

ABREACTION: BABY OR BATHWATER?

Richard A. Chefetz, M.D.

Richard A. Chefetz, M.D., is in the private practice of psychiatry, in Chevy Chase, Maryland, and on the faculty of the Institute of Contemporary Psychotherapy in Bethesda, Maryland, and the Advanced Psychotherapy Training Program of the Washington School of Psychiatry in Washington, D.C.

For reprints write Richard A. Chefetz, M.D., 2 Wisconsin Circle, Suite 210, Chevy Chase, Maryland 20815-7003.

ABSTRACT

Abreaction refers to the discharge of pent-up affect through spoken language that relieves pathogenic intrapsychic tensions which are residua of trauma (Laplanche, 1967; Moore, 1990). This definition is inadequate and mired in Freud's early models of the mind, both the hydraulic and topographic models, and nineteenth century models of hypnosis. Abreaction may more usefully be defined as the verbal or non-verbal expression of intense affect, which when associated with a coherent narrative of experience, may provide relief of chronic anxiety states.

Affect is the centerpiece of experience. It is the prime contextualizer of meaning. Ego mechanisms of defense all alter the meaning of experience in an effort to reduce threats to psychological equilibrium. The destruction of context and meaning via dissociative adaptations is an effective and primitive mechanism of protection from both external impingement and internal conflict. Isolation of affect (Freud, 1955), is a dissociative process. It is important to understand that dissociative phenomena do not bypass ego functions.

Post-traumatic adaptations may include a profound secondary alexithymic state. This may seem hidden in the wake of powerful affective storms. The affect-phobic nature of the person prone to abreaction is a major impediment to treatment.

The primary task of treatment is stabilization of the patient prior to "working through" the sequelae of trauma. The mid-phase of treatment may involve continued psycho-educational efforts to identify and name affects, the use of "dream-rules" in the interpretation of abreactive narrative, and a utilization approach which welcomes affect into the treatment setting in a safe, skilled environment. Management of countertransference responses to avoid enactment which could lead to boundary violations is essential.

Like it or not, abreaction occurs regularly in psychotherapy and in the rest of people's lives. A cognitive-psychoanalytic model of treatment eschews the idea of a

"planned abreaction" while recognizing that the psychoanalytic psychotherapy of persons who have suffered trauma which meets or exceeds that of criterion A for Post-traumatic Stress Disorder (American Psychiatric Association, 1994) is likely to be associated with abreactive phenomena. In most of the situations to be described, Criterion A., which describes a "single blow" trauma, seems to become meaningless in the face of years of repetitive, horrific, terrifying, hopeless, helpless, inescapable injury. A comparison of single blow and multiple blow trauma is addressed by Terr (1991).

Is what I practice, what you practice, a so-called repudiated "abreactive" therapy (Blum, 1992; Freud, 1959; Glover, 1924)? By dismissing abreaction as a valid therapeutic action, clinicians leave themselves vulnerable to not knowing what to do when abreaction of an intense variety intrudes into the consciousness of the patient and the quiet of the consultation room. Even though some regarded abreaction as defunct, "the intrusion of unconscious ideation into the cognitive field and, simultaneously, a change in the realm of affects and emotions remained the curative factors in psychoanalytic treatment" (Ilan, 1977).

If Freud had been a better and more knowledgeable hypnotist, and had already invented twentieth century psychoanalysis before he met Anna O., abreaction and catharsis would still be seen as valid components of a therapeutic armamentarium that would also include free association, analysis of unconscious fantasy, and many other approaches as well.

It is true that Freud said he abandoned hypnosis and suggestion because of therapeutic failures. General experience suggests, however, that therapeutic failures do not necessarily by themselves discredit methods of treatment that are attractive for other reasons. Freud himself adds other reasons for having abandoned the techniques, e.g., his feeling of inaptitude for hypnosis and discomfort with the deliberated dishonesty of suggestion. (Friedman, 1977, pg. 626)"

Psychoanalysis is still stuck, in my opinion, with adherence to the controlled regression and sensory deprivation typical of the classical analytic situation, in which patients

give up motility by stretching out on a couch, cannot see their therapist, and are given the direct suggestion to speak of whatever comes to mind. While there is little "classical analysis" still being practiced, the basic frame of this treatment remains unchanged. This "non-hypnotic" technique relies on verbal expression. On the other hand, some dynamic and cognitive therapies not subject to the discipline of psychoanalytic thinking have, in my opinion, tended to ignore the role of fantasy formation in intrapsychic experience, and, at times, created risk for patients by interpreting their convictions about "traumatic memories" as veridical in nature, and not subject to the vagaries of distortion inherent in human memory.

Current knowledge about limbic system organization of memory and experience would suggest that non-verbalizable, inchoate, coenesthetic, implicitly encoded intrapsychic material is more likely to emerge as the patient's physiologic disequilibrium or enactment than as an expressed narrative (Chused, 1991; McLaughlin, 1991; Metcalfe, 1996; Rauch, 1996; Schore, 1994; Terr, 1991; van der Kolk, 1996). The intense affective displays usually associated with elaborate planned abreactions occur routinely and spontaneously as "mini-abreactions." These are more likely consistent with clinicians' saying to themselves and their patients: "You sure did get a lot of stuck feelings out today," as opposed to thinking, "That was a hell of a mini-abreaction, what would that have been like if they'd really let it all hang out?!"

EGO AS ORGANIZING PRINCIPLE

The idea of ego, an organizing principle, is attractive in many ways. Ego function refers to a whole compendium of conscious and unconscious processes that organize the "experience of experience." One aspect of ego function is the assignation of affect to experience. It would appear that much of this occurs through two main limbic structures, the hippocampus and the amygdala (Metcalfe, 1996; Schore, 1994; van der Kolk, 1996). The hippocampus organizes everyday experience by helping to create a narrative which obeys the laws of normal ego function in regard to time, space, identity, and routine emotional content. The hippocampus facilitates verbal memory, explicit memory. Hippocampal wiring is most closely associated with parts of the cerebral cortex which are thoughtful, social, and civilized. The amygdala deals with intense emotion, non-verbal encoding, implicit memory, and it has wiring which makes connection with thalamic pain centers, and a rich array of connections to visual and other sensory modalities. The logic associated with implicit memory resembles dream logic since implicit function may lack the guidance of the hippocampal narrative. All remembered experience must be associated with affect because the hippocampus and amygdala seem to assign an affective descriptor as a routine part of encoding memory. Affect is a centerpiece of the context which describes

every experience. It may even be that affect acts as a first order organizer in the creation of dream narratives (Palombo, 1978).

THE CENTRALITY OF AFFECT

Why is affect so important? It is at the center of all experience. Affect is a recursive percept of psychophysiology. It is a moment-to-moment summation of the varieties of physiologic experience which may be conscious or unconscious. It is coenesthetic in its origin, inchoate. Affect has qualities of level of arousal, time, space, associated narrative, and ideational content. Affect can be intense, occurs concurrently and sequentially, is in relation to environment, is part of a story, and is associated with named ideas such as sad, happy, etc. Affect reflects alterations in physiology which are associated with states of being, ego states (Beebe, 1997; Brenner, 1982; Coen, 1997; Emde, 1991; Garfield, 1995; Jones, 1995; Lewis, 1993; Lichtenberg, 1989; Nathanson, 1992). Affect may cause a disequilibrium in physiology if a person becomes overwhelmed (e.g., hyperventilation when sobbing, panic states with excessive adrenalin).

Access to the lived experience of affect is a focal point of therapeutic modalities which relieve pathologic patterns of relating in victims of trauma (Davies, 1994; Garfield, 1995; Horowitz, 1986; Krystal, 1988; Lewis, 1987; Meichenbaum, 1994; Orange, 1995; Phillips, 1995; Shapiro, 1995; Watkins, 1992). A thoughtful reading of this work, and that of many others, reveals that the patient's experience of intense affect in the therapy session is contained by the judicious application of techniques which either strengthen ego capacity to manage intensity the patient could not originally manage, or to provide the patient with an experience of learning a technique, self-hypnosis, guided imagery, etc., which teaches the patient that he or she can tolerate the intense affect because it can be modulated and/or will pass. Ego strengthening often occurs in the relationship with the therapist, both through the therapist's interest and willingness to hear the patient's story, and in the therapist's capacity to model the management of intense affect by "metabolizing" projective identifications of the patient's unwanted mental contents (Baker, 1997). A simple example of this is listening to a patient's story of abuse and the therapist noticing his own fantasies of being hurt or retaliating against those persons who hurt the patient, or the therapist's own disliked persons. Metabolization of these "induced" fantasies could simply be to note out loud to the patient that "there seems to be some unexpressed fear in the room since you told your story. Have you noticed that too?"

The dissociatively-adapted person does not know that affect can be spent and resolved. His or her experience has been that affect rises to an unbearable crescendo and then suddenly ends, only to reappear intensely and repetitively with triggering. Offering to teach such a person "how to feel"

may be experienced as threatening. To experience affect without the benefit of a coherent narrative means that the context of one's life remains a mystery. Teleologically speaking, this is exactly what the unconscious, dissociative mechanisms of defense are trying to do, maintain confusion and destroy meaning which if understood would destabilize psychophysiological balance. A positive therapeutic experience is one in which affect can be experienced with the resolution of fear or conflict. This experience of mastery and guidance of one's emotional outpourings is a core feature of all dynamic and much modern cognitive therapy. But, our patients will not learn to tolerate affects which their therapists avoid, deny, or otherwise ignore.

DOES DISSOCIATED EXPERIENCE BYPASS THE EGO?

Dissociated experience does not bypass the ego. Affect experienced during abreaction bypasses neither the ego of the patient nor the therapist. Traumatic adaptations which involve dissociation are adaptations of the ego, albeit, like other "defenses" they are unconsciously activated. The implications of this are profound when considered in the context of "the truthfulness" of abreacted affect. The abreaction of affect may be subject to the same ego mechanisms of defense as are all other "mental contents." Displacement, symbolic substitution, and condensation may all be visible in abreacted material, just as it occurs in dreams or apparently can occur during the course of hypnosis, or regular conversation (Hammond et al., 1995). Abreaction is subject to the same problems of mnemonic distortion as other "remembered" experience. Some psychological theories continue to generate hypotheses which suggest that the mind may "take in" experience without "alteration" which then becomes an "un-mentalized" nodal point (Fonagy, 1997; Mitrani, 1996). It is not that these authors misunderstand the point being made here, but the use of language such as "un-mentalized" leaves the reader with the connotative inkling that experience enters the mind and stays there, somehow untouched, nascent. This issue is elegantly described in the notion of "unformulated experience" (Stern, 1997). Theoretical stances which posit the existence of cortical or sub-cortical veridical "snapshots" of experience continue to represent a mythology of the mind which is unproductive at best and seriously misleading at worst. "Partially mentalized" or "unformulated" experience is likely to be a more accurate terminology.

As clinicians we must insist on the compassionate maintenance of uncertainty if we are to be of use to our patients. Otherwise, we risk inadvertently pressuring our patients to confabulate or act out. We may also encourage our patients to express material violently if we convey to them that the only safe and proper setting for the release of intense affect is the hospital. It is important that our patients get the message that the proper place for feeling occurs when there is

enough ego strength to tolerate the affect, and that is what treatment will focus upon first. The frequent dilemma of the initial moments of treatment of post-traumatic disorders is that our patients present to us because they are already flooded with unbearable affect. Building a structure in the middle of a flood is difficult.

ALEXITHYMIA AND THE EXPRESSION OF INTENSE AFFECT

Alexithymia, as an unconscious strategy, is a key to psychological survival. Bringing affect to consciousness often results in an increasingly painful awareness of one's injuries and the secondary muting of experience. It is when the alexithymia and numbness, in and of themselves, become psychologically painful that there is energy and interest in "feeling." Alexithymia is an important ingredient in the development of a fragmented sense of self.

Repeated sadistic attacks on a person lead to appreciation of an environment which is filled with toxic injury, deprivation, and neglect. Self-soothing is unknown in the context of these failures. This is also a reflection of an environment which provides little or no experiential model of soothing. The body and mind are either "on alert" or "off alert," adrenalin flows or it does not. What is allowed into conscious awareness are the physiologic dialectics like hot-cold, or wet-dry. These describe extremes in the experience of our baseline homeostasis which makes a difference in survival. Our physiology teaches us that experience is black-white, or on-off. "Borderline" relating makes sense in this context. Who needs names for affects?

It is in this setting that a person develops who is without words for moods, that is, alexithymic. There is no survival value in having consciousness for the subtlety of experience. The traumatized person learns that it is safer to not feel and to be immune to being influenced by all but the most dramatic internal or external change. To do otherwise is to be consciously, obsessively, reiteratively, hypervigilant and overwhelmed. Honestly, given the choice of this kind of alertness versus being numb, who would not prefer numbness?

The analysis of alexithymia may involve the scrupulous but non-intrusive attention of the therapist to the patient's bodily states as in body language, facial expression, eye closure, eye-roll, swallowing, goose-bumps, and things as simple as putting on or taking off of sweaters when there is no discernible change in room temperature. All these phenomena are usually unconscious for the patient, but can be made conscious by thoughtful inquiry. While biofeedback teaches people about muscle tension and blood pressure, in most psychotherapy settings this is neither available nor recommended. Becoming conscious of one's body is a prerequisite for naming emotion and experiencing affect. Otherwise, the body says what the mouth can not.

For example, in a recent consultation/teaching inter-

view of a middle-aged man in inpatient treatment for pedophilia, the consultation question posed by the staff was: "When is it that we can begin to believe what this man is saying?" After a few minutes of talking with the patient about what he hoped to get out of the consultation, I discovered what the staff had meant. This man's compliance with every hypothesis I put forward left me with the intense feeling of being used, of being a clinician without any effect or value for my effort as each of my comments were enthusiastically accepted. The first opportunity to see how real this man could be came when I stated a hypothesis, that the people with whom he had long-term sadomasochistic relationships had eventually been as much in control of him as he had controlled them. On the one hand he quickly misinterpreted this to mean that he need not feel so guilty for what he had perpetrated, a relief to his narcissism. On the other hand, he was overcome with an obvious (to me) storm of affect. His eyes visibly filled with tears that did not flow, he swallowed repeatedly, and his upper body became tense as he scrunched his shoulders together. I asked how he felt, but he looked as if he did not know the meaning of my question. He then half said, half gasped: "Relieved." I asked if he noticed any other emotions. He looked as if I were suddenly speaking a foreign language. But then I asked him if his body felt at all different from usual. He was able to describe the tension in his chest, the swelling in his throat, and the dammed up tears in his eyes. "I didn't notice until you asked!" He said this in a way that was genuine. He had been oblivious to those physical tensions which had been present and described a component of emerging affect. After a few more minutes we could talk about signals in his body which were indicators of fear, sadness, and grief. Prior to that, he had no names for his physical experience of affect and no consciousness for the physical experience. What he did have was a sadistic mother who usurped the value of knowing what he felt through her mortifying dismissals of his value as a human being. It was ego-adaptive for him to not know how awful he felt.

It ought to be clear that the occurrence of the abreaction of intense affect is a complex process with neurobiological, psychological, and interpersonal meanings. Abreaction is not only a spontaneously occurring event, but a valuable part of what the competent clinician must be skillful in facilitating. Otherwise, the stumbling clinician communicates discomfort and difficulty with the patient's affective dimensions. The suicidal patient can feel the countertransference distancing of the "freaked out" clinician (Gorkin, 1987). Our utilization of the spontaneous occurrence of abreaction is in its infancy. Sadly, the recent resurrection of theories of abreaction and catharsis without attendant thoughtful analysis, maintenance of boundaries, and respect for the vagaries of memory have made clinicians shy away from intensive studies of the therapeutic action inherent in abreaction.

MANAGING ABREACTION: CASE VIGNETTES AND GUIDELINES

The approach I recommend in the management of abreaction is one which works steadily toward the development of coherent narratives of experience. These are affectively rich resources for lessons in life which are based on the ability to meaningfully interpret experience in both the past and the present. Events, intrapsychic and otherwise, have meanings which are associated with beliefs that guide our actions. There is a fully available context for living, one which makes use of the integrative notion inherent in the BASK (Behavior, Affect, Sensation, Knowledge) model (Braun, 1988). This is a cognitive-psychoanalytic frame. The unexamined life is worth living; it is just harder to live than the examined life. The clinical setting for such a stance is comprehensible in the following examples.

Vignette Number One

A 28-year-old woman with dissociative identity disorder (DID) was admitted to an inpatient program due to overwhelming attacks of panic, suicidal intent with a plan, and difficulty functioning at work as a crisis counselor and advocate for rape victims. She insisted that she was an accomplished professional and that her work could not possibly be a trigger of her symptoms. As a clinician new to the treatment of dissociative disorders I listened thoughtfully as she talked about how she was clear that if she could just work through the images of rape in her mind, then she would feel better. She talked in detail about the setting of one incident, but began to feel cold as she spoke. She asked if she could cover herself with the blanket I kept in the bookcase. I used this blanket for late night naps when I was on call at the hospital. She continued talking, but soon noted that it was too much effort, and she was too physically uncomfortable to talk while sitting up. "Would you mind very much if I just stretched out on the floor and covered myself with this blanket? I think I would feel better there. I just don't think I can talk about this if I don't stretch out." The fact of the matter was that at some six feet tall, when she stretched out on the floor of my tiny office, she occupied nearly the entire floor space. As she continued to talk, her voice first became monotonic, and then she began to writhe in obvious pain. There was no communication to be had with her, and I had never seen an abreaction before. My panic was clear in my voice as I fumbled with inquiries about what was happening. I was completely ineffective. It was probably a good thing that the patient seemed to ignore me. I ended up sitting silently, wondering what would happen next, and how I would explain all this to my supervisor. After a few minutes her movements stopped, and her tears did too. I was glad that somehow, in just a few short minutes after that, she seemed fully functional.

In supervision I received instructions about "grounding"

and other routine management suggestions about abreaction. I was asked to do more work with the patient to establish what kind of scene was being enacted and to attach it to the story of her life. I was discouraged from proceeding with another abreaction until there was a full understanding of what was going on.

The patient was quite cooperative in providing details of her experience. In fact, before the session was half over she had satisfied the criteria I had been given for proceeding with an effort to pull together the BASK elements of the past. She wanted the blanket again. An abreaction ensued. This time she responded quickly to the grounding suggestions. She said she felt better afterward, but she felt that she was still somewhat detached from the experience.

In the next session there was a repeat of the second session. Something was wrong. It was as if the abreaction was sought out, but not transformative in any way. Did the action of the abreaction *in my presence* hold the meaning of what was going on? It was as if I were watching her being raped, and not only was I doing nothing about it, I was encouraging it. I should have known better than to let her repeat this same episode. I felt this in the context of the therapy, and in the context of a supervised case. I told the patient that I was clear that there would not be another attempt at abreacting this scene, something I now regretted encouraging. I told her that I should have known better, that it was as if I were watching her being raped and doing nothing about, and I would not do that again. It was then that she surprised me by beginning to cry.

The scene she then recounted was of being raped while the rape was observed by a second perpetrator, who then took turns while the first rapist watched. I had been cast as the one who watched. The abreaction was a transference enactment (Chused, 1991; McLaughlin, 1991; see also Baker, 1997).

Vignette Number Two

A 30-year-old woman in treatment for DID had an abreaction at work when the elderly demented man whom she was bathing grabbed both of her arms at the wrists and held them in "an iron grip." The more she struggled, the more his grip tightened. Her colleague was unable to loosen this man's hands. As time wore on, the patient became more and more frightened, uncontrollably, and quietly began to weep. By the time her colleague had distracted the man, who then automatically let go of my patient, she could barely breathe from the fear. For two hours she sobbed. Exhausted, totally spent, she recovered herself after falling asleep, but then left work early, went home, and continued her sleep.

The next day she reported this episode as if it had no meaning other than that of the incident with the demented man at work. She had no recollection of any incident in her life that matched this description. She also knew that she had dense amnesia for much of her life prior to age thir-

teen. Both this amnesia and the sadistic behavior of her father during that period of time had been corroborated in an interview with a woman who had briefly been her stepmother during those years.

Asking the patient's inner world to associate to the feeling of the grip on the wrists, an eight-year-old female part emerged. Frightened and reticent to speak, I gently asked her if she knew something about the wrists. She could only nod her head "yes." Recalling to her the image from some artwork that she had spontaneously drawn two years previously, we talked quietly about the lightly drawn pencil image of forced fellatio with her father. In the picture his hands were on the sides of her head. As she talked, she felt pressure on her head, but also on her wrists. In the drawing she had no arms. She wept as the knowledge of her father, holding her by the wrists, pressed against her head, came into focus. Subsequent work in the session involved a powerful appreciation that it had been necessary for him to hold her wrists because she was resisting him. While the image of her being trapped was upsetting, the fact of her resistance relieved her of a heavy shame. She had always believed his words: "You like this, you whore!" The patient could later proceed to push through anxieties related to giving up the picture of her father as loving her like "a princess," a beloved myth. The absence of arms in the drawing supported her amnesia for the conflict. Resistance to remembering her sordid past was ensconced in an intense attachment to the abuser which protected her image of a safe childhood (Blizard, 1997). Encouraging this woman to become absorbed in the somatic feelings around her intense reaction at work allowed her to work through intense affect with the support of the therapeutic setting. Her alexithymia was also less dense afterward.

Vignette Number Three

A 25-year-old man with dissociative disorder, not otherwise specified (DDNOS), reported a scene from his childhood where his mother had encouraged him, as a four-year-old, to go out on the ball field where his father was playing softball. His instructions were to stand in the outfield. Father was up at bat. The patient described how his mother yelled to catch the ball when his father hit a line drive right at him. Sitting in his chair and describing this scene, my patient held his arms wide, as if getting ready to give someone a big hug, to illustrate his pathetic efforts to catch the speeding ball. He went on to describe how the ball had hit him right in the "solar plexus." It knocked him down, "knocked the wind right out of me to the point where all I could do was whimper. I couldn't even speak." His mother ushered him off the ball field while his father still stood on first base. He went on to talk about the sense of betrayal he had over the idea that his parents would not have kept him safe. He was appalled at his father's lack of empathy; father had run to first base and stood there, while his son, my patient, was knocked off his

feet and on to his back in the outfield. For a brief few moments in the session there were nearly stifled tears, quickly wiped away, associated with the sadness and anger mingled in this scene.

The next session started with the patient stating: "I have something to tell you which I feel you are going to be angry about." He said that although he had felt much better after the last session, he had also begun to wonder about what he had told me. He now realized that in the scene he described there were many other children on the ball field. He reasoned that his parents were no more likely remiss than the other parents who had been there. He had liked the idea that I encouraged him to express his anger, but he now thought that his anger was exaggerated. "I liked the idea of a strong authoritative person joining me in being angry with my parents. I feel safer being angry with my parents when there is someone else who is strong and can be angry with me. Being angry made me feel like I was not a little jerk who had been out on the ball field and ended up embarrassed and feeling stupid for not being able to catch the ball. I don't think the ball was a softball, it was a mush ball. I think that my mind was confused about the mush ball being "soft" and I just connected the soft "mush-ball" with the idea of a softball. I doubt that it could have hurt me or anyone else. I think that I have wanted to find something to be angry with my parents about. I don't know why. I guess I feel angry with them, but I have no explanation for why. I know there are all kinds of ways in which I was disappointed by them and had my feelings hurt which they never knew about." We talked about his continued sense of betrayal by his father that did not change with the new explanation of his recollection, and he went on to connect this with other times of betrayal. His fear that I would be angry with him for changing his story was in the transference associated with his father, a man who had always obsessively insisted on precision in the use of language. He expected that I would berate him and humiliate him.

Vignette Number Four

A 25-year-old woman with DDNOS described her impossible, blinding headache, a headache which had gone on for three days without relief. She had been to see her physical therapist, but there was no decrement of pain. "She thinks that it may be something that she did to me on Wednesday morning that caused the headache, but neither of us can figure out what it was." "Can you tell me about your headache," I asked, "where it hurts, what makes it better or worse?" This patient's history of severe headache was of concern. Did she have true migraine which needed a specific treatment, or did she have severe muscle contraction headache? I could see from her squint that light bothered her eyes and caused pain. Her pattern was bilateral and the most sensitive area was a tender place in her scalp over the frontal region, away from classical temporal areas. It was likely a muscle con-

traction problem, tension. I went after dynamic issues that could be contributing.

"Tell me about Wednesday from start to finish." She described her day in detail. The source of her headache became apparent. She was quietly enraged with her husband. She had spent much of the afternoon reading papers for his review. They were complex financial documents which she had placed in neat piles on the broad seat of his desk chair so that he would see them as he entered his home office. The other flat spaces were too cluttered for her to have put them anywhere else. After hours of detailed work she had felt satisfied, and she looked forward to his approval. He had arrived home long after their small children had gone to bed, seen papers on his chair, and in a moment laced with an air of dismissal, scooped all the papers up with one hand and threw them all over his desktop while collapsing into his chair in one deft movement. Enraged with him, but even more terrified that he would see that she was angry, she burst into tears, and the headache began.

As we talked about issues in the transference regarding the history of her experience with anger, I began to formulate a plan to help her let go of some of the muscle tension in her body. I asked her to imagine the outline of her body, to see the tense areas as red and the most relaxed areas as a deep cool blue. She saw "red hot" areas in her head, but, surprisingly, also in her hands. She talked about "these calm hands that just would like to kill somebody, but lay here limp, like they were just dead sticks." I recalled a hypnotic metaphor of breaking up stones with a sledgehammer to release physical tension and anger. It only took a brief moment to introduce the word "sledgehammer," but with hardly another moment gone by she had clearly entered a terrified panic state. With eyes closed, feet now on the chair and knees under her chin, she shook with terror while she covered her eyes and wept. "You don't have a sledgehammer here, do you," she said pleadingly. She did not know me. There was substitution and displacement in her experience, just like in a dream. To her, I was clearly someone other than myself. There was an unmistakable dread in her rising, child-like, squeaky voice. The next twenty minutes were spent with my calm assertions of safety, orientation in time for the date, day, and year, references to the beautiful Fall weather outside, stating my name, my relation to her, what we did, and so on. She gradually, but very slowly, was able to open her eyes. It was obvious that she was hallucinating. She had calmed down some. Then she abruptly shifted: "Why did you say 'sledgehammer?'" Do you have a sledgehammer? Have you ever used one? Do you know what it's like to be hit by a sledgehammer? Have you ever seen a small animal crushed by a sledgehammer, have you?" There was an odd combination of anxiety and power in her voice. It felt like a combination of accusation and fear. "Have you ever seen a puppy crushed with a sledgehammer, have you?" She was now nearly hysterical, with rapid hyperventilations. She slipped half

out of the chair, one knee on the carpet, the other on the seat, her head on the arm rest, face buried between the armrest and its junction with the back of the chair, pressed into that corner as far as it could go. "I want to go away, far away. I'm going away. I don't know where, but I'm going." She began to weep. I apologized for "saying words I didn't know you weren't ready to hear." I might have asked her if it was O.K. to think about sledgehammers, but I also had a sense that would have triggered her too.

The last few minutes of the session were spent gently suggesting that she could open her eyes and see for herself that it was safe here. I continued re-orienting her every few minutes, and helped her to leave some of her dissociative adaptations by having her focus on the real feeling of the leather against her face and the carpet on the floor under her leg. I asked her what she had planned for the afternoon, a clear signal that the session needed to draw to a close and that she had a life outside the consultation room. She worked visibly harder to orient herself. She looked around the room with less vigilance. Her hallucinations had stopped. She stood, at first unsteadily, but then with more confidence. She spoke as if emerging from a fog, "I'll see you sometime, sometime later." I spoke in a routine manner, "Yes, I'll see you Tuesday morning, 11 A.M." She left. I heard the outside door to the office open. I waited 30 seconds and looked down the hallway for her. She had obviously picked up speed and had left without difficulty once she was out of the suite.

Vignette Number Five

In work with a DID patient, the meaning of the presence of abreaction may be quite complicated. For example, a complicated patient with years of self-mutilation was referred to me by a colleague who decided that she did not want to do outpatient psychotherapy any longer. She preferred to limit herself to her inpatient work and to have "more of a life." What a novel idea! The patient was devastated by the loss. She was also confused by my stance. I did not work with contracts, not wishing to constantly be writing new ones after old ones were broken, and I did not call 911 each time she appeared in my office with a new laceration. Instead, I carefully, and with some intensity, expressed the sentiment that I could not control her, and that she would be the one to decide if she needed hospitalization, within the boundaries of common sense and my responsibility to protect her from herself and keep the community safe. This patient was upset by my stance. It meant to her that "You don't give a damn what happens to me. I could do anything and you would just sit there on your ass and do nothing!" My statements that her cutting left me feeling sad because I had a sense that one day she would regret having mutilated her body seemed to do little to help.

She began to have abreactions associated with hallucinations of alter personalities and misdeeds from the past. There was a lot of affect, but it was loosely held, without a

context; it was disorganized, frightening, and exhausting. Even after all her therapy time, she, like many other patients, had continued to maintain, at choice moments, the sentiment that "I do not have parts, that's a bunch of crap!" But now these hallucinations forced her to say: "I am really crazy! I had no idea that stuff like this could happen. I've always thought that my shrinks were nutty for telling me I had parts, but I'm not so sure now." I had been working steadily toward an alliance with the main persecutor alter, a mother introject, whom the patient reported was too crazy to go to therapy and had never talked to other therapists. Using techniques articulated by Blizard (1997), I posited that it was not that the mother-part wanted to stay out of therapy, it was that nobody else wanted to deal with her feelings of self-hatred and other strong emotions. I suggested that she had been trying to get to therapy to tell her own story, but that others had been frightened and blocked her attendance. I openly hypothesized that the mother part was giving the rest of the mind hallucinations which would get my attention and punish those who opposed her coming to therapy. In the next session the mother part appeared, unannounced, non-verbal, in a deep auto-hypnotic state, but the hallucinations stopped, and a new younger, 20-year-old self aspect emerged. This part was hitherto unknown in the system, had self-respect, and thought that what other parts were doing to the body was crazy. The work to respect the patient's self-determination seemed to have done some good. The hallucinations and abreaction had pushed the system toward some growth. In DID, an abreaction may have a number of meanings.

GUIDELINES

In General: The abreaction of intense affect is not a goal of psychotherapy; it is an inevitable concomitant experience in the therapy of persons with post-traumatic histories, physical and/or sexual abuse, neglect, and related intense experiences. The initial goal of all psychotherapeutic treatment is to provide a secure and stable base for further work. This is true of behavioral, cognitive, and psychodynamic approaches. While regression which occurs in the service of ego development and growth is a normal part of the treatment, this regression is an "in and out" phenomenon which should be contained by the boundaries of the therapy session and not leave the patient functionally impaired. While abreaction may occur during hospitalization, encouragement of patients to make use of the hospital to abreact affect may bypass the need to thoughtfully analyze and approach difficult material in a stable clinical setting. This stance may inadvertently leave the patient with the impression that they cannot safely feel intense emotions without the support of the hospital. Belief in the need for hospitalization to do abreactive work may represent a countertransference intolerance of intense affect in the consultation room. It may also suggest an over-dedication to the

work of the therapy and a paradoxical message to the patient to remain ill in order to make the clinician feel good (Searles, 1967). Clinicians who seek a set of specific guidelines for hypnotically managed abreaction, with a less psychoanalytically inclined frame, will likely benefit from Maggie Phillip's and Claire Frederick's excellent review of hypnotic technique (Phillips & Frederick, 1995).

Maintain a Calm Aura: There is nothing as counterproductive as a nervous pilot who repeatedly reassures the passengers of his airplane that the turbulence they are noticing is not a problem. Leaning back in the chair and saying calmly: "I can see you are having a hard time; these feelings are strong, but they will get spent and pass; let's work on letting go of them," may seem out of place to an observer who sees the patient abreacting. But our patients do not miss a beat of the pulse of the session; they miss little of what we say, even if it seems otherwise. The abreaction of affect passes. If patients activate dissociative processes to deal with the affective intensity, then they were too overwhelmed to deal with it. But the clinician must feel capable of weathering the storm, remaining affectively present, noticing out loud what is happening, and leading the patient to a more present-oriented venue. Harsh, anxious, or annoyed tones in the voice of a clinician will likely send the patient into a deeper spiral. The use of voice is a valuable capacity. It is worthwhile, in my experience, to listen to tape recordings of how you sound in the clinical setting, and hear what patients hear. Some clinicians are able to do this simply by listening to their speech as they speak, but not all of us are so talented.

Some patients will consciously, or unconsciously, test the clinician's strength by abreacting in an apparently uncontrolled manner to see of what the therapist is really "made." This is a variation on the theme of the patient having an unconscious pathogenic belief about themselves (Weiss, Sampson, Harold, & the Mount Zion Psychotherapy Research Group, 1986). Our post-traumatic patients, in my experience, routinely expect that their therapists will look good, sound good, and even be good, before we abuse them.

Be Capable of Uncertainty: The act of working with clinical material indelibly changes the material just as the action of measuring an atomic particle changes the properties of the particle. Of what is it that we wish to be certain? I believe it is our respect and compassion for what it is to be human. As illustrated in the case of the four-year-old baseball player (Vignette Number Three), recalled material, abreacted or not, is subject to all kinds of processes. The central issue in that vignette was one of humiliation and betrayal. That did not change with revision. But we must create a situation where revision is possible. This uncertainty must be modeled by the clinician. The dissociative patient is intolerant of uncertainty. Ambiguity often led to trauma. In some therapies, achieving the tolerance of a lack of clarity is a primary therapeutic task.

Track the Affect in the Patient and in the Clinician: Shifting intense affect is the prime predictor of "switching" from one ego state to another. This is true, in my experience, regardless of diagnosis, and is a good thing to watch in neurotic patients too. Attention to body language is an important cue. Persons who are telling their story using hand gesticulations, and other metacommunications are more affectively free than those who tell a story with a stiff body and monotonic vocalizations. The rigid postures and verbalizations of our patients can tell us that they are in difficult territory and need gentle and empathic responses which mirror rather than probe or confront.

In Vignette Three, empathic attunement and mirroring of the patient's anger toward his parents helped him to locate his own affects, however truncated. The distortions present in the narrative he created to explain his anger and describe the setting of betrayal needed major revision in the second session, but he felt free to do so in the treatment. His freedom to revise the narrative was constrained by the transference, but his sense of betrayal by his father was a core theme which rang true in both the original and revised historical narrative. On the one hand he enjoyed my alliance with him in pursuing themes which spoke of his anger. On the other hand, I had not taken over his anger. I had not pressured him to be angry. In fact, I had told him that it felt sad to think that a person as accomplished as his father had been so emotionally limited. I had offered that his parents would both have been horrified to understand the numerous ways in which they had humiliated him. This inter-generational perspective, where the limitations which parents bring to parenting, as a result of defects in their own upbringing, creates a sense of non-blaming responsibility in the analysis of the meaning of the patient's experience. This man both longed for attachment to his elderly parents, something for which he had always struggled, and feared to own the distasteful affects associated with a childhood filled with fear of father's outrageous temper tantrums and inappropriate competitiveness with his children. Tracking the affect with empathic mirroring allowed a balanced exploration of the narrative, which filled in with as little pressure as possible.

Make Note of Pressures Toward Enactment: Affect is a first order organizer of experience and exists at the core of person schemas (Horowitz, 1991) which could be used to describe the ego organization of alternate self aspects in DID. Tracking affect may lead a clinician to form hypotheses about sequences of affects and accompanying repetitive narratives which create a pressure for enactment. In other words, the repetition of an affectively-laden narrative creates tension and frustration in the speaker and the listener. As this pressure builds up, it leads to a sense of a compelling need to take action to relieve it, either with words or deeds. For example, my wish to be a good clinician and relieve the headache of my patient in the fourth vignette led to a spontaneous abreaction. Instead of listening, naming affects, making con-

nections between past and present, and asking the patient what would help them to move the "red" out of their bodies and find more "blue," I took on the hero role, wielding power and control, and introduced a word with powerful connotations. Even if it had not been a specific trigger, "sledgehammer" has more destructive and violent connotations than would have been necessary for this patient to relieve a small amount of pressure. I was intolerant of my patient's pain, suggesting that in this situation, my reserve tolerance was exhausted, and I wanted relief. As I looked back on the morning of this visit, there was ample reason for me to have exhausted my reserves by the time I met with this woman. In fact, both of the patients I saw at the end of the day ended their sessions with a sense of what one of them articulated: "You're not listening to me today. I don't get it. This session was not helpful. I feel worse now than when we started talking. Why don't you seem to hear me?" While statements like these are not uncommon in a therapy, and may represent distortions in the transference, etc., when they happen in a series of sessions during the day, all of which have poor outcomes for the patient, it may be wise for the clinician to look at his own need for re-fueling and nurture. Lack of attention to these issues leaves pressure to take action as a too real option and may energize serious countertransference mistake (Davies & Frawley, 1994; Pearlman & Saakvitne, 1995).

Avoid Re-Victimization and Enactment of the Traumatic Transference: The patient in Vignette Number One had organized, with my unwitting assistance, a scene of re-victimization. The transference feeling that the perpetrator should "know better" than to engage in misdeeds is one which presents thoughtful clinicians with numerous double-binds. On the one hand, not to approach the scene of abuse as part of the historical narrative is to ignore the patient's need to tell the story of his or her life. On the other hand, to continue the retelling of a story which does not move the therapy forward, and leaves the patient exhausted, is abusive. In the first instance the clinician falls into the category of the colluding parent who ignores the needs of the child. In the second transference position, the clinician acts in the spirit of the perpetrator of abuse who permits seduction of their aggression (Loewenstein, 1957) in response to the child's request for relief of anxiety. So, what is a good clinician to do? If the story is told there is one negative transference position, and if the story is not told there is another. A solution is in presentation of the countertransference dilemma to the patient for his understanding and problem-solving with the clinician. This serves multiple purposes. The conflict on how to proceed becomes the patient's conflict too. To appreciate the conflict means that a new narrative is constructed which holds the clinician's caution on behalf of the patient. This respectful stance often leads to an experience of sadness and hopelessness that the situation can ever be resolved. There is also terror that the clinician will proceed anyhow. Access to these

affects occurs when the patient holds the conflicting transference perspectives. In the open holding of the countertransference dilemma, the clinician has modeled a tolerance for affect which the patient may adopt. Once this new affect becomes known and experienced, the pressure for abreaction of the scene from the past either disappears altogether, or is reduced to the extent that the story can be told in a manageable way.

Do Your Homework: Clinicians who work with post-traumatic patients need the best training possible to remain technically excellent as well as capable of empathic attunement. Clinicians must enter the clinical dilemmas which our patients bring or we will have lost our role responsiveness (Sandler, 1976). We must allow ourselves to be used as transference objects. That does not mean that treatment should be one enactment after another. There are routine pitfalls which can be avoided. Skills in technique which are specific to the management of intense affect may be exceedingly useful. The point here is that excellence in hypnotic technique, EMDR (Shapiro, 1995), and related techniques for the working through of experience related to intense affect and cognitive distortion may be useful. These techniques are beyond the scope of this project. They are not required. But they sure make life easier for patient and clinician. I cannot imagine practicing psychiatry in the trauma field without these skills. Actually, I can imagine it; I just would prefer not to think about the problem of doing without those skills.

BABY OR BATHWATER?

There is enough pressure being brought to bear on clinicians who are traumatologists regarding the problems of memory and the use of techniques such as hypnosis without talking again about abreaction and creating more waves on the therapeutic ocean. But talk we must. It is not O.K. with me to be silent about the utility of abreaction any more than it is O.K. to keep secrets about abuse. It does not matter what technique you use, or what theory you hold if you are a poor student, or a student who believes that there is a simple formula for doing the work of psychotherapy. In such cases the outcome will be poor. Few people are so naive, luckily, but there are some.

Abreaction is not going to go away. What must change is what we understand about it, and how to make use of it as it occurs. We must be skillful and pay heed to the limitations of technique and theory.

The abreactive materials buried in our patients' stories are like "diamonds in the rough." That's more the flavor of what abreacted material is like. It must be closely examined, finely honed, thoughtfully worked. In so doing, we come to appreciate new facets of the diamond, new ways of seeing ourselves and each other. Let's take better care of our babies. ■

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