ABSTRACT

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INTRODUCTION

Dissociation is born of overlochng trauma. Stn. inappropriate 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 disrelated 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 nature is arch as found in the history of those who multiple personality disorder (NIPD) and other dissociative disorders implies the loss of an internal 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 of unprotected vulnerability (Auerhahn & Laub, 1984; Figley, 1986; Krstal, 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 meaningless lie at the center of post traumatic responses and are the raison d'être for dissociation.

Dissociation provides the method (It 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 definitively. Thus, in the view of most psychotherapists, a Psychiatric reworking of the trauma which identifies, releases, and assimilates the dissociated aspects becomes necessary to provide resolution and integration.

Abreactive work is an integral part of the assimilation process with traumatized and dissociative patients (Braun, 1986; Comstock, 1986; Figley, 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, relearning, and relarning that occur during abreaction. However, abreactions that are poorly timed or directed, incomplete, distorted, too intense, or too attenuated will retrigger the patient, promote deeper entrenchment in dissociative defenses, trigger premature re-repression, and create problematic transference issues.

scribed (Comstock, 1986; 1988; Klunt, 1983, 1988; 1989; Putnam, 1989). The carefully planned use of hypnorigtic techniques for facilitation, stabilization, and cmmuniieness of abreactures has been explored (Bliss, 1986; Hilt, 1982, 1983; 1485b; Putun, 1985; Shapiro, 1988). Hypnorigtic techniques during the abreactive 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 abreactive theory, Putnam (1989) has described several tapes of hypnotherapeutic techniques to prepare for and to utilize with abreaction. These include trance-inducing and protection building techniques: techniques for penetrating amnestic barriers; and a reactive healing techniques such as the screening brain, permissive amnesia, symptom substitution, age progression, autohypnosis, facilitation of co-consciousness, and deep trance (1=1-223-31).

The use of hospitalization and restraints continues, and (or extremely painful abreactures 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 & Niahan, 1984; Khan, 15186).

Although the literature agrees that abreaction is both useful and necessary for the integrative process following trauma, a conceptual framework that enables it will pass 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 be 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 abreactures 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, quantity, severity, and dysfunction (Beahi, 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-Murray, Koby, & van der Kolk, 1987; Jehu, Klassert, & Gazan, 1955; (rick, 1985; Ross & Gahm), 1988b); the BASK model of dissociation (Braun, 1985, 1988a, 1988b); and existential philosophy is applied to psychotherapy (Frank), 1963; Spiegel, 1988; Zalom, 1980.

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

- Providing protection
- Eliciting dissociated aspects
- Alleviating the existential crisis
- Eating a gestalt experience: and
- Empowering the patient

Providing protection

This is the imperative phase of abreactive work. The first step in effective abreaction begins well before the working phase of therapy. An adequate holding environment must be prepared before abreactive work is initiated. Protection must be afforded before, during, and after the abreactive event.

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

In traps: ethic safety

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

2. Level of the (center Ego State (Internal Self Helper) and other knowledgeable persons in 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 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.

4. Knowledge of the general world view of the individual and the various alters - the contexts in which the abreaction will initially be processed (Courtois, 1988; Donaldson & 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 be identified and resolved.

6. Characteristics of amnestic barriers (rigid, permeable; unidirectional, bidirectional). The degree of permeability is often an indication of readiness for
inenerios (and abreactions) to be shared.

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

8. Decisions regarding which alters should be present, who should hear, and the dynamics of the relationships among alters involved in the abreaction. For example, if an abreaction is likely to overwhelm a particular alter, that alter may be protected from the trauma until his/her defenses are more intact.

9. Co-opting and refraining negative or punitive alters prior to abreaction to prevent negative internal responses so abreaction (Kluft, 1981; Putnam, 1989; Nijenhuis & 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 therapy.

11. Reconstructing, developing, and maintaining internal cognitive structures and unconscious ‘meaning structures’ within which to process abreacts (discussed below, and (Courtois, 1988; Joint, Klasesti, & Galan, 1985; Crzek, 1985) on cognitive processing of trauma: and, Liman & Brothers. 1988, pp. 2-3; Stoloruw & Lachniautn. 1984%85, p. 26 on ‘neanirng strucW. Abreactive work that is not couched within an adequate cognitive schema will traumauize the patient (Braun, 1986; Comstock, 1986; Mutt, 1981; 1985).

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

13. Modifications in the internal architecture/space: to provide safety and comfort (Comstock, 1986). For example, special rooms for ‘telling the secrets” may be internally constructed (imaginatively) to provide a sense of safety, of alters who need not be present for abreactive experiences may 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 functions of abreaction.

Interpersonal safety

1. Continuous attention to issues of trust, both among alters sued within the therapeutic relationship (Braun, 1986; Kluft, 1981, 1985b).


5. Interpersonal use of self as a grounding during and after abreaction and other methods of reality orientation to aid the patient in distinguishing “here and now” from “then and there” (Comstock, 1986; Iutttuti, 1989).

6. Encouraging the patient to build support networks within the family and within the community (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 be within reach of a distraught or angry alter.

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

3. Hospitalization and restraints may be considered for Planned and difficult abreacts (Braun, Sachs, & Shepp. 1988; Young, 1986).

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

5. Establishment and maintenance of a safe, structured environment outside the therapy hour. The
patient living in chaos is not at viable ctttrtdidate for the rigors ol’aheacive t’nrk.

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

7. Cessation of rations (Ellie age 6, lift o site.o uenr-, el)i.1-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 intrapsycliri factors (jidle individual, the interpersonal field, and the environment. 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 Irtriification plursof abreaction in which lire dissociated aspects of the trauma 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 le-clings and information. Alters can successfully abreact to the alter without direct access to the body. Thus, elicitation implies that the alter is accessible to the abreaction process; it does not necessarily mean that the alter must be iii executive control of the body.

Dissociated aspects contain vital information the patient needs in order to assimilate the trauma. Each dissociated component was encapsulated and thrust out of control of the body. Thus, elicitation is an important aspect of the abreaction process. Elicitation allows the patient to access and discharge the traumatic experience.

The existential crisis must be alleviated during abreaction by re-creating the trauma as a conscious 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 of basic assumptions needed for ontological and psychological security. These basic assumptions 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 (Janoff-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 cases) the cognitive structures to process the event may have never developed. or may 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 inability to learn from experience, and to existential crisis.

Closely paralleling the shattering of the basic assumptions described by anon-Hillman (1985), Liman and Brothers (1988) contend that the dissociative symptoms following traumatic experiences manifest the shattering of two archaic narcissistic fantasies, those of (in)potence and of merging. and of the faulty restoration (either defensive or compensatory) of these fantasies. Ender normal (non-traumatic) defense mechanisms these fantasies serve its tntconscedoticis meaning structures which organize experience of the self its relation to self-Object (Stolorow & Lachmann, 1984. p. 26; L.lltman Brothers, 1988. pp. 2-2.). The dissolution of these fantasies can lead to developmental and integrated psychologic experience of the trauma becomes absolutely intolerable. Dissociation will then occur in response to the intolerable moment of the existential crisis. This, in itself, is an integrative task is to "unfreeze" the moment so that she can experience it in a different way, and thus mine toward a solution that will prove to be lasting. "I freeze her—" the moment involves reconstructing the trauma in a way in which contiguity 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 trauma are based on subjective experience rather than on the traumatic event itself, the existential crisis is 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 intolerable existential dilemma. Serial splits may contain a number of existential crises related to the same event. Creating a gestalt

This is the A.slschen pidalof 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 coltinum of space and time, with the past and present now clearly delineated. A gestalt experience offers new perspectives and information about the trauma to the individual so that she/he can rework the meaning of the trauma in a constructive 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 fantasias-s can be rebuilt and restored, providing a base of ontological security within which the patient can be assimilated.

Ross and Gahatt (1988S1) have described a number of cognitive distortions commonly made by MPII patients. These distortions preclude adequate trust across the trauma. Of these distortions, few of these distortions include: (1) the belief that dissociated parts are actually separate selves, therefore whatever trauma those parts endured are irrelevant to the individual; (2) that the victim is responsible for the abuse, therefore the abuse was deserved; (3) the belief that the victim is responsible for the trauma; (4) that the victim is responsible for the victimization of the abuser, therefore the abuse was deserved; (5) 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 be released and assimilated.

Fine (1988a; 1988b) has emphasized the importance of 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 reconnected in the abreactive process. She has described the pathological determinants of thought in MPL. These determinants include dichotomous thinking; selective action; arbitrary inference; overgeneralization; catastrophizing and ulcatastrophizing; time distortion; excessive responsibility and irresponsibility; circular thinking; and n6s-assuming cruxial (Fine, 1988h). 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 from existing as an object toward selfhood with implied control and meaning. It 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 be 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 of the 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 malleable 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 customary repertoire of the therapist - the circumscribed and judicious use of therapeutic touch. Traumatic memories can be “redone” in fantasy so that the patient gains a sense of mastery. For example, the individual can imagine that the abuse is stopped, or revenge is sought, or she is rest lied or has special powers over the abuser, etc. The patient can image a favorite, soothing place in which to rest and heal; this can be 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 and tied following abreaction. This provides a predictable, soothing, and restorative experience; strengthens the therapeutic relationship 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 self 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 from the abreaction.

However, if such experiences are inserted prematurely in a way that alternates the work of the abreaction excessively. Over abreaction will have to be repeated and the positive experience cannot be assimilated, for the patient is still “stuck” in the unresolved, ed crisis of the trauma. There is a frequent temptation for therapists to “rescue” the patient from the pain of abreactive work. More often than not, this seems to occur at the point in the abreaction in which the existential crisis becomes imminent. A therapist must not be 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 to 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**

This is the A 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 are rebuilt and reorganized and 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 be protected, reinforced, and strengthened to prevent de-stabilization and 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 .socal support networks as well as mastery over the t'ma are necessary. New coping; skills mnst he leatrued within the cont 'xt of the assimilated infor
'n ation of the abreaction.

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


2. Affective management. Teaching the patient ho 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 interpersonal interactions (Courtois, 1988; Keane, Fairbank, Caddell, huniei ing & Bender, 198.5).

4. Shifting control from an external to 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).


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 preliminary exploration of this process, and utilizes an integrated theoretical basis and clinical approach. The abreactive process has been described and includes: (1) Providing protection (preparation); (2) Eliciting dissociated aspects (identification); (3) Alleviating the existential crisis (resolution); (4) Creating a gestalt (assimilation); and (5) Erripower Mg the patient (applicati(n). ■

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