whole.

Trauma of a severe and ongoing nattn e si ich as found in the historyohthose who multiple personality disorder (N1PD) and other dissociative disorders implies the loss of an hiterrral locus of control with resultant helplessness, the Presence of disintegrative terror in response to 1) the threatened annihilation of self and 2) to the experience ofunprotected vulnerability (Auerhahn & Laub, 1984; Figley, 1986; Kr}stal, 1968; Spiegel, 1988; van der Kolk, 1987). In catastrophic trauma the individual is reduced to an object with loss of the identity and meaning that normally provide a structure for ontological security: one is deprived of the basic need to experience continuity of being in a predictable and safe environment with relatively stable object relations. This helplessness. terror, and concurrent meaninglessness lie at the center of post traumatic responses ; and are the raison d'etre for dissociation.

Dissociation provides the method (1t didn't happen to me") by which the individual attempts to preserve the basic ontological security needed to maintain a cohesive sense of self and experience. Yet numbing and denial the leakage into consciousness of dissociated aspects of the trauma manifested and intrusion phenomena is evidence that dissociation is insufficient to resolve the trauma definiti'ely. Thus, iii the viewof most psychotherapists, a Psychic reworking of the trauma which identifies, releases, and assimilates the dissociated aspects becomes necessary to provide resolutic m and integration.

Abrcactive work is an integral part of the assimilation process with traumatized and dissociative patients (Braun, 1986; Comstock, 1986; Figlev_ 1985: Kluft, 1984, 1985b: Putnam, 1989: Ross & Callan, 1988a; Spiegel K Spiegel, 1978; van der Kolk. 1987: van der Kolk & Radish. 1987). Change and master evolve through the remembering, releasing, and relearning that occur during abreaction. However, abreactions that are poorly timed or directed, incomplete.distorted. too intense. or too attenuated will retrrcnatize the patient. promote deeper entrenchment in dissociative defenses, trigger premature re-repression, and create problematic transference issues.

The literature offers some caveats regarding the uses of abreaction with dissociative patients. Klttft (1988a) discusses the clangers of intense abreaction~ with the elderly and/or the infirm. The need to avoid abreactions in a group setting for multiple personality disorder patients has been observed (Caul, Sachs, & Braun, 1986). Many authors emphasize the importance of cognitive schema to organize the meanings of trauma, including verbal processing of the events (Braun, 1986; Donaldson & Gardner, 198): Fine, 1988b: Fish-Murray, Koby, & van der Kolk, 1987: Horowitz, 1976: Jehu. Klassen, & Gazan, 1985; ()rick, 1985).

Chu (1988a) and Kluft (1985b) describe the need to recognize. respect, and work through resistances to the uncovering of repressed or dissociated material inherent in abreactive experiences. Negative responses of the patient to the pain of abreaction have been delineated. These include resistance; multiple crises; suicidal, homicidal. and/or self nnttilative actions; substance abuse; and further dissociation and re-repression (Braun, 1986; Chu, 1988a; Courtois. 1988; Khuft, 1984, 1985b). Potentially harmful cottntertransference responses to the painful material presented by severely tratunat.ized patients, and indirectly, by ensuing abreactive work, have been described (Courtois, 1988: Daniell. 1980; Kluft, 1985b).

A variety of specialized techniques to manage abreactions and other de-repression phenomena have been de-

scribed (Comstock, 1986. I988: Klult, 1983, 1988. 1989; Putnam, 19891. The carefully planned use of hypnotic techniques for facilitation, stt.tenuation, :tne1 conminmeni of abreactions has been explored (Bliss. 1986;]hilt, 1982. 1983. 14f85b; Putn,un, 19851; Shapiro, 1988). I-hypnotic techniques during the ahrcactivc process may include supportive. uncovering, crisis, and integrative interventions. Kluft (1989) has described a number of. specific temporizing and pacing techniques useful in abreactive work. In addition to offering a thorough overview of ahreactivc]cork, Putnam (1989) has described several tapes of Itipnotherapcuttie techniques to prepare for and to utilize with ahreactions. These include trance-inducing and rtppm t building techniques: techniques for penetrating ,mmestic harriers; and ahreactive % healing techniques such as the screening bruin, permissive amnesia, symptom substitution. age progression, autohypuosis, facilitation of co-consciousness, and deep trance (l>1~.223-~31).

the use of hospitalization and restraints fin prolonged. intense, and (or extremely painful abreactions has been described (Sachs. Braun, & Shepp, 1988; Young, 1986). Abreactive Ivor]. utilizing modified play therapy has been advocated for children with multiple personality disorder (Fagan & 111cNlahon. 1984: Khan. 15186).

Although the literature agrees that abreaction is both useful and necessary for the integrative process following trauma, a conceptual framework that etu olllpasses the entire process of abreaction with dissociative patients has not been described. The purpose of this article is to provide a model for abreaction with dissociative patients and to delineate the necessary components of effective abreaction. This model has evolved out of all attempt to synthesize theory and clinical practice in order to provide a practical and systematic approach to abreaction (Steele, 1988). It is a strategic rather than a tactical course, and is designed to he used to inform any number of techniques and therapeutic approaches. It is meant to provide a general conceptualization of the entire abreactive process rather than a step-by-step linear treatment progression. Those in clinical practice will recognize that ahrcactions can, and often do, extend beyond one session for days, weeks, or even months.

Dissociation has been described as existing on a continuum with a wide range in quality, qua ntny, severity, and dysfunction (Beahi s, 1982; Price, 1987; Ross. 1988a: Spiegel, 1963; Watkins & Watkins, 1979-8(f). Although the focus of this paper is on the specific applications to multiple personality disorder, the most extreme and pervasive harm of dissociation. This model may be utilized with any type of trauma-related dissociative disturbance.

Several theories and models which are important in defining and conceptualizing abreactive work with trauma victims have been utilized in the development of this working model. These include state dependent learning concepts (Braun. 1984; Lich. 1980; Rossi, 1986); post traumatic stress theory (Coons & Milstein. 1984; Figlev, 1985, 1986; Horowitz, 1976; Mutter, 1986; Ochberg, 1988; Spiegel, 1984. 1988; van tier Kolk, 1987); cognitive perceptual development and distortion in abuse (Fine, 1988a, 1988b; Fish-Murrav, Koby, & van der Kolk, 1987; Jehu, Klassert. & Gazan, | 955; ()rick, 1985; Ross & Gahm), I988h); the BASK model of dissociation (Braun. 1985. 1988a, 1988h); and existential philosophy is applied to psychotherapy (Frank], 1963; Spiegel, 1988; Zalom, 1980.

The model includes the following components, with "PEACE" providing a convenient tnnenaonic acronym:

- Providing protection
- Eliciting dissociated aspects
- :alleviating the existential crisis
- (,-eating a gestalt experience: and
- Empowering the patient

Providing protection

This is *the I'wperatiotu [ahasc* of abreactive work. The first step in effective abreaction begins well before the working phase of therapy. An adequate holding environment must he prepared before abreactive work is initiated. Protection must he afforded before, during- and after the abreactive event.

A number of factors should he considered in creating a sale context for abreaction. Issues in the realms of the intrapsvchic, interpersonal, and environmental are delineated below. This is *not* meant to he an exhaustive list, but does provide a basis for the creation of protection, which must ultimately he tailored to the needs of the individual.

In traps): ehic safety

1. Prior awareness of general content which allows fair snore e{>mplete planning of a cone-olled abreaction (,Sachs, Braun, & Shepp, 1988).

2. 1'se of the (:enter Ego State (Internal Self Helper) and other knowledgeable personafin states to facilitate abreaction. The status of the Center Ego State and allied concepts remains the subject of differing opinions within the field.

3. A working knowledge of defensive patterns of the it individual and the various alters that are likely to be used to cope with the stress of abreaction in order to assess and predict acting-out potential.

I. Knowledge of the general world view of the individual and the various alters - the cotmtext in which the abreaction will initially be processed (Courtois, 1988; I)onaldson & Gardner. 1985).

5. Awareness of the meaning of "telling" to the individual and to the various alters. Issues of shame, guilt, badness, injunctions against telling, split loyalties. Religious taboos. and, in the case of cult abuse, internal cues for self-destructive behavior may all create resistances to abreactive work. and therefore must he identified and resolved.

6. Characteristics of amnestic barriers (rigid, permeable; unidirectional, bidirectional). Hie degree of permeability is often an indication of readiness for

ineniories (and ahreactions) to be shared.

7. Consideration of th e characteristics of alters doing the work; e.g., age, cognitive abilities, functions. relative position and power iii the .system, etc.

8. Decisions regarding which alters should he present, who should hear. and the dynamics of the rclationsfsips among alters involved in the abreaction. For example, if an abreaction is likely to overwhelm a particular alter, that alter tier he protected from the ttteutcnv until his_' her defenses are snore intact.

9. (;o-opting and refraining negatie or punitive alters prior to abreaction to prevent negative internal responses so abreaction (Kltrft, 198 I. 1985h; Putnam. 1989; N,+1'atkitts & Watkins, 1988).

10. Modulating the intensity of the experience and tailoring the experience to what can be tolerated, always titrating the work against existing ego strength, and building ego strength throughout the system over the course of theratpv.

11. Reconstructing. developing. and maintaining internal cognitive st'uctures and unconscious "meaning structures'· within which to process abreactions (discussed below. and (:ourtois, 1 988: Jeint, Klasseti, & Galan, 1985; C)rzek, 143$5 on cognitive processing *of* trauma: and. Liman & Brothers. 988. pp. 2-3: Stoloruw & Lachniautn.]984%85. p. 26 on ' nieanirtg st'uctures"). Abreactive work that is not couched within an adequate cognitive schema wi11 rctraunuuize the patient (Braun, 1986; Comstock. 14)86; Mutt, 1981; 19851)).

12. Sequencing within a particular ibreactive event. so that a sense of continuity and finiteness is provided. Having an alter tell the ·`end" of the memory, providing ti me lines (Putnam, 1989), and identifying and reconnecting serial splits are a few methods to facilitate sequencing.

13. Modifications in the internal at elute cture/space: to provide safety and comfors (Comstock, 1986). For example, special rooms for "telling the secrets" I ay be internall°constructed (imaginatively) to provide a sense of safety, of alters who need not be present for abreactions ma) be placed in an internal safe space where they will be unaware of the memory work.

14. Adjunctive use of medications to provide intrapsychic comfort and equilibrium, including modulation of anxiety, depression, sleep, etc. (Barkin, Braun, & Kluft, 1986; Loewenstein, Hornstein, & Farber, 1988: Yost, 1987).

15. Attention to the internal pacing of the patient and the various alters.

16. Education of each alter about the purposes and fttnctiitns of abreact inn.

Interpersonal safety

1. *Continuous* attention to issues of trust, both *among* alters sued within the therapeutic relationship (Braun. 1986; hluft, 198·1, 1985b).

Maintenance of boundaries and the therapy franc (Braun. 1986: Chu. 1988a; hhtft, 198-1, 1985h; Langs. 1979).

3. Working through of transference issues (Braun, 1986: (aitt, 1988a; (:ourtois. 1988; Wilbur. 1988).

1. Awareness and resolution of countertruusfereuce issues related to the patient in general and to abreactive experiences in spec It is crucial that therapists be aware of their own tolerance liar the work. and have ways of releasing the feelings much work engenders within them and of renewing themselves to avoid or at least minimize the possibility of burn-out and secondary post-traumatic st'ess disorder. (f3raim, Olson, Marten, Gray, & Pucci, 1987: Courtois, 1988. Olson, clawtc•n. & Braun 1988: Putnam, 1989).

5. llreraprutic use of self as a grounding daring and after abreaction and other methods of reality orientation to aid the patient in distinguishing "here and now' from "then and there" (Comstock, 1986: I uttt<uti, 1989).

ti. Encouraging the patient to build support networks within the f:unily surd within the conununits (Sachs, 1986).

7. Teaching significant others about abreaction and supportive measures they can provide the patient.

Environmental safety

1. The therapist 's office should be "abreaction-proof. " This is not meant to be an implicit message to act out, but is a common sense approach to safety. For example. sharp objects should not he within reach of a distraught or angry alter.

2. It may he useful to consider the availability of back-up therapists to contain or restrain the patient during abreaction, cir to support the patient during difficult periods in the event of the I triman. therapist's absence.

3. I lospitalization and restraints tray be considered for Planned and difficult abreactions (Braun, Sachs, & Shepp. 1988; Young, 1986).

4. Reliable transportation to and from the office if the patient cannot safely drive after ahreaction.

5. Establishment and maintenance of a safe, structured environment outside the therapy hour. The

patient living in chaos is not at viable cttrtdidatc for the rigors ol'ahrcaclive tt'nrk.

(i. Creation of a safe frame within the session (involves trusti, e.g., locking doors, closing blinds, making a safe corner, dimming or brightening the lights, etc.

7. Cccoside'rationi ()Ellie age°. lilt o sito.i uenr~, eluuli~t o1 life,and the phvsica] condition of the patient (Mull. 1988).

8. Length and spacing of sessions. Adequate time must he allowed, and prompt subsequent .sessions are available.

The provision of safety and protection involves consideration of complex interactions arming the intrapsyclrii factors ()idle individual, the interpersonal field, and the environmem. Protection is our ongoing issue iii treatment and shottlcl he continuously nionitorcd. Once the process of protection is addressed and appropriate measures instituted to ensure its continuity in the treatment frame, the second phase of abreaction begins.

Eliciting *dissociated* aspects

This is the *Irlrrrlifiratioo* plurscof abreaction in which lire dissociated aspects of the tratnna are found, and then elicited for the purpose of abreaction. Elicitation crust follow identification in order for an abreaction to be complete. since in order for master to occur, all dissociated aspects of the experience must he accessed and discharged of lc-clings and information. Alters can successfully abreact tote rnalh without direct access to the body. Thus, elicitation implies that the alter is accessible to the alneactive process; it does not necessarily mean that the alter mist be iii executive control of the body.

Dissociated aspects contain vital information the patient needs in order to assimilate the tratuna. Each dissociated component was encapsulated and thrust out of consciousness because of its own unique untenable quality, be it affect, sensation. behavior, thought, or various combinationsof the above (Braun, 1985, 1988a, 1988b). Experience in any given moment consists of behavior, affect, sensation. knowledge (BASK) and the reconstruction of that experience, especially experience which is as emotionally charged and conflict-laden as trauma, must include all aspects of' experiencing. Aspects that remain dissociated will continue to int'ude into consciousness. Clues to the dissociated aspects of experience will he contained in the memories, affects, somatic manifestations, Phobias, compulsions, hallucinations, and the metaphors of the patient and the variousalters (Braun.1988a. 1988b;Comstock, 1986; Groves, 1987,1988; van der Kolk, 1987; van der Kolk & Radish, 1987).

Traumatic experiences are encoded as state-bound information which is accessible only in the psychophysiological state of the individual at the time of the trauma (Braun. 1984; Eich, 1980; Mutter, 1986; Putnam, 1985; Rossi, 1986; van der Kolk & Greenberg. 1987). Severe trauma almost invariably produces an altered state. As hvpnoidal dissociatier states are chained together over time by common affective themes, they may become ;dternate personalties or personality states (Braun. 1984, 1985. 198G, 1988x. 1988b; Spiegel, 1951, I(ISO. These personalities and states lutist be accessed and discharged of the energy related to the trauma.

However, catharsis, in itself, is not sufficient to resolve the trauma. In order for abreactisc work to he effective e.eilr<usis mils(Ix linked with cognitive restrtutleoi , and with the resolution ofexistential dilemmas inherent the u annna (]anofl-Bnlnian, 1985:ja miff-Bulnrtn & Frieze... 1983; Jelin, et al., 1985; Kristal, 1968: Silver, et al.. 1983). NA'lien new or led onsiructed cognitive schema are provided, the existential crises can be processed anti become arne►tahle to change and resnltuion. One the dissociated ;tspeets of the traurua are made available for treatment. these specific existential crises will bee cone evident, and at this point, the al]reactive work shifts its focus toward these dilemmas.

Alleviating the** existential **crisis

This is the *Resolution phase of* abreaction. Trauma precipitates an existential crisis for the individual in which death (oranniliilation - thepsvchologicalcorollaevofthreatened hiological death), meaninglessness, isolation, and freedom must he confronted in a very literal tray (Frank], 1963; Groves, 1987, 1988; Lerner. 14180; Silver. Boone & Stones, 1983; Spiegel, 1988;Yalom, 19e80). Existential themes are manifested in the verbalizations of Ile patient and the various alters. Typical existential responses to trauma include: "I ate going to die," or "I wish to die, or "The pain is too much to tolerate" (Death); "Wiiv is this happening." or "Why me?" (Meaninglessness). "1 ate alon'; there is no one who can/will help." or"I am had/ dirty. gttiltv!differetit and can't he with others in a uieaningfulwav" (isolation): "Could I have stopped it?" or "I *should* have stopped it: " (Freedom and Responsibility).

The existential crisis must be alleviated during abreaction by re-creating the trauma as a con t iguot is experience on a continuum of space and time with the four dimensions of BASK reconnected in the patient's experience. Then, based on new perspectives formed by the linking of BASK components and on cognitive frames derived from present reality, the patient can discover the resolution of the crisis.

The existential crisis is precipitated by the experience of becoming an object, (thereby losing one's sense of personal meaning) , and by the shattering ofbasic assumptions needed for ontological and psychological security. These basic asstnuptiotis include: (I) the belief in personal invulnerability; (2) the perception of the world as meaningful and comprehensible; and (3) the view of oneself in a positive light (]anofl-Bulman, 1985, p. 18). One loses the ability to fit the experience into existing mental structures due to the overwhelming nature of the traumatic event; thus meaning cannot be assigned. Furthermore, in the case of child abuse (the precipitating factor of the dissociative process in the vast majority of multiples) the cognitive structures to process the event may have never de'eloped. or tnav have had a faulty development (Fine, 1988a: 1988b: Fish-Murray. et al., 1987: jelm, et al., 1985; Orzek, 1985). This lack of internal categorization and assimilation leads to a sense of chaos, intrapsy-

chic disorganization, interpersonal distancing. environmental unpredictability due to the inhility to learn from experience, and to existential crisis.

Closely paralleling the shattering of the basic atSSUmptions described by 'anon-Hillman (1985), Liman and Brothers (1988) contend that the dissociative symptoms fol o wing trauma arc manifestations of the shattering of two archaic narcissistic fantasies, those of(ininipotence and of merging. and of the faulty restoration (either defensive or compensators') cif those fantasies. Ender normal (non-traumatic) eireunxt;tnces these fantasies serve its ttnconscdotis "meaning structures" which organize experience of the sell its relation to self-Object (Stolorow• I.achmann, I9S4 .'85. p. 26; L!ltnan Brothers, 198<8, pp. 2-:?). The dissolution of these fantasies c-onttihtttes to the existential dilemmas, since one loses a sense of invulnerability and an ituernal lotus of control necessary for ontological security (omnipotence), and also loses the connectedness to others ttccessuv for security within a social context (merging). Dissociative responses ser'e to protect the individual from the impact of these shattered fantasies.

The f tntasv of omnipotence is particularly salient to the existential crises precipitated by trauma. (.atilt and onnripotent responsibility (self blame) arc frequent responses to trauma which defend against the realization of absolute helplessness and vu]nerahility. The fantasy of merger is shattered either by the isolation iutposed by the trauma or be the extreme invasiveness and destructiveness of perpetrators, especially family members who might otherwise provide the child the basis for an ideal image with which to merge. These fantasies must be correctly restored in therapy so they may be developmentally transformed and integrated into meaning structures within winch the existential crisis can he resolved and the tratnna mastered.

Resolution of the crisis actually occurred when the trauma ended, but the individual remains "stuck" in the preresolution phase of the crisis by virtue of the dissociative process. Mutter (1986) and Groves (1987. 1988) have suggested that individuals (or alters) become psychologically. and usually unconsciously, stuck in the trauma, unable to move beyond the trauma to the point where they know it has ended and they have survived. The paradox of dissociation is that it protects one from the impact of the trauma by abdicating the continuous memory, identity, and/or consciousness that must be maintained to effectively process the event. Thus, one defends against the impact at the expense of resolution.

Responses to the trauma are frozen in the dissociated state so that. the patient experiences a circular, fixated pattern of guilt, helplessness, despair, terror, and/or rage. In the moment of existential crisis the individual knows that to move forward in time means that the intolerable will happen. For example, she will be killed (death); be abandoned or "dirty" (isolation); he forced to commit morally reprehensible acts (freedom and responsibility); and will become an object of senseless abuse rather than a self (meaninglessness). To prevent the intolerable, the individual remains "frozen in time" in the existential crisis, unable to move beyond the trauma. The goal of abreactive work, at this point. is to identify the existential crisis, to alleviate the fixation point, and help the individual mote through it, past the trauma. to the Point where she realizes (um onscioush as well as cognitively) slit trauma is over. Adequate cognitive and unconscious mental structures must be developed and maintained in order to process and resolve these dilemmas.

For instance, the child personality who huddles terrified in the corner waiting for her father to come and hurt her must finally none beyond the terror of that motuen ;uul learu that daddy will no longer curate_ that the moment of terror is now dtr the past, that she has grown up and has control she did not have then. She is frozen in a moment of ti me in which her ontological truth is impending annihilation.

In this case the patient is attempting, through dissociation and creation of a traumatized child alter, to maintain her pre-traumatic sense of identity, and resists the new identity of "victim" by assigning that identity to the alter. Abreaction provides the patient with a means to integrate the post-irannlatic identity (victim) with the aspects of her identity that are alre adywithin her awareness. The therapeutic task is to "unfreeze " the moment so that she can experience it in a different way, and thins mine toward a solution that will pr<nnote nrasteiv. "I nfree'zing-" the moment involves reconstructing the trauma in a way in which contiguous memory and consciousness can be restored, meaning can be assigned, and self can be assimilated. This is the essence of abreactive work.

Since responses to tramtna are based on subjective° experience rather than on the t.rallm<ttic event itself. the existential crisis the worst, the intolerable moment of the event) will vary from individual to individual. and from alter to alter within the same event. The existential crisis is manifested at the point when some component(s) of the subjective experience of the trauma becomes absolutely intolerable. Dissociation will then occur in response to the ontetable existential dilemma. Serial splits may contain a number of existential crises related to the same event.

Creating a gestalt

This is the *A,s,ciuulalion* pilawof abreaction in which the dissociated aspects are pulled together in the safe context of the controlled abreaction to create a gestalt experience, and the moment of existential crisis is re-created to gain mastery. The four dimensions of BASK are reconnected along a cotltinlutm ofspace and time, with the past and present now clearly delineated. A gestalt experience offers new perspectives and information about the t'auma to the individual so that she/he can rework the meaning of the trauma in a const'uctive and healing way. Then the traumatic experience can be assimilated into the larger context of the patient's life. Under state-dependent learning conditions the patient can now find new solutions beyond the fixation point of the existential crisis. This, in itself, is an integrative event, and will provide a basis for further assimilation.

Cognitive processing as well as affective expression is necessary. The assignment of new meaning to the trauma will allow the event to be incorporated into existing or newly developed mental structures. Shattered assumptions and

narcissistic fattstasie-s can be rebuilt and lranshn tied, providing a base of ontological security within which the WHOM! can be assimilated.

Ross and Gahatt (198S1r) have described a number of cognitive distortions commonly made by MPII patients. These distortions preclude adequate tnasten over the trauma. Ftrrexanrplc,afew'of these distortinnsittchule: (1) the belief that dissociated parts are actually separate selves. therefore whatever trauma those parts endured arc irrelevant to the individual; (21 the that the victim is responsible lor abuse, therefore the abuse was deserved; (3) the belief that the]least is the present therefore the trauma never ended; and (-1) the belief that anger is wrong, therefore the rage at the trauma cannot he released and assimilated.

Fine (hiS8a; l9S8l) has emphasized the importance (i1 understanding the patient's cognitions both as an entry into the patients reality and as a mediator among the four dimensions of B: Sh, which must be recunnectecl in the• abreactive process. She has described the pathological determinants of thought in MPL). These determinants include dichotomous thinking; selective abstraction; arbitrary• inference; overgeneralization; catastropltizing and ulecatastrophizing; time distortion; excessive responsibility and irresponsibility; circular thinking; and n6s-assuming crtusaliu (Fine, I988h). Cognitive restructuring is crucial prior to abreaction to provide a new frame for the corrective abreactive experience. Restructuring and refraining should also continue to be a focus during and after the abreaction.

Verbalization of the trauma provides the means by which cognitive frames can be formed. This is a first step toward mastery. moving the patient away front existing as an object toward selfhood with implied control and meaning. I t is within the context of the telling and of the subsequent hearing of the trauma that assimilation becomes possible. It provides a context for meaning to he re-established. In talking about die trauma, often a long-held secret from self and others, patients decrease their isolation and take their first step toward acknowledging their identity as traumatized victims, from whence they can begin to weave that meaning into the total fabric of their lives.

Positive healing experiences are beneficial in solidifying gains made from the resolution of the existential crisis and from the assimilation of new information. Of course, by far the most important positive experience will be provided over time by the predictable context and the secure boundaries ofthe therapeutic alliance. However, here I am referring not. to this process, but to specific events within the context of this relational process. These events serve to provide patients with a base of new experiences from which to test the reality of their new-found and fragile perceptions about self and others.

The provision of such experiences may include the use of a variety of techniques, a few of which are internal dialogues that promote empathy and cooperation among alters; rituals and other symbolic activities; imagery and fantasy; and - if such practice is within the usual and customtar repertoire of the therapist - the circtnnscribed and judicious use of therapeutic touch. Traumatic memories can be "redone" in fantasy so that the patent gains a sense of ttasterv. For example. the individual can image that the abuse' is stopped, or revenge is sought, or shei hc- is rest lied or has special powers over the abuser, etc. I'he paatie•nt. cam image a favorite, soothing place in which to rest and heal; this can he coupled with deep relaxation and affirming statements. This author frequently uses a hypnotic transitional space - the image of a Healing Pool - in which the lessons learned are emphasized intntediau h following abreaction. This provides a predictable, .soothing. and restorative experience; strengthens the therapeutic relalion-Ship in a hypnotic state; provides it transitional space between the highly emotional atmosphere of abreaction and the relaxed, alert state desired for the patient. to end the session; provides a "meeting' place for dissociated aspects of sell to assimilate the trauma and interact with each other; and finally, it is a ritual that solidifies the meaning of the trauma and the lessons learned front the abreaction.

However, if such experiences are inserted prematurely rn- in a way that alternates the work of the abreaction excessively. Ow abreaction will have to be repeated and the positive experience cannot be assimilated, for the patient is still 'stuck" in the unresol'ed crisis Mahe trauma. There is a frequent tetmptat.ion hfor therapists to "rescue" the patient from the pain of abreactive work. More often than lint, this seems to occur at the point in the abreaction in which the existential crisis becomes snstnife.sted. Phis is a counter transh-'rential response to avoid facing one's own existential crises, which will be triggered by the intensity oft he patient's struggle. Rescuing must not he confused with resolution. Therefore, it is necessary to he clear that the existential crisis has been successfully encountered and mastered by the patient. At that point experience t:tar be given.

It is not unusual that an abreaction is not completed in one session, but extends over a period of days, weeks, or months. It is possible to work its segments, closing off the intensity of the process between sessions. In such cases, positive experiences may be given toward the end of the session in order to close down the affect and remain within the designated time structure. In this way, positive experiences are inserted within the rhythm of the abreaction and the time frame, and serve to create closure for the session, but are not used to cut short work on the existential crises for the comfort of the therapist..

Once assimilation occurs and begins to solidify, the patient can regain control over intrapsychic splits and external realities.

Empowering the patient

t his is the *A ~~ilz:catmrt* phase of abreaction. Patients now *have* a new context for being. They can begin to recognize new choices and solutions. increasingly operating from a position *of* control, hope, and wholeness. Assumptive worlds arc rebuilt and reorganized cognitive structures begin to provide organization and meaning. It is important to solidify these gains because the assimilation achieved in abreactive work creates a fragile new identity. It must he protected, reinforced, and strengthened to prevent dest-ucturirtg by old defensive patterns, cognitive distortions, or external experiences. This is a time for patients to regain the capacity

to exercise the ability to influence the course of their lives (Flannery, 1987). (ood .social support networks as well as mastery over the t'auma are necessary. New coping; skills nntst he leatrued within the cont'xt of the assimilated inlor-'n ation of the abreaction.

Numerous useful strategies may he employed by' the therapist at this point to solidify the inu'gratiye experiences of abreaction. The list that follows is far from exlmttstive:

1. Cognitive rest' ucutring around the lessons learned (Braun, 1986; Donaldson Gardner. 1)183: Fish-Muray. Kobv & van der Kolk, 1987; Fine, 1988a. l 988b; Jehu, Klesscr & Jai.an, 1985; Orzek, 1985; Ross &- Gahan, 1988b).

2, .Affective management. Teaching the patient how to feel again. Identifying feelings and learning effective management and modulation (Flannery, 1987).

3. Behavioral changes, including reduction of victim behaviors, increased assertiveness, and improved inter-per.sctnal interactions (Courtois, 1988; Keane, Fairbank, Caddell, 'huniei ing & Bender, 198.5).

I. Shifting control from an external Loan internal locus,

5. Promoting healthy lifestyle choices - nutrition, exercise, sleep and work habits, etc. (Flannery, 1987).

6. The enhancement of pleasure and meaning through involvement in hobbies or worthwhile activities.

7. Utilization of relaxation, including meditation, deep muscle relaxation, imagery, self-hypnosis (Flannery, 1987).

8. Building social support systems, including emotional support. encouragement, advice, companionship, and tangible aid (Figlev, 1986: Sachs, 1986).

9. Marital and family therapy as an adjunct (Figley & Sprenkle, 1978; Sachs, 1986; Sachs, Frischhc:riz, & Wood, 1988).

10. Learning and practicing general coping skills beyond dissociation.

11. Grief work about the trauma and its impact on the individual. Grieving can shift emotional energy from the past and reinvest it into the self and the present.

12. Dealing with issues of anger and outrage.

SUMMARY

This paper has described a conceptual model for abreaction. Although abreactive work is an integral part of therapy with dissociative patients, and abreactive techniques are avidly sought by therapists, little has been reported in the literature about the context and the nature of the process. The model presented here is a pr eliminary exploration of this process, and utilizes an integrated theoretical basis and clinical approach. The abreactive process has [wen described and includes: (l) Providing protection (preparation); (2) Eliciting dissociated aspects (identification); (3) Alleviating the existential crisis (resolution): (4) Creating a gestalt (assimilation): and (5) E:rtipowei Mg the patient (applicati(n). ■

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