

A MODEL FOR ABREACTION WITH MPD AND OTHER DISSOCIATIVE DISORDERS

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ABSTRACT

A conceptual model for abreactive work with multiple personality and other dissociative disorders is presented. The context and process of abreaction are described. The model includes the following components: Providing safety and protection (preparation); eliciting dissociated aspects of the trauma (identification); alleviating the fixation point in existential crisis of the trauma (resolution); creating a gestalt with the dissociated aspects within reconstructed cognitive schema (assimilation); empowering the patient through the return of an internal locus of control, restoration of contiguous consciousness and memory, and assimilation of identity (application).

INTRODUCTION

Dissociation is born of overwhelming trauma. Survivors of severe trauma who have utilized dissociative defenses may have disturbances and interruptions of identity, consciousness, and/or memory (American Psychiatric Association, 1987). The therapeutic task with such individuals is to reassociate disrupted 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 such as found in the history of those who multiple personality disorder (MPD) 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, 1985; Krystal, 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'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 Psychic 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 & Gahan, 1988a; Spiegel & Spiegel, 1978; van der Kolk, 1987; van der Kolk & Kadish, 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 retraumatize 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. Kluft (1988a) discusses the dangers of intense abreactions 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, 1985; Fine, 1988b; Fish-Murray, Koby, & van der Kolk, 1987; Horowitz, 1976; Jehu, Klassen, & Gazan, 1985; Orzek, 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-mutilative actions; substance abuse; and further dissociation and re-repression (Braun, 1986; Chu, 1988a; Courtois, 1988; Kluft, 1984, 1985b). Potentially harmful countertransference responses to the painful material presented by severely traumatized patients, and indirectly, by ensuing abreactive work, have been described (Courtois, 1988; Danieli, 1980; Kluft, 1985b).

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

scribed (Comstock, 1986, 1988; Kluft, 1983, 1988, 1989; Putnam, 1989). The carefully planned use of hypnotic techniques for facilitation, attenuation, and containment of abreactions has been explored (Bliss, 1986; Kluft, 1982, 1983, 1985b; Putnam, 1989; Shapiro, 1988). Hypnotic 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 work, Putnam (1989) has described several types of hypnotherapeutic techniques to prepare for and to utilize with abreactions. These include trance-inducing and rapport building techniques; techniques for penetrating amnesic barriers; and abreactive/healing techniques such as the screening room, permissive amnesia, symptom substitution, age progression, autohypnosis, facilitation of co-consciousness, and deep trance (pp.223-234).

The use of hospitalization and restraints for prolonged, intense, and/or extremely painful abreactions has been described (Sachs, Braun, & Shepp, 1988; Young, 1986). Abreactive work utilizing modified play therapy has been advocated for children with multiple personality disorder (Fagan & McMahon, 1984; Kluft, 1986).

Although the literature agrees that abreaction is both useful and necessary for the integrative process following trauma, a conceptual framework that encompasses 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 an 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 abreactions 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 (Beahrs, 1982; Price, 1987; Ross, 1988a; Spiegel, 1963; Watkins & Watkins, 1979-80). Although the focus of this paper is on the specific applications to multiple personality disorder, the most extreme and pervasive form 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; Eich, 1980; Rossi, 1986); post traumatic stress theory (Coons & Milstein, 1984; Figley, 1985, 1986; Horowitz, 1976; Mutter, 1986; Ochberg, 1988; Spiegel, 1984, 1988; van der Kolk, 1987); cognitive perceptual development and distortion in abuse (Fine, 1988a, 1988b; Fish-Murray, Koby, & van der Kolk, 1987; Jehu, Klassen, & Gazan,

1985; Orzek, 1985; Ross & Gahan, 1988b); the BASK model of dissociation (Braun, 1985, 1988a, 1988b); and existential philosophy as applied to psychotherapy (Frankl, 1963; Spiegel, 1988; Yalom, 1980).

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

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

Providing protection

This is the *Preparation 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 safe 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.

Intrapsychic safety

1. Prior awareness of general content which allows for more complete planning of a controlled abreaction (Sachs, Braun, & Shepp, 1988).
2. Use of the Center Ego State (Internal Self Helper) and other knowledgeable personality 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 context 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 amnesic barriers (rigid, permeable; unidirectional, bidirectional). The degree of permeability is often an indication of readiness for

memories (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 memory until his/her defenses are more intact.

9. Co-opting and reframing negative or punitive alters prior to abreaction to prevent negative internal responses to abreaction (Kluft, 1984, 1985b; Putnam, 1989; Watkins & 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 abreactions (discussed below, and Courtois, 1988; Jehu, Klassen, & Gazan, 1985; Orzek, 1985 on cognitive processing of trauma; and, Ulman & Brothers, 1988, pp. 2-3; Stolorow & Lachmann, 1984/85, p. 26 on "meaning structures"). Abreactive work that is not couched within an adequate cognitive schema will retraumatize the patient (Braun, 1986; Comstock, 1986; Kluft, 1984; 1985b).

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 time 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, or alters who need not be present for abreactions 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 and within the therapeutic relationship (Braun, 1986; Kluft, 1984, 1985b).

2. Maintenance of boundaries and the therapy frame (Braun, 1986; Chu, 1988a; Kluft, 1984, 1985b; Langs, 1979).

3. Working through of transference issues (Braun, 1986; Chu, 1988a; Courtois, 1988; Wilbur, 1988).

4. Awareness and resolution of countertransference issues related to the patient in general and to abreactive experiences in specific. It is crucial that therapists be aware of their own tolerance for 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 stress disorder. (Braun, Olson, Mayten, Gray, & Pucci, 1987; Courtois, 1988, Olson, Mayten, & Braun, 1988; Putnam, 1989).

5. Therapeutic 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; Putnam, 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 primary therapist's absence.

3. Hospitalization and restraints may 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 abreaction.

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

patient living in chaos is not a viable candidate for the rigors of abreactive work.

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. Consideration of the age, life expectancy, quality of life, and the physical condition of the patient (Kluft, 1988).
8. Length and spacing of sessions. Adequate time must be allowed, and prompt subsequent sessions are available.

The provision of safety and protection involves consideration of complex interactions among the intrapsychic factors of the individual, the interpersonal field, and the environment. Protection is an ongoing issue in treatment and should be continuously monitored. 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 *Identification phase* of abreaction in which the dissociated aspects of the trauma are found, and then elicited for the purpose of abreaction. Elicitation must follow identification in order for an abreaction to be complete, since in order for mastery to occur, all dissociated aspects of the experience must be accessed and discharged of feelings and information. Alters can successfully abreact internally without direct access to the body. Thus, elicitation implies that the alter is accessible to the abreactive process; it does not necessarily mean that the alter must be in 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 consciousness because of its own unique untenable quality, be it affect, sensation, behavior, thought, or various combinations of 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 intrude into consciousness. Clues to the dissociated aspects of experience will be contained in the memories, affects, somatic manifestations, Phobias, compulsions, hallucinations, and the metaphors of the patient and the various alters (Braun, 1988a, 1988b; Comstock, 1986; Groves, 1987, 1988; van der Kolk, 1987; van der Kolk & Kadish, 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 hypnoidal dissociative

states are chained together over time by common affective themes, they may become alternate personalities or personality states (Braun, 1984, 1985, 1986, 1988a, 1988b; Spiegel, 1984, 1986). These personalities and states must 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 abreactive work to be effective catharsis must be linked with cognitive restructuring, and with the resolution of existential dilemmas inherent in the trauma (Janoff-Bulman, 1985; Janoff-Bulman & Frieze, 1983; Jehu, et al., 1985; Krystal, 1968; Silver, et al., 1983). When new or reconstructed cognitive schema are provided, the existential crises can be processed and become amenable to change and resolution. Once the dissociated aspects of the trauma are made available for treatment, these specific existential crises will become evident, and at this point, the abreactive 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 (or annihilation - the psychological corollary of threatened biological death), meaninglessness, isolation, and freedom must be confronted in a very literal way (Frankl, 1963; Groves, 1987, 1988; Lerner, 1980; Silver, Boone & Stones, 1983; Spiegel, 1988; Yalom, 1980). Existential themes are manifested in the verbalizations of the patient and the various alters. Typical existential responses to trauma include: "I am going to die," or "I wish to die," or "The pain is too much to tolerate" (Death); "Why is this happening?" or "Why me?" (Meaninglessness). "I am alone; there is no one who can/will help," or "I am bad/dirty/guilty/different and can't be with others in a meaningful way" (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 contiguous 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: (1) 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 multiples) 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; Jehu, et al., 1985; Orzek, 1985). This lack of internal categorization and assimilation leads to a sense of chaos, intrapsychic

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 Janoff-Bulman (1985), Ulman and Brothers (1988) contend that the dissociative symptoms following trauma are manifestations of the shattering of two archaic narcissistic fantasies, those of omnipotence and of merging, and of the faulty restoration (either defensive or compensatory) of those fantasies. Under normal (non-traumatic) circumstances these fantasies serve as unconscious "meaning structures" which organize experience of the self in relation to selfobject (Stolorow & Lachmann, 1984/85, p. 26; Ulman & Brothers, 1988, pp. 2-3). The dissolution of these fantasies contributes to the existential dilemmas, since one loses a sense of invulnerability and an internal locus of control necessary for ontological security (omnipotence), and also loses the connectedness to others necessary for security within a social context (merging). Dissociative responses serve to protect the individual from the impact of these shattered fantasies.

The fantasy of omnipotence is particularly salient to the existential crises precipitated by trauma. Guilt and omnipotent responsibility (self-blame) are frequent responses to trauma which defend against the realization of absolute helplessness and vulnerability. The fantasy of merger is shattered either by the isolation imposed by the trauma or by 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 which the existential crisis can be resolved and the trauma mastered.

Resolution of the crisis actually occurred when the trauma ended, but the individual remains "stuck" in the pre-resolution 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); be 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 move through it, past the trauma, to the Point where she realizes (unconsciously as well as cognitively) the 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 move beyond the terror of that moment and learn that daddy will no longer come, that the moment of terror is now in the past, that she has grown up and has control she did not have then. She is frozen in a moment of time 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-traumatic identity (victim) with the aspects of her identity that are already within her awareness. The therapeutic task is to "unfreeze" the moment so that she can experience it in a different way, and thus move toward a solution that will promote mastery. "Unfreezing" 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 trauma are based on subjective experience rather than on the traumatic event itself, the existential crisis (i.e., 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 untenable existential dilemma. Serial splits may contain a number of existential crises related to the same event.

Creating a gestalt

This is the *Assimilation phase* of 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 continuum 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 fantasies can be rebuilt and transformed, providing a base of ontological security within which the trauma can be assimilated.

Ross and Gahan (1988b) have described a number of cognitive distortions commonly made by MPD patients. These distortions preclude adequate mastery over the trauma. For example, a 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) the belief that the victim is responsible for the abuse, therefore the abuse was deserved; (3) the belief that the past is the present therefore the trauma never ended; and (4) 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 patient's reality and as a mediator among the four dimensions of BASK, which must be reconnected in the abreactive process. She has described the pathological determinants of thought in MPD. These determinants include dichotomous thinking; selective abstraction; arbitrary inference; overgeneralization; catastrophizing and decatastrophizing; time distortion; excessive responsibility and irresponsibility; circular thinking; and mis-assuming causality (Fine, 1988b). Cognitive restructuring is crucial prior to abreaction to provide a new frame for the corrective abreactive experience. Restructuring and reframing 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 the 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 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 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 image that the abuse is stopped, or revenge is sought, or she/he is rescued 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 immediately following abreaction. This provides a predictable, soothing, and restorative experience; strengthens the therapeutic relationship in a hypnotic state; provides a 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 or in a way that alternates the work of the abreaction excessively, the abreaction will have to be repeated and the positive experience cannot be assimilated, for the patient is still "stuck" in the unresolved 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 manifested. This is a countertransference response to avoid facing one's own existential crises, which will be triggered by the intensity of the patient's struggle. Rescuing must not be confused with resolution. Therefore, it is necessary to be clear that the existential crisis has been successfully encountered and mastered by the patient. At that point experience may 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 in 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 *Application 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 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 destructuring 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). Good social support networks as well as mastery over the trauma are necessary. New coping skills must be learned within the context of the assimilated information of the abreaction.

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

1. Cognitive restructuring around the lessons learned (Braun, 1986; Donaldson & Gardner, 1985; Fish-Murray, Koby & van der Kolk, 1987; Fine, 1988a, 1988b; Jehu, Klesser & Jazan, 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 interpersonal interactions (Courtois, 1988; Keane, Fairbank, Caddell, Zimering & Bender, 1985).
4. Shifting control from an external to an 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 (Figley, 1986; Sachs, 1986).
9. Marital and family therapy as an adjunct (Figley & Sprenkle, 1978; Sachs, 1986; Sachs, Frischholz, & Wood, 1988).
10. Learning and practicing general coping skills beyond dissociation.
11. Griefwork 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) Empowering the patient (application). ■

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