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Abreactive Work with Sexual Abuse Survivors: Concepts and Techniques

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Abreaction is the revivification of past memory with the release of bound emotion and the recovery of repressed or dissociated aspects of a remembered event. While abreaction is an integral part of most psychotherapeutic work, it is essential with sexual abuse survivors. It provides a psychic reworking of the trauma that identifies, releases, and assimilates the unresolved aspects of the abuse, allowing resolution and integration on both psychological and physiological levels. This chapter focuses on the specific type of abreactive work involved in the recovery and healing of dissociated memories of childhood sexual abuse.

Unresolved, unassimilated trauma creates dysfunction in the client's life, causing flashbacks, overreaction to stimuli, distortions of perceptions, and high levels of internal stress. Change and mastery evolve through the remembering, releasing, and relearning that occur during abreaction, so the trauma no longer has an unconscious effect on the client's behaviors and belief systems in the present. Planned abreaction can provide a step-by-step framework in which memory work can be done safely, giving the client mastery over what he or she could not control as a child.

Abreaction was originally described by Breuer and Freud (1957) as a cathartic technique for hysteria. Its use as an effective process with victims of trauma was proposed by Lindemann (1944). However, abreaction with combat veterans during World War I and World War II met with mixed results and fell into disuse for a variety of reasons. During the Vietnam War, abreaction again became an important part of the treatment for posttraumatic stress disorder (PTSD). During the 1980s, there was a renewed interest in the works of Pierre Janet (a contemporary of Freud), Charcot, Binet, Prince, and others (Ellenberger 1970; van der Hart and Friedman 1989). These men used abreactive work in the treatment of hysteria, which is the historical antecedent of what are now termed traumatic stress and dissociative disorders. In addition, the increasing knowledge about the relationships among trauma, PTSD,

dissociation, and hypnosis—including their physiological components—has led therapists to reconceptualize the process of abreactive work, making it more effective with traumatized individuals (Kingsbury 1988; Nichols and Efran 1985; Ochberg 1988; Spiegel 1986a, 1986b, 1988).

Over the past decade, as additional victim populations have been identified and treated, abreaction has gained in popularity as an important component of the overall treatment. Currently, many clinicians agree that abreactive work is a necessary part of the assimilation process with most survivors of childhood abuse (Bass and Davis 1988; Braun 1986; Courtois 1988; Figley 1985; Gil 1988; Kluft 1984; Putnam 1989; Ross 1989; Spiegel and Spiegel 1978; van der Kolk 1987; van der Kolk and Kadish 1987). However, most of the literature on treatment of adult survivors of childhood abuse does not address the context and process of abreaction in detail.

The concept of abreactive memory work and the related concept of dissociation are often misunderstood and not used adequately by therapists who work with adult survivors of childhood abuse. Some therapists use abreactive work instinctively with abuse survivors without having a conceptual basis for their work; some understand the need for abreactive work but are intimidated by its intensity; some see it as a separate process to be done by a specialist, such as a hypnotherapist. Others are not aware of the need for abreactive work and focus on alleviating the secondary symptoms of the trauma without dealing directly with the past. While we believe that abreactive work is an integral part of the process of working with most survivors, it must be adequately timed, managed, and processed, or it may retraumatize the client, promote further repression and dissociation, produce negative transference reactions, trigger nontherapeutic regression, and even precipitate psychotic decompensation, self-mutilation, or suicide attempts. Thus, the appropriate use of abreactions is paramount for a safe and effective therapy.

This chapter delineates the context and process of abreactive work. Much of the conceptual basis and many of the techniques presented here have been derived from recent work done with multiple personality disorder (MPD). It is the authors' contention that survivors of childhood sexual abuse (and other types of abuse and trauma) may be placed on a dissociative continuum. MPD is the most extreme and pervasive form of dissociation, and during the 1980s, by far the most research and clinical work in the area of dissociation and abreaction was done with MPD. Thus, there is a wealth of information in the MPD literature that may be used with other survivors of childhood abuse. In no way is this meant to imply that all survivors of childhood abuse should be treated as multiples. Multiplicity is a specific diagnostic entity with its own indigenous phenomenology. Although a substantial minority of childhood abuse victims are multiple, the majority are not. Many concepts and techniques that have been developed for the treatment of MPD can, however, be modified for effective use with other dissociative clients.

Some abreactive techniques, such as those for facilitation and containment, are emphasized here, together with some of the more common and generally useful ones. What is most important is that the therapist understand the process and goals of abreactive work and the concept of dissociation. Then, both therapist and client together can use their creativity to develop techniques tailored to the needs of the individual client.

A number of the techniques presented in this chapter are hypnotic in nature. Hypnotic techniques are particularly useful in the management of abreactions because of the similarity between the dissociative state of consciousness present during abreactive work and the state of consciousness produced by hypnosis (Kingsbury 1988; Spiegel 1986a). There is evidence that childhood abuse victims are highly hypnotizable (and, thus, easy hypnotic subjects), although the reasons for this are not entirely clear. Calof (1987) has referred to the use of hypnosis with survivors of sexual abuse as an approach of "fighting fire with fire," meaning that hypnosis is the intervention matched most closely with the dissociative defenses of the client (Kingsbury 1988).

A note of caution: Hypnosis is a specialized therapeutic technique that should be used in a circumspect and carefully planned manner. Therapists should *never* attempt to use hypnosis without adequate training and supervision and should be well versed in indications, contraindications, proper induction procedures, and ethical considerations. Information and training may be obtained from the American Society of Clinical Hypnosis, 2250 East Devon Avenue, Suite 336, Des Plaines, IL 60018. A number of basic texts on clinical hypnosis also are available (Hammond 1988a, 1988b; Wright 1987).

Other important areas discussed in this chapter include the therapeutic use of the client's dissociative skills in the abreactive process, a conceptual framework for abreaction, and a review of countertransference issues that arise in doing abreactive work with survivors. Particular emphasis is placed on setting a safe context for abreactive work.

The concept of dissociation is vitally important in abreactive work and will provide a foundation for the understanding and management of abreactions. Activation of traumatic memories without adequate defenses will overwhelm and retraumatize the client. Dissociation is the defense the client used at the time of the trauma, and by accessing the trauma within this defensive structure, the client will retain the capacity to work through the abuse at his or her own pace.

What Is Dissociation?

Dissociation is a psychophysiological process in which there is a separation or nonintegration of emotions, thoughts, sensations, or behaviors from the current stream of consciousness. *DSM III-R* defines dissociation as "a dis-

turbance or alteration in the normally integrative functions of identity, memory, or consciousness" (American Psychiatric Association 1987, 269). Ross (1989) defines it simply as a lack of association in which aspects of consciousness that are normally associated within one's awareness are compartmentalized into separate areas of consciousness so that there is no longer an association between one aspect and another. One is usually aware of one's thoughts, feelings, and sensations at a given moment. In a dissociative process, one or a combination of those aspects may be separated from the current field of consciousness.

For example, many individuals appear calm following a traumatic event such as a car accident in spite of the fact that they have just had a very frightening and even life-threatening experience. Such individuals have dissociated their intense affect from their current awareness. And, as those who have had such an experience know, intense affect is likely to find its way into conscious awareness sometime (hours, days, or weeks) after the original experience.

Dissociation occurs on a continuum of awareness that begins with full awareness and progresses through suppression to repression and then dissociation (Braun 1984a, 1988a; Hilgard 1977; Ross 1989). Repression, for the purposes of abreactive work, is considered to be a special case of dissociation with three basic differences:

1. Dissociation creates an amnestic barrier that prevents the interchange of memories and experience, whereas repression creates amnesia only for unacceptable impulses and affects.
2. Repression is a purely psychological phenomenon, whereas dissociation has both psychological and neurophysiological components.
3. Repressed material is pushed from the conscious arena into the unconscious at some time after a traumatic event, whereas dissociation occurs at the moment of trauma so that the conscious material becomes encoded into a separate consciousness rather than becoming unconscious.

Dissociation is a universal survival response. When an experience is more than a child's mind can tolerate, he or she must escape. The human instinct to survive is paramount. When a being is small in size; dependent on others for nurturance, protection, and connection to the world; and unequipped to integrate abusive traumatic experiences (because of a lack of experience and inadequate cognitive schema), he or she is left with no alternative except to dissociate, or to decompensate psychologically. In dissociating, the child disengages his or her feelings, sensations, behaviors, or cognitive knowledge during abusive events and deflects those into a separate consciousness in which the events are recorded and encoded.

Dissociation helps to preserve the basic ontological security needed to maintain a cohesive sense of self and experience. It is the mechanism that allows one to say, "It didn't happen to me." Yet dissociated aspects of the trauma leak back into consciousness in alternating cycles of numbing/denial and intrusion so that, ultimately, dissociation is not sufficient to protect the survivor from the impact of trauma (Horowitz 1973, 1976).

Dissociation is an interesting and challenging clinical phenomenon, but it is crucial for the therapist never to lose sight of the human being who has come for treatment. For survivors, dissociation is the way in which they have survived the intolerable. The very personal meaning and value of the dissociative process is best conveyed by the words of one of our former clients:

> I knew my ugly, bruised body couldn't go anywhere, so I just left it there, where it had been deposited by (the abuser). But I could and did leave. I simply let the soft purple fog engulf me, and I sunk deep into the darkness until the pain and fear and the taste of salty tears belonged to someone else, and I was free.

Types of Dissociative Experiences

Dissociation occurs on a continuum ranging from normal experiences to the extreme of MPD. Normal dissociation is an integrative function of the ego that filters extraneous stimulation from the field of consciousness to prevent sensory overload. Highway hypnosis, engrossment in a television program, and daydreaming are examples of normal dissociative experiences. The content of normal dissociation is very narrow and specific, its duration is brief, and the individual realizes that dissociation has occurred and quickly reestablishes control (Sachs and Frischholz 1989). Dissociation may be used as a defense during trauma or during an experience that is not in the normal range for a given developmental stage of life. It is considered to be dysfunctional when it becomes a primary defense rather than an emergency measure, when the individual cannot reestablish control, when there is no awareness of dissociation, when it is used in inappropriate contexts, and when its intensity and duration are disruptive to the individual's life.

Braun (1988a, 1988b) has described the BASK model of dissociation, which is conceptualized along four dimensions of experience: behavior, affect, sensation, and knowledge. During trauma, any one or any combination of these four dimensions may be dissociated from consciousness.

By using these four dimensions in abreactive work, the therapist can determine which are missing from the client's experience and, thus, which need to be accessed and integrated. For example, if a client reports a brutal rape very calmly, the therapist will recognize the missing dimension of affect. Sometimes a client will report with intense affect an episode of abuse that

must have been physically painful, but the client will say his or her body felt "numb," hence missing sensation. Amnesia is the indicator for dissociated knowledge components.

Behavioral components often intrude into the present and can be puzzling and frightening to the client. For example, a client began a session by reporting an overwhelming urge to curl up on his side with his knees to his chest (behavioral clue). This was accompanied by a sensation of pressure and burning in his rectum (sensory clue). Following these clues, he was able to access the dissociated knowledge component, which was an episode of being sodomized by an uncle. Such combinations of sensory and/or behavioral clues that occur without a cognitive component are known as somatic or body memories and are extremely common in survivors of childhood physical and sexual abuse.

The degree and manifestation of the dissociation depends on a number of factors, such as the age of the victim, severity and length of abuse, number of abusers, family modeling of dissociation, genetic predisposition, presence of restorative factors in the environment, and presence of normal psychological building blocks. These include cognitive lines of separateness, imaginary playmates, state-dependent phenomena related to trauma, ego states, degree of separation-individuation, and maturity of self and object representations (Kluft 1984).

Dissociation may be temporal, as in amnestic episodes related to traumatic events, or spatial, as in out-of-body experiences and fugue states (Spiegel 1984). The continuum of dissociative experiences includes normal experiences such as hypnosis and automatism, out-of-body experiences, localized and generalized psychogenic amnesia, fugue states, object fixation, profound detachment or depersonalization, derealization, somnambulism, possession states, mystical experiences, ego states (Watkins 1979–80), and MPD. PTSD, a diagnosis often used for adult survivors of childhood abuse, also is considered to be dissociative by many leading experts in the fields of abuse and traumatic stress (Courtois 1988; Donaldson and Gardner 1985; Figley 1985, 1986; Gil 1988; Mutter 1986; Ochberg 1988; Price 1987; Putnam 1985, 1989; Ross 1989; Spiegel 1984, 1988, van der Kolk 1987).

Dissociation is present as a physiological process in a number of organic conditions. These include post–head injury amnesia, electrical injury, toxic conditions, petit mal seizures, infections, metabolic disorders, drug and alcohol use, medication reactions, and temporal lobe epilepsy. Such organic problems must be ruled out if a client is currently dissociative. There is some indication that the type of dissociation present in organic disorders is qualitatively different from trauma-induced dissociation (Loewenstein and Putnam 1988). Furthermore, those who use dissociation as a psychological defense have a history of dissociative episodes prior to physical injury or illness.

Assessment of Dissociative Phenomena

Since the recognition of dissociative phenomena is crucial for the effective treatment of abuse survivors, assessment strategies for the identification of a client's dissociative capacities are important. There is much information to be gained regarding the client's ability to dissociate if the therapist is alert to clues in the client's presentation, beginning in the first session. The survivor usually will understand questions about dissociative phenomena immediately if they are asked in nonclinical terms—for instance, "Do you have times that you feel lightheaded or spacy?" "Do you sometimes feel as though you're not quite real?" "Do you know how to 'check out' when you're nervous or afraid?" "Are there times that you can remember the beginning and the end of an event but not the middle?"

Table 1–1 lists some self-reported indicators of possible current dissociation. Table 1–2 lists some indicators of possible dissociation observed in session. These indicators will be useful in assisting the therapist in determining the nature of the client's dissociative experiences. These are not exhaustive lists but do include some of the more commonly found indicators. And, of course, the presence of some of these signs and symptoms may not necessarily mean that a dissociative process is occurring. Any one sign (with the exception of current loss of time and amnesia) may not be significant in terms of a dissociative process, but the therapist should be alert to clusters of these indicators. It is always important to rule out an organic process and Axis I diagnoses other than dissociative disorders. Yet dissociative symptoms very commonly have disguised presentations that mimic physical illness and/or other Axis I diagnoses. The presence of several of these indicators raises an index of suspicion about a dissociative process, and further inquiry should be made of the client.

One can expect more severe forms of dissociation and more frequent dissociation if one or more of the following apply:

1. There were multiple abusers.
2. The abuse was violent or sadistic.
3. The onset of abuse was at an early age.
4. The abuse extended over a period of time.
5. Family members modeled dissociation in their interactions with the client and with each other.
6. There was further trauma upon disclosure, or there was no disclosure.
7. There is a genetic predisposition to dissociate.
8. The client has no memory prior to the abuse, poor memory of the abuse, and/or poor memory of childhood in general.
9. The client reports current dissociative experiences, especially loss of time.

Table 1–1
Self-Reported Indicators of Possible Current Dissociation*

Impulsive behaviors/self-abusive behaviors
Impulsive spending
Sudden gambling, shoplifting, or promiscuity
Substance abuse
Overeating, binging, or purging
Self-mutilation
Compulsive exercising
Accident-proneness
Sexual acting out
Inability to remember recent events or parts of events
Vague, fuzzy, or unclear memories of recent events
Loss of time or inability to account for time
Depersonalization
Feeling parts of one's body change
Feeling outside of one's body
Anesthesia and paresthesia
Feeling of unreality
Unexplained or unusual phobias
Panic attacks
Impaired concentration ability
Limited coping abilities
Unexplained behaviors
Finding oneself in an unfamiliar place
Finding evidence of having done things that one does not remember doing
Finding various articles in one's possession that one does not remember buying
History of disorganized behavior
Inability to complete projects
Needing lists and notes to organize
Forgetfulness

* Many of these experiences occur in drug-induced altered states; therefore, it is necessary to inquire as to whether these experiences occur at times other than with the use of drugs or alcohol.

Upon receiving reports of any current dissociative behavior, further screening for MPD or another severe dissociative disorder is always indicated. The therapist should explore the extent to which the client is dissociating, how much awareness the client has that he or she is dissociating, and how much control the client has over whether or when he or she dissociates. This information can be gathered while asking about general coping styles and the presenting complaints. For instance, a client may report that he feels nervous around older men because his abuser was his grandfather. When the therapist asks him to give an example, the client replies that he went to a dinner party and was seated next to a man who was about seventy years old and kept nudging him with his elbow as he talked.

"And did you get nervous?" the therapist asks.

"Yes, I didn't want to sit near him," the client replies.

Table 1–2
Indicators of Possible Dissociation Observed in Session

Behavioral clues
- Staring
- Repetitive movements (such as rocking)
- Rigidity of the body
- Unresponsiveness
- Disorientation to time, place, or person
- Responses to visual, auditory, or tactile hallucinations
- Seizurelike behavior
- Signs of regression (childlike voice, posture, or habits)
- A subtle but definite change in face and/or posture that can be recognized in a client that you know well.

Affective clues
- Reports of feeling paralyzed, numb, terrified, spacy, floating, feverish, dizzy, cold, far away, icy, lightheaded, lost, confused, distant, disconnected, weird, or not feeling anything
- Affect that is incongruent in type or intensity with the current situation
- Labile (unstable) affect
- Rapid shutting down of affect
- Lack of affect

Sensory clues
- Limb paralysis
- Numbness, partial or complete
- Anesthesia
- Paresthesia
- Tingling or buzzing
- Trouble hearing
- Choking or sensation of suffocating
- Tightness in chest
- Tunnel vision or psychogenic blindness
- Pain in parts of the body, most notably pelvis, rectum, vagina, throat, jaw, wrists, ankles, neck, or abdomen
- Headaches
- Nausea
- Sensation of falling
- Coldness
- Stigmata, such as bruising, bleeding, or blistering
- Palpitations

Cognitive clues
- Verbal clues to past dissociation
  - "I left my body and went to the ceiling."
  - "I don't know if that happened to me or to my brother."
  - "I saw it happen to this other little boy."
  - "I knew it was happening, but I thought about something else."
  - "I remember him walking in the door, and the next thing I remember, he was walking out."
  - "He came over to the bed and turned out the light . . . and I went out to play."
  - "It must have been scary because my sister started to cry."
- Intrainterview amnesia—evidence that the client does not remember portions of the session
- Microamnesia—extremely brief episodes of amnesia during which the client does not hear all or part of what was just said
  - "Sorry, I missed what you said."
  - "I didn't hear you."
  - "I was thinking about something else."
- Tangential or circumstantial thought patterns
- Confabulation (building a story on minimal facts)

"And what happened? Do you remember anything else about that dinner?"

"No, I just had to sit there, and I really don't remember much, except how glad I was to leave."

As this is pursued, it becomes clear to the therapist that the young man had dissociated and the entire night was fuzzy except for being nudged by this man's elbow and feeling fearful, after which he blocked out all sensory and affective content.

Two reliable instruments are used to measure dissociative experiences. The Dissociative Experiences Scale (DES) is a short, self-administered screening questionnaire that gives a wealth of information on the types and frequency of dissociative experiences in a given individual (Bernstein and Putnam 1986; Ross, Norton, and Anderson 1988). The Dissociative Disorders Interview Scale (DDIS) is a structured interview that distinguishes among various *DSM III-R* diagnostic categories related to dissociation (Ross et al. 1989; Ross 1989, 314–334). Other instruments have been developed but have not been widely tested on clinical groups, and validity and reliability have yet to be established.

Theoretical Framework

There is now a wide acceptance that childhood sexual abuse is traumatic and harmful and that it often produces long-term sequelae in the adult survivor. The extent of negative effects depends to some degree on a number of external factors, such as age of onset of abuse, length and severity of abuse, and number of perpetrators. In addition, an individual's responses to trauma depend not only on the objective severity of the trauma but also on the subjective experience of what happened. Thus, different individuals may have different responses to the same traumatic event. In no way does this suggest that sexual abuse is not traumatic to some individuals, but it is important to be aware of the various possible responses. It is crucial for therapists to understand the individual's worldview and the personal meaning that individual attaches to the trauma.

How does sexual abuse traumatize the child? Childhood sexual abuse produces psychophysiological stress primarily related to activation of the autonomic nervous system (ANS). Psychologically, when an individual is unable to tolerate the trauma and a "fight or flight" response is not possible, he or she attempts to escape through dissociation. The individual either will have amnesia for the event ("It never happened"), will have an out-of-body experience, or will create an alternate personality ("It happened to someone else, not me"). There is a concurrent physiological process in response to the stress of the trauma. This process creates an altered state of conscious-

ness in the victim that is a hypnoidal dissociative state (Rossi 1986; Rossi and Cheek 1988; Spiegel 1986b). In other words, a stress reaction creates chemical changes in the brain and body, which in turn produce dissociation. Dissociation is similar in nature to the altered state of consciousness produced by hypnosis. Thus, during trauma an individual is in a hypnotic state.

Traumatic experiences are encoded as state-bound information that is accessible only in the psychophysiological state of the individual at the time of the trauma (Braun 1984a, Eich 1980; Mutter 1986; Putnam 1985; Rossi 1986; Rossi and Cheek 1988; van der Kolk and Greenberg 1987). These states contain the dissociated aspects of the trauma. Since they must be accessed for the trauma to be resolved, the therapist who is skilled in recognizing dissociative states and phenomena will have myriad therapeutic options for abreactive work.

Childhood sexual abuse implies the loss of an internal locus of control, with resultant helplessness and the presence of disintegrative anxiety in response to the threatened annihilation of self (Figley 1985; Krystal 1968; Spiegel 1988; van der Kolk 1987). The victim becomes an object rather than a person (depersonalization), losing the self-identity and meaning that normally provide a structure for ontological and psychological security. It is not uncommon for physical security also to be threatened, so the individual literally has no arena in which to maintain the sense of safety and stability that are the necessary underpinnings of living.

Several basic assumptions allow us to maintain our psychological and ontological security in the world. These assumptions include the belief in personal invulnerability, the belief that the world is meaningful and comprehensible, and the view of oneself in a positive light (Janoff-Bulman 1985). They also provide the foundation on which we build cognitive frames to make sense out of our experience. Sexual abuse, as well as other childhood abuses, shatters these assumptions. The abuse is so overwhelming that a child's cognitive structures may be inadequate to process it, much like the analogy of a child attempting to assimilate the concept of infinity (Fish-Murray, Koby, and van der Kolk 1987; Jehu, Klassen, and Gazan 1985; Orzek 1985). The unprocessed traumatic experiences force survivors to maintain an unconscious awareness of their extreme vulnerability, of the dangers of their world, and of their own sense of worthlessness. Because survivors are unable to make sense of, and thus to integrate, the trauma, they continue to remain stuck in the helplessness, anxiety, and meaninglessness of the experience. This is the base for secondary symptom formation.

The experience of trauma and the ensuing shattered assumptions lead survivors into existential crisis (Steele 1988, 1989a, 1989b). The existential crisis will be contained in the worst subjective moment of the trauma for a given

individual. An existential crisis is a critical period in which one confronts several issues (Frankl 1963; Grove 1987, 1988; Silver, Boon, and Stones 1983; Spiegel 1988; Steele 1989a; Yalom 1980):

1. Death (or annihilation, the psychological corollary of threatened biological death)
2. Meaninglessness
3. Isolation
4. Issues of freedom and responsibility

Most individuals face these issues symbolically; survivors of childhood abuse often encounter them in the form of literal experiences. It is just such moments that the client must access within the abreaction to resolve the traumatic experience.

The crisis of death is a moment in which one believes that one will die or be annihilated and is helpless to prevent it. The crisis of meaninglessness is a moment in which one's experience is so overwhelming that it makes no sense and cannot be categorized. In addition, one may lose a clear sense of identity both as an individual and as a part of a social setting that provides a context for meaning. The crisis of isolation is a moment in which one is alone at a time when connection with another is most needed. This crisis is often heightened because parents who should be the significant others with whom the child can connect often are the perpetrators of the abuse. The crisis of freedom and responsibility is a moment in which one is utterly helpless, when there is absolutely no internal locus of control at a time when one's own or another's physical and/or psychological integrity is threatened. As a result, individuals may acquire either or both of two defensive postures: (1) They may respond with helplessness to any choice points (learned helplessness), or (2) they may assume an omnipotent responsibility for what has happened, blaming themselves for causing the abuse.

Attention becomes focused and fixed during trauma so that the field of consciousness (that which is held within conscious awareness at a given moment) narrows. This limits the amount of information that can be processed by the individual. Simultaneously, the usual defenses and screening functions of the ego are overwhelmed, and the individual cannot modulate the impact of the trauma. The individual essentially becomes a "blank slate" on which traumatic experiences, including the shattered assumptions and existential crises, are imprinted. Imprints have potent and lasting effects because they are paired with powerful affects and limited attention at a time when the individual has no ability to defend against them. These imprints are frozen as state-specific information within dissociated states. During abreaction, the dissolution of the imprint will occur as its emotional energy

is decathected and as the resulting cognitive distortions are reframed. Imprinting is an important concept because it explains the powerful effect of dissociated material on the individual. Stressors (triggers) that are similar in structure to the trauma activate ANS activity, which partially releases the encoding of the imprint, resulting in the intrusion of flashbacks, nightmares, and other derepression phenomena.

By virtue of the dissociative process that is used to defend against these intolerable dilemmas, the survivor becomes fixated in particular moments of unresolved existential crises that have been imprinted. These moments become frozen in time as state-dependent phenomena and thus are refractory to change except within the state in which they occurred. The survivor experiences a bind: Dissociation defends against the disintegrative anxiety related to the existential crisis, but it also prevents resolution by keeping the crisis out of conscious awareness.

The therapeutic goal of abreaction is to unfreeze this moment of ontological insecurity and bring it into conscious awareness so that it can be reexperienced in a different way within the context of therapy. The existential crisis must be alleviated during abreaction by recreating the trauma as a contiguous experience on a continuum of space and time with the four dimensions of BASK reconnected in the client's experience. As the BASK components are linked, they will add clarity and new perspectives to the memories. The existential crisis will become manifest during this process. Cognitive frames that have been formed during preabreactive work can then be added to create new perspectives from which the client can discover the resolution of the crisis.

The experience of trauma, including the shattered assumptions and the existential crisis, results in a traumatic triad of helplessness, terror, and meaninglessness (Steele 1989b). This triad becomes imprinted, thus forming a wedge in the space-time continuum in which time is expanded because of the intensity of the experience, then frozen in a dissociated state (see figure 1–1). Because of the dissociation of at least some aspects of this experience from awareness, and because of the powerful and concentrated imprinting of this experience on the psyche, this experience will continue to have a powerful effect on the individual's life. This traumatic triad can be considered to be the abreactive target. If the client can be released from the "trap" of terror (disintegrative anxiety), meaninglessness, and helplessness, he or she can be empowered to resolve the trauma and to heal. The actual clinical process of accessing the abreactive target is discussed in the section "Alleviating the Existential Crisis."

Having provided a conceptual basis for abreactive work, the next logical step is to discuss the structure and planning of abreactions. For therapists who have witnessed spontaneous, unplanned, and distressing flashbacks by their clients, however, it is clear that abreactions are not always planned and that

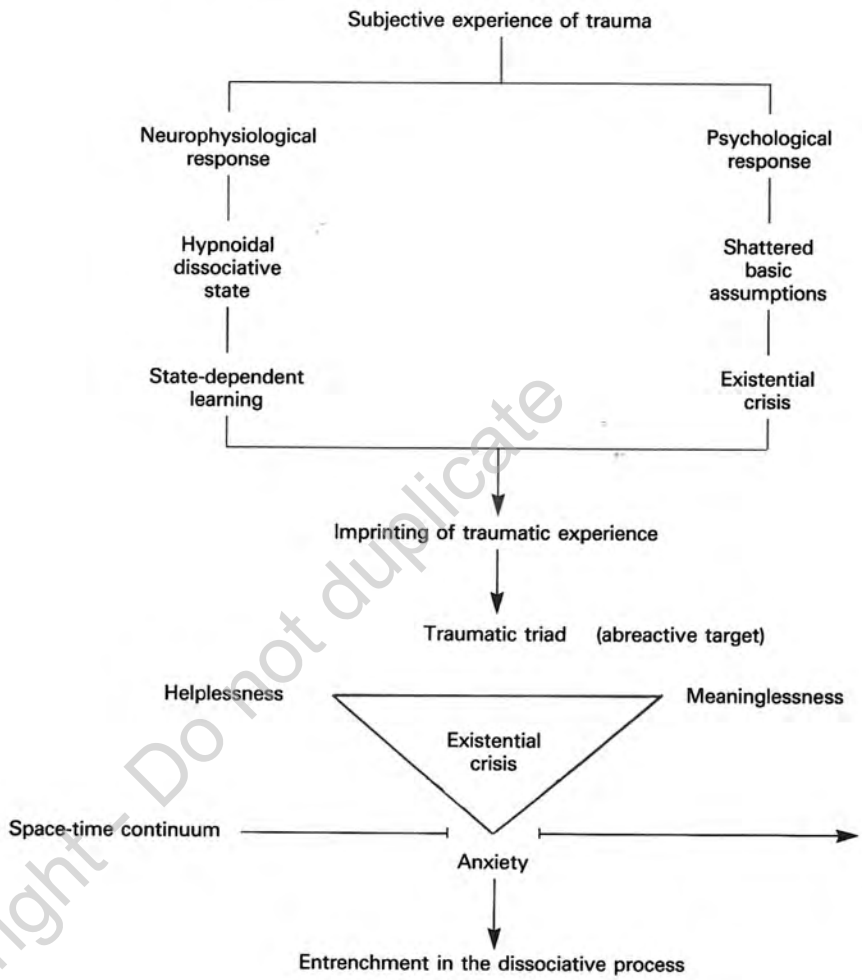

Figure 1–1. Dissociative Responses to Severe Abuse

flashbacks are usually an integral part of therapy with survivors of childhood abuse. Therefore, it is essential to provide some guidelines for understanding, framing, and containing flashbacks (spontaneous abreactions) before proceeding to planned abreactions.

Spontaneous Abreactions

What to Expect

The intense nature of many abreactions is often related to the fact that sensory-perceptual, affective, behavioral, or cognitive components present during the abuse (which have been dissociated and concentrated over a period of years) emerge with the full impact with which they were originally experienced. Abreaction is, in a sense, a time-distortion phenomenon in which the past is brought into the present, the present fades out, and the past becomes the experienced reality in the present. For the moment of the abreaction, reality becomes at least partially altered, and the client responds as though he or she were living in an experience from the past. In other words, during abreactions (spontaneous or planned), the client will be in an altered, dissociative state. Thus, it is crucial for the therapist to understand and be able to use dissociative phenomena therapeutically and to understand that abreactions are dissociative in nature.

Spontaneous abreactions are frequently experienced through conscious and unconscious flashbacks, which may occur during waking or sleep states (Blank 1985). Flashbacks are a reflexive, incomplete, uncontrolled, and fragmentary reexperiencing of trauma, with much of the content occurring unconsciously. Thus, despite the fact that catharsis and memory recovery may occur during flashbacks, these episodes are experienced as overwhelming and traumatic in themselves, and the original traumatic experience is not accessed in a linear fashion within a cognitive frame for understanding, which would promote resolution. Flashbacks can be very frightening, and without a cognitive understanding of the intense affects and sensory experiences that are part of spontaneous abreactions, clients often feel "crazy."

Conscious flashbacks include a cognitive component during which the client has at least partial conscious recall of the traumatic event. Additional dimensions of experience related to the trauma also are present, such as behaviors, affects, or sensations, including vivid multimodal hallucinations. There may be a disorientation to time, place, and person in which the client believes himself or herself to be living in the moment of the remembered trauma, without complete awareness of the present reality. Conscious flashbacks often are dramatic and easy to identify, although when they are misinterpreted by the therapist, they most often are labeled as psychotic episodes.

Unconscious flashbacks are more insidious and difficult to identify but are common occurrences in survivors of child sexual abuse, and their identification will greatly facilitate abreactive work. Unconscious flashbacks are the reexperiencing of some aspects of the traumatic event without conscious awareness. They are triggered by intrapsychic, interpersonal, or environmental cues of which the client is unaware. These cues are actually state-

dependent stimuli that access the dissociated aspects of the original trauma (Eich 1980).

For example, a client experienced a panic attack as he walked down an enclosed concrete stairwell. He reported this in session and said he felt he was losing his mind, as he had never been afraid of stairs before. As the event was processed for clues that might have precipitated the panic, the client revealed that he had been eating a candy bar while walking down the stairs. It was discovered that as a child, he had been lured into a similar stairwell by a man offering him chocolate candy. He was subsequently brutally raped, and the complete cognitive memory of that trauma had been dissociated. It was the pairing of the two innocuous and specific environmental cues of chocolate and the stairwell that triggered an unconscious flashback. The panic attack was a reexperiencing of the affective response to the rape. Yet because the client had no conscious awareness of the triggering cues or of the trauma, he reexperienced the affect without the ability to process it. It was only when he was able to access the full cognitive memory along with the affect in an abreactive session that he was able to gain resolution. Following the abreactive session, he was no longer triggered by stairwells or candy bars.

Triggers also may be developmental or related to situational factors in the client's life that may symbolically or structurally recreate some aspect of the traumatic scenario (Gelinas 1983). These may include the onset of adult sexual behavior, marriage, death of a perpetrator or protector, divorce, childbearing, one's child reaching the age of onset of the client's own abuse, weight loss, serious illness, or job changes.

The effects of triggers may intensify as clients become engaged in therapy and begin to focus on their history. They are more susceptible to triggers and resultant flashbacks when they are fatigued, stressed, or physically ill. Thus, the state of physical health, rest, nutrition, and stress reduction are all important issues to consider when the client is experiencing frequent, uncontrolled flashbacks.

Clients can be taught to recognize impending spontaneous abreactions in an effort to reduce their occurrence during the course of therapy. Signals often alert the client to an impending abreaction (table 1–3). He or she can learn to report early signs of impending abreactions to the therapist, and together they can plan a session to deal with the memory, or they can "contain" the memory by therapeutically using the dissociative skills the client already employs. It is useful to reframe cognitively the frightening signals of flashbacks as important messages that the client is giving himself or herself. The client can then acknowledge the signals as a sign of progress and can begin to have a sense of control as flashbacks become viewed more as a therapeutic instrument with which the client can cooperatively work rather than as an experience of total and meaningless dyscontrol.

Within a session, the therapist may recognize restlessness, hypervigilance, exaggerated startle responses, poor concentration, and evidence of increased

Table 1–3
Signs of Impending Abreactions

- Dizziness or lightheadedness
- Headaches
- A subjective sense of "shifting" or "movement" inside the head
- A sinking or drowning feeling
- Telescoping or tunnel phenomena in which one feels physically distant from current reality
- Confusion and/or disorientation
- Hallucinations
  - Auditory
  - Visual
  - Kinesthetic
  - Rapid "snapshot" images of the abuse
- Sudden and unexplained onset of dysphoria
  - Free-floating anxiety and dread
  - Panic attacks
  - Irritability
  - Depression with weakness and/or unusual fatigue
- Secondary responses to dysphoria
  - Self-mutilation or suicide gestures and attempts
  - Missing or canceling therapy appointments
  - Alcohol and drug use
  - Binging and purging or anorexia
  - Sexual acting out
- Sleep disturbances
  - Sleep avoidance
  - Insomnia
  - Hypersomnia (not common)
  - Frequent sleep interruptions
- Nightmares with specific themes related to abuse
  - Night terrors
- Phobic reactions to external stimuli
- Physiological signs of automatic arousal, with or without associated feelings of panic
  - Tachycardia (rapid heart rate)
  - Palpitations
  - Sweating
  - Dry mouth
  - Diarrhea, nausea, or vomiting
  - Hyperventilation
  - Hypervigilance and scanning
  - Exaggerated startle responses
  - Increased motoric tension and/or activity
    - Agitation
    - Pacing
    - Restlessness
  - Fight or flight responses
    - Increased aggression
    - Withdrawal

dissociation in a client just prior to spontaneous abreactions. Often the content of the session will trigger these, and the therapist will become astute in recognizing what material is most likely to produce spontaneous abreactions. He or she should approach these areas with caution in the beginning stages of

therapy and at any other times that abreactions are not desirable (such as shortly before the therapist's vacation). Various types of acting out often precede abreaction, especially acts of self-mutilation, alcohol and/or drug use, binging or purging, and boundary testing with the therapist. Such acts temporarily relieve the internal pressure and dysphoria that are commonly experienced with the onset of abreactions.

When a client enters a spontaneous abreaction, the manner in which the therapist responds will affect the client's experience of the flashback. It is necessary for the therapist to remain calm and in charge. The therapist's own sense of helplessness, coupled with the contagious nature of the client's anxiety, will tend to increase the therapist's anxiety. The therapist should consciously relax his or her own body, breathe slowly and evenly, and help the client to pace his or her own breathing. The therapist should make eye contact if possible. This will provide a grounding in reality. It is helpful to speak slowly, clearly, and calmly. Suggestions given to the client should be simple, concrete, specific, and gently repetitious.

Containing Spontaneous Abreactions

The therapist faces a difficult and delicate choice point when confronted with a client who is in the midst of a spontaneous abreaction. Should the therapist help the client "get out" of it, or should the therapist facilitate movement into a therapeutic abreaction? The primary criteria for the successful management of flashbacks are as follows:

1. To prevent a retraumatization of the client
2. To ensure that the client has adequate ego strength and is oriented enough to the present to maintain his or her grounding in reality.
3. To modulate the intensity of the experience enough so that learning can occur
4. To provide a workable linear and cognitive frame within which to process the memory

If these criteria cannot be met within a given abreaction, then the therapist should make every effort to contain it until a later time.

In making the decision about whether to contain or facilitate a flashback, the therapist must consider a number of factors.

1. Is the timing right within the session? Abreactive work should not be started after the first third of a session. An ideal abreaction is begun with preparatory work in the first third, the actual abreaction in the second third, and closing and processing in the final third of a session. If an extended session

is needed, this should be planned ahead of time with the client's consent. Unplanned, prolonged abreactive sessions can give the client a sense of interminable pain.

2. Does the client have the ego strength to process disturbing memories and intense affects? If not, it is advisable to contain the abreaction until further ego strengthening is accomplished within the therapy. If the client is totally overwhelmed with intense affect and is not oriented to the present, it is advisable to distance him or her from such a malignant process.

3. Is the context for abreaction safely set? The internal and external context for abreactive work is critical, and no planned abreactive work should occur before this is well in place. Setting the appropriate context is discussed in detail later in the chapter.

4. Is the client asking to "get out," or is he or she willing to go deeper? It may be useful to say something like "When this happened back then, you had no choices. Now you have a choice about whether you would like to continue and find out what happens next." Lending some control to clients is critical in enlisting their cooperation in such a painful process and ultimately in empowering them.

5. Is the therapist grounded enough in his or her knowledge and skills to manage the process? Is he or she psychically and spiritually prepared for the intensity of the experience?

If flashbacks are interfering with both the client's everyday life and the therapy, the client can be taught to avoid for a time the environmental cues that are known to trigger abreactions. Bedrooms, basements, closets, beds, bathrooms, nighttime, and the many sensory cues related to sexual activity are common environmental cues for triggering abreactions for survivors. Obviously, one cannot avoid these entirely, but the anxiety and fear may be countered by providing rituals of safety for a period of time. For instance, nightlights, changing the color of sheets, an audiotape of a soothing voice giving orienting information, appropriate transitional objects, sleeping on the couch instead of the bed, and other temporary environmental changes may be used as stopgap measures. Cognitive framing and thought-blocking techniques may be somewhat useful at this point, but the underlying memories often must be addressed before this is entirely successful.

Temporary time-limited contracts may be made between the client and his or her sexual partner to facilitate the containment of flashbacks. These may include a period of celibacy, elimination of specific sexual activities, and other approaches that give the survivor more conscious control over the initiation, type, and frequency of sexual activity. Obviously, if the client is in an abusive relationship, sexual or otherwise, the current abuse must be addressed before any historical work is done.

Once clients have a moderate amount of ego strength, have been taught

to recognize impending abreactions, and have experienced a number of planned abreactions, they can be taught to manage and process spontaneous abreactions outside of therapy. But this is usually a late development in therapy; in the beginning, flashbacks will simply retraumatize them. Most abreactions are frightening and painful experiences. Therapists must help clients to have control during abreactions in session for them to be willing to risk managing spontaneous abreactions on their own.

If the decision is made to help a client contain a memory, there are a number of ways to distance him or her from the flashback experience. If it is obvious that a client is experiencing flashbacks early in therapy, it is often useful to make a contract for him or her to attempt to separate cognition and affect and to hold the affect until it can be safely processed in the therapy session. This must be done prior to the moment when a client is actually in the midst of a flashback. To accomplish this, the therapist must enlist the client's dissociative skills. The effectiveness of such techniques depends to some degree on the dissociative ability of a given client. For example, one client who was having frequent flashbacks decided to (imaginatively) put all the accompanying feelings into a balloon and then send the balloon to her therapist's office, where she could access them during the following session.

If a client is at the point where he or she can begin to tolerate some of the effect, the following technique may be useful. The client is asked to imagine a container that can hold the feelings he or she is unable to tolerate. Then the therapist asks the client to gather all the feelings and put them into the container, except for a small amount (teaspoonful, cupful, handful, or the like) that the client actively chooses to feel.

As the client enters a spontaneous abreaction, the therapist may shift to the use of the third person, referring to the client as he or she. "And what does *she* experience now?" This creates an artificial dissociation between the adult client in the office and the inner child* who experienced the abuse years ago. This allows the client to observe and report the experience rather than being trapped in the affect of the past.

Further distancing can be accomplished by the use of past instead of present tense: "And so it *was* very scary for him *back then*." It is also important not to ask affectively directed questions, such as "What was he feeling?" but to focus more on cognitive themes such as "What was he thinking?" This will help begin to reduce intense affect by refocusing attention away from the affect and by adding a cognitive dimension to the experience.

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* The term *inner child* is used here to denote the state of the individual during the remembered childhood trauma. The inner child is a common phenomenon in survivors of childhood abuse and represents a wide spectrum of dissociative responses that may range from metaphorical self-perceptions to ego-state phenomena to actual alternate personalities (Summit 1987).

Once this dissociation is accomplished, the therapist can suggest that the inner child ("the part of you that was there then") can go to a previously determined internal safe space. A safe space is an imaginative phenomenon created to assist the client in feeling safe, relaxed, and protected.

Safe spaces should be developed in the initial stage of therapy, prior to abreactive work. To create a safe space, the client is asked to imagine a place that is completely safe and comforting while in a state of relaxation. The client can be taught to relax and go to this space outside of therapy with practice. Once the client practices this on a regular basis, he or she may be able to use it when overcome by spontaneous memories or intense affects.

There are several keys to effective safe spaces:

1. The space must feel unequivocally safe to the client.
2. The space is more effective when it comes from the client's psyche rather than from a suggestion made by the therapist.
3. The type of safe space will change with the client's needs; thus, it must be updated and revised periodically.
4. Each aspect of the inner child (the part[s] of the client that hold the abuse memory) will need his or her own safe space.
5. The safe space must be elaborated through all five senses to enhance the effectiveness of the experience. For example, the therapist may ask about colors, descriptions of scenery, sounds, and smells.

Common safe spaces include hideaways in the woods or mountains, beaches, caves, rooms or a version of the therapy room, bubbles, or being with protector figures such as animals, people, or objects.

Other ways to create distance in a flashback include gradually moving the experience farther from the direct experience of clients by having them see it as a play they are watching from a front-row seat, then having them move to the back of the theater, then having it on a large movie screen, then moving it to a smaller television screen, and so on. Alternatively, clients may be able to imagine a book in a library that contains the abuse memories. Clients are instructed to close the book whenever they need or want to, and put it back on the shelf whenever they have read enough for one time (Braun 1984b). Or the memory may be put in a container with a lid that is under the client's control.

The therapist can reorient clients by reminding them to be both "here and there at the same time," while offering them a bridge to the present. Bridges may be auditory, kinesthetic, or visual. An auditory bridge can be created simply by talking to the client and saying, "As you hear the sound of my voice, let my words wrap around you and bring you back. Follow the sound of my voice back to now." Tactile bridges are useful but can be dangerous. If the

therapist touches a client in the midst of an intense abreaction, the client may incorporate that touch into the abuse scenario and the therapist will become the perceived abuser. At first it may be more useful to ask clients to feel the couch, to feel that they have pants on, to feel something in the environment that was not likely to have been present during the abuse. After the client is oriented, the therapist may say, "And if you like, the adult part of you can hold my hand now as a reminder that part of you remains here in the present with me." This offers the client a choice about touch. Visual bridges may be used in a similar way: looking to see that he or she has pants on, looking around the room, looking at the therapist, and so on. It is useful to establish such bridges with the client before a planned abreaction begins.

It may be possible to suggest that the client change a small part of the image or experience as an entry into helping him or her get out of it. For instance, a client may be asked to change his or her position in the image so that he or she is watching the scene from above or from another angle. This is often quite difficult once the client is fully into an abreaction and is more useful in the early stages of a flashback.

Several other hypnotic techniques can be used to end a spontaneous abreaction. These are usually most successful when used within a planned, controlled abreaction but may be attempted to contain spontaneous ones. The therapist can attempt to limit the amount of time an intense affect is experienced by saying, "I am going to count from ten to one. You need only feel what you are feeling for ten seconds. As I count, you can feel less and less, until, at the count of one, you can move completely away from that feeling." Age progression can be used to move an individual through a traumatic event to its end. Sometimes an inner child state can be put to sleep for a brief period of time.

These are temporary, stopgap measures to be used when abreactive work is not desirable or useful. They should not be used to cut short abreactive work for the convenience or comfort of the therapist. Whenever possible, once an abreaction has started, it should be allowed to run its course.

Occasionally, once amnestic barriers begin to be breached in the course of therapy, a malignant derepression and flooding of memories may occur. If, in spite of competent containment measures, the client continues to have uncontrolled flashbacks or becomes overtly psychotic, a brief hospitalization and the adjunctive use of medication are indicated for the purpose of stabilization. Once the client is stabilized, additional containment and ego strengthening measures should be instituted before returning to abreactive work, and closer attention should be paid to pacing. Occasionally, a client will not be able to tolerate abreactive work. In this case, supportive rather than uncovering therapy is indicated, and the trauma should be sealed over as the therapy focuses on current issues that will maintain and improve the client's functioning capacities.

A Model for Planned Abreactions

Although abreactions may seem to be a confusing, frightening, and disconnected experience for the client (and sometimes for the therapist), abreactive work should follow a logical process. If the therapist can guide the course of each abreaction through this process, abreactive work should prove to be efficient and effective.

Of course, many abreactions do not contain an entire memory. The same memory may need to be abreacted several times in order to access all the missing pieces (Putnam 1989). Not every memory will have to be abreacted; some generalization begins to occur as various types of memories are processed (Ross 1989). The therapist should understand that this process will take a long time (months to years) and that it should not be hurried. Each client will need and tolerate differing amounts of abreactive work, and even with good work, this phase probably will seem to last longer than the client or the therapist wishes.

The logical question to ask is "When has enough abreactive work been done?" The answer often comes in retrospect because new memories may emerge over the course of therapy after the major portion of abreactive work is thought to have been completed. Usually, however, some signals indicate that abreactive work is finished. These include evidence of the following:

1. The client has a relatively continuous memory of the traumatic time period(s).
2. He or she is not currently dissociating in an uncontrolled or dysfunctional way.
3. He or she is not experiencing flashbacks or reliving the trauma in other ways.
4. He or she can remember and talk about the trauma without intolerable affect.
5. He or she has developed a subjective sense of the personal meaning of the trauma.
6. He or she expresses interest in and hope for the future rather than feeling overwhelmed by the past.

The conceptual model presented here can be followed both within a given session during an abreactive event and through various segments of an abreactive process that may occur over a longer period of time. The abreactive process can be conceptualized as a model that has five basic components forming the convenient mnemonic PEACE (Steele 1988, 1989a). This model includes the following:

Preparing the context

Eliciting dissociated aspects

Alleviating the existential crisis

Creating a gestalt

Empowering the client

This conceptual model is based on a number of theoretical and clinical paradigms of trauma, including the following five components:

1. State-dependent learning (Braun 1984a, Eich 1980; Rossi 1986; Rossi and Cheek 1988)
2. Posttraumatic stress theory (Figley 1985, Horowitz 1976; Mutter 1986; Ochberg 1988; Spiegel 1984, 1988; van der Kolk 1987)
3. Cognitive distortion patterns in abuse victims (Fine 1988a, 1988b; Donaldson and Gardner 1985; Fish-Murray, Koby, and van der Kolk 1987; Jehu, Klassen, and Gazan 1985; Orzek 1985; Ross and Gahan 1988)
4. The BASK model of dissociation (Braun 1985, 1988a, 1988b)
5. Existential psychotherapy (Frankl 1963; Spiegel 1988; Yalom 1980)

The following sections address each of these five components in turn.

Preparing the Context (Preparation Phase)

Planned abreactions should not be undertaken in the early phase of treatment, although spontaneous abreactions may occur. The early phase of treatment includes the assessment period and the time in which a stable therapeutic alliance is being established, as well as a stabilization period for the client who enters therapy in crisis. A context of safety must first be established within the whole therapeutic process, as well as before, during, and after each abreactive event.

The therapist can do certain things to create a safe context for abreaction. Intrapsychic, interpersonal, and environmental issues are delineated below. This is not an exhaustive list but offers a basic framework for the creation of a safe and stable context for abreactive work. Such a context is crucial because of the rigorous and painful nature of abuse memory work.

Intrapsychic Safety

1. Simply talking about safety with a client introduces a concept and conveys a concern that the client has never, or rarely, experienced. From the very

beginning of the therapeutic relationship, the therapist must ask, "What would help you to feel safe now?" By doing so, the therapist is giving the client permission to begin to feel that he or she has a right to feel safe.

2. Helping the client to define and normalize dissociation and other survival mechanisms not only alleviates some of the client's fear that he or she is "crazy" but also lays the groundwork to enlist dissociative skills therapeutically to the advantage of the client.

3. Creating an internal safe space will allow the client to begin to learn to modulate intense experiences through imagery and relaxation and will provide a sense of internal safety.

4. Recognizing "triggers"—events, words, people, or objects that cause flashbacks—is an essential step in identifying feelings or thoughts that need to be "contained" or "saved" until later, thereby giving the client a sense of control.

5. The client must feel relatively secure that he or she will be believed. With each "telling," he or she will have fears about being punished, not being heard, or not being believed. The fact that the therapist will listen, believe, and not punish needs to be reinforced over and over again for the client.

6. The therapist needs an awareness of the individual's subjective meaning of "telling." There are many prohibitions against talking about the abuse (Lister 1982). These include issues of shame, guilt, and badness; injunctions against telling; split loyalties; religious taboos; and, in the case of cult abuse, internal cues for self-destructive behavior (Steele 1989a). These need to be cognitively and/or affectively addressed prior to abreactive work.

7. A working knowledge of the individual's defensive patterns will help in predicting stress reactions to an abreaction.

8. It is important to know the individual's general worldview and his or her awareness of family rules and messages (Harris and Colrain 1986). The context in which the abreaction is processed will depend in large part on the cognitive reframing that has already occurred (Courtois 1988; Donaldson and Gardner 1985).

9. The therapist must constantly modulate the intensity of the experience to what the individual can tolerate, always titrating the work against existing ego strength and building ego strength over the course of therapy.

10. General awareness of the cognitive content and identification of the missing pieces of abuse memories allow for more adequate planning and a structure within which to process abreactions (Courtois 1988; Putnam 1989; Ross 1989). Abreactive work that is not couched within an adequate cognitive schema can retraumatize the patient (Braun 1986; Comstock 1986; Kluft 1984, 1985).

11. The adjunctive use of medication may be useful to modulate secondary symptoms such as anxiety, depression, and insomnia. Chronic responses to trauma often are all or nothing. Indiscriminate and intense psychophysio-

logical responses (such as panic attacks) to all stimuli sometimes need to be decreased temporarily so that the individual may be amenable to therapy. Medication may be quite useful in reducing such intense responses. For example, clonazepam has recently been used successfully to mitigate the panic and nightmares related to PTSD (Loewenstein, Hornstein, and Farber 1988). It is important to note, however, that no medication ameliorates dissociative symptoms and none will substitute for appropriate containment interventions by the therapist.

12. To empower the client, the therapist must be willing to give him or her control whenever possible (without abdicating the therapy to the client) and to take the mystery out of the therapeutic process by educating the client about the purposes and functions of abreactive work. Empowering the client also means trusting the client's pacing.

Interpersonal Safety

1. The therapist must constantly give attention to issues of trust within the therapeutic relationship (Braun 1986; Kluft 1983, 1984, 1985). A solid therapeutic alliance is absolutely essential before abreactive work is undertaken. Traumatized clients cannot be expected to develop rapid, absolute trust in the therapist; this is an unrealistic goal and is often based on a countertransferential need for the therapist to be liked and seen as good (Chu 1988b). In the beginning, however, the client must be able to give the therapist the benefit of the doubt.

2. The use of touch in psychotherapy is a controversial subject. Whether touch will be used in the therapy will be dictated by the beliefs and comfort level of the therapist. It is the authors' practice to use touch judiciously and with forethought. Survivors are often ambivalent about touch: They yearn for safe touch, and yet their experience has been that touch is frightening, painful, and/or intrusive. Therefore, the therapist should scrupulously examine his or her motivation to touch the client. Touch should never be given if it is for the benefit of the therapist, or if it obstructs therapeutic work by rescuing or prematurely comforting the client. It is essential that the client feel that he or she has control over not being touched. To maintain safe boundaries, there may be times that the therapist chooses not to touch the client in spite of a request to do so. For instance, it is common for survivors to have difficulty distinguishing between nurturing and sexual touch; it is important to make the distinction cognitively with the client before touch is initiated.

3. Maintenance of boundaries and the therapy frame will provide a sense of protection for the client and will relieve him or her of the responsibility of taking care of the therapist (Braun 1986; Chu 1988a; Kluft 1984, 1985). The therapist must be consistent and predictable and strictly adhere to clear boundaries, particularly in the area of sexuality. Breaking sexual boundaries with

any client is unethical and traumatizing to the client. Clients who have a history of sexual abuse are especially vulnerable to inappropriate sexual behavior from anyone in a position of power and trust (Pope and Bouhoutsos 1986).

4. Transference issues need to be worked through both prior to and after abreactive work (Braun 1986; Chu 1988a; Courtois 1988; Wilbur 1988). Survivors of childhood abuse will develop a traumatic transference during the course of therapy (Spiegel 1984, 1988). The traumatic transference is not only object relations based but also scenario based in that the client will unconsciously set up a double bind within the therapy session that reenacts episodes of abuse. The therapist will be seen as alternately withholding or punitive. This transference must be carefully monitored and interpreted, with "here and now" constantly distinguished from "there and then."

5. Resistance to abreactive work is almost universal because of the recall of deeply painful affects and sometimes horrendous memories. It is easy to imagine why clients would prefer not to remember much of what has happened to them. Resistance must be acknowledged and addressed rather than bypassed; vital information about the client and his or her response to the trauma is contained in such resistance. Chu (1988a) states:

> The resistance and the resulting crises of the patient in treatment are the substrate for the therapeutic process itself. . . . They [resistances] represent major opportunities for further understanding of the patient, as the patient and therapist together experience the vicissitudes of the patient's life. (p. 37)

At the same time, the therapist must gently and firmly guide (not shove) clients who are pain-phobic toward healing abreactive work. There is a complex, delicate, and ever-changing balance between respecting the client's resistance and guiding the client into abreactive work. The therapist must be exquisitely sensitive to this balance with each client.

6. Abreactive work requires that the therapist cultivate an acute awareness of countertransference issues related to the patient in general and to abreactive experiences specifically. Therapists ought to have a clear sense of their level of tolerance for such work. They need to develop ways of releasing and renewing to minimize the possibility of burnout and secondary PTSD (Braun et al. 1987; Courtois 1988, 229–243; Olson, Mayton, and Braun 1988; Putnam 1989; Ross 1989). Therapists who are working with survivors need resources for resolving countertransference issues, including personal therapy, group supervision, and/or individual consultation.

7. The therapist can use the concept of self as a grounding during and after abreaction and other methods of reality orientation to assist the client in distinguishing "here and now" from "there and then" (Comstock 1986; Putnam 1989).

8. The client ought to be encouraged to develop support networks within the family and within the community (Sachs 1986).

9. The client and/or the therapist can teach significant others about the purposes of abreaction and supportive measures they can provide the client.

Environmental Safety

1. The office of the therapist must be "abreaction-proof." This is merely a common-sense approach to basic safety issues. For example, sharp objects ought not to be openly available during a session in which the client may be very distraught or angry.

2. The therapist ought to be aware of the client's safety if he or she is driving to and from the office and should have the client arrange reliable transportation or provide time for the client to reorient before leaving the office.

3. It is important that a safe, structured environment outside the therapy hour be established and maintained. The client whose life is chaotic and unpredictable is a poor candidate for abreactive work.

4. A safe and trusting framework within the session needs to be created tailored to the individual's needs. For example, the client may wish to sit close to the door, have the blinds closed, or have the lights dimmed.

5. In planning abreactive work, the therapist must consider the age, life expectancy, quality of life, and physical condition of the client. Abreaction can be rigorous work, and sealing over, or modified abreactive work that includes techniques to minimize intensity, ought to be considered in some cases where the intense emotions generated by abreactive work would pose a threat to physical health (Kluft 1988, 1989). In the case of clients with imminent terminal illness, sealing over and focusing on improving the current quality of life is recommended, since abreactive work may take considerable time (months to years) and the client may find current concerns more salient and pressing.

6. When planning abreactive work, the therapist needs to be flexible concerning the length and spacing of sessions. Adequate follow-up sessions ought to be planned after intense abreactive work to help the client process what happened cognitively.

7. When the abuse has been exceptionally severe, sadistic, or ritualistic, such clients may require the protective environment of a hospital during abreactive work. Clients may become acutely suicidal or homicidal as they remember severe abuses. Contracts for no suicide or homicide are essential. Planned hospitalization to process such intense memories can be useful, but this option needs to be used sparingly and judiciously to avoid overwhelming the client. Clients who have experienced sadistic and systematic abuse are much more likely to be severely dissociated and fragmented; therefore, extra attention must be paid to ego strengthening, containment, and titration of affect. There are many specialized techniques for working with severe or ritualistic abuse victims, but these are beyond the scope of the chapter.

When working with clients with MPD, all of the above issues are applicable. There are also a number of concerns specific to MPD that are beyond the scope of this chapter. Several sources deal specifically with abreactive work in MPD (Braun 1986; Comstock 1986; Putnam 1989; Ross 1989; Steele 1989a).

Based on this context for abreaction, it is important to recognize a number of conditions that contraindicate abreactive work. These include the following:

1. The early stages of therapy
2. An unstable therapeutic alliance
3. Current and ongoing abuse
4. Current acute external life crises
5. Extreme age, severe physical infirmity, and/or terminal illness
6. Lack of ego strength, including severe borderline and psychotic states or pathological regression.

The provision of safety is an ongoing issue in treatment and ought to be continuously monitored. Once protection is ensured within the therapy, the actual abreactive work can begin.

Eliciting Dissociated Aspects (Identification Phase)

Dissociated aspects contain vital information that the client needs to assimilate the trauma. Successful abreactive work requires the reconstruction of the experience of trauma so that it may be reworked in therapy. Dissociated components of experience, including behaviors, affects, sensations, and knowledge, must be brought into the client's awareness in a timely manner. Thus, it is imperative for the therapist to elicit these aspects during the course of abreactive work. Any aspects that remain dissociated will continue to force the client to alternate between numbing and intrusive symptoms in order to ward off their impact. To elicit the dissociated components, the abreaction must first be initiated.

Five basic elements are involved in the initiation of an abreaction:

1. Contracting to work on a specific issue or memory
2. Developing a cognitive frame in which the memory can be processed
3. Using adjunctive modalities
4. Developing a safe context for a particular abreaction
5. Identifying missing BASK components

Some BASK components will be identified during the development of a cognitive frame, and others will be identified during the actual abreaction.

It is useful to contract with clients about doing abreactive work. This empowers them by giving them choices and a sense of control. Contracting may be as simple as asking whether the client would like to explore the memory. It may include considerations of timing (now or later) and the scope of the abreaction ("what happened with my brother but not what happened once my father came in with us").

When a client has blocked the memory of large portions of his or her childhood, a basic frame of reference, including time, place, and person, ought to be developed before any abreactive work begins. For instance, clients can be encouraged to explore what it was like at school; what the structure of a typical day might have been; what their favorite clothes were; what they liked to eat; what kinds of fun experiences they had; when they learned certain developmental tasks; who lived in their house; who slept in which room; when they might have moved from one place to another. Sometimes it is useful for them to collect stories about their childhood from friends and family (Herman and Schatzow 1987).

As clients become more familiar with the general historical context of their childhood, they can begin to explore more affectively loaded areas related to the abuse issues, such as what it was like to be with mother, father, or brother. Family photo albums can be brought to session, and as the client and therapist view the pictures and talk about the content and context of each picture, much information about the client's family life will be revealed. Gradually, as more information is gained in the early stages of therapy, the client will begin to develop more of an understanding of what it was like for him or her during childhood. This is the context in which the sexual abuse can be understood. For example, a client may remember that it was difficult to talk to his father, that in fact his father was quite stern and distant and they rarely talked at all. In the future, when he feels guilty that he did not tell his father about the sexual abuse by his mother, he will have a broader context in which to understand and process that experience.

For a planned abreaction it is useful to develop a cognitive frame around a specific memory or issue in the same manner in which a general frame for childhood was developed. As much knowledge as possible about the particular memory ought to be gathered prior to the abreaction (Sachs, Braun, and Shepp 1988). There are a number of ways to get such knowledge. Some of the most useful ones involve the use of adjunctive modalities.

Nonverbal modalities are especially helpful in working with abuse survivors. For many individuals, the task of "telling" horrendous memories is overwhelming and frightening, making verbalization difficult in the beginning. Injunctions against telling, including threats of death, are powerful imprints and inhibit survivors well into therapy (Lister 1982). Many trauma victims are alexithymic and do not have the vocabulary or cognitive structure to describe their internal affective experience (Krystal 1968).

Alexithymia is a syndrome commonly seen in severely traumatized individuals. Such individuals experience emotional states as undifferentiated, poorly verbalized, and primarily somatic, and there is a general inability to translate the somatic sensations into affective states. Thus alexithymic individuals are unable to utilize affects as signals about emotional states and therefore cannot describe how they feel (Krystal 1979).

Somatic and affective memories that are not coupled with cognitive content may be difficult to express verbally. And abuse memories that do not include eidetic images, such as preverbal memories or memories that are so dissociated as to be dreamlike, cannot be verbalized in the usual way.

Also, many abuse memories are quite fragmented and are thus difficult to communicate in a meaningful way. In such cases, a number of adjunctive, nonverbal modalities are useful in initiating abreactions. These include, but are not limited to, sandtray work (Sachs 1989); journaling (Courtois 1988; Sachs, Braun, and Shepp 1988); movement therapies (Chess 1989); music; the use of anatomically correct dolls and puppets; and artwork (Dyck 1988; Greenberg and van der Kolk 1987; Wohl and Kaufman 1985), including clay (Geeseman 1988), finger paints, drawing, and collages.

Journaling is one of the most useful ways to get cognitive material. A client may be asked to write about a specific time period or relationship or about a specific incident of abuse. To gain the cognitive information without the affective component, the client can be asked to write the memory as if it were a story that is about someone else.

Artwork is a powerfully effective way to gather cognitive material and to initiate abreactions. For instance, a client can be asked to draw a picture of himself or herself during the age(s) at which the abuse occurred. Critically important details which the client might otherwise have never thought to bring up with the therapist, may be revealed in such drawings. Clients also can "draw" feelings, giving them substance and form, thereby providing a concrete expression of, and sometimes containment for, the feelings. If the client is having flashbacks or dreams related to the abuse, he or she can draw the associated images.

Once cognitive framing and adjunctive modalities have been used to provide a structure for the abreaction, specific safety measures may be undertaken to ensure the abreaction. Guidelines for setting the general context for abreactive work are delineated in the section "Preparing the Context." Other interventions may be used to set the specific context for a particular abreaction. The therapist can arrange for preestablished cues, or "bridges" between the past and the present, that will orient the client. Clients can be given permission to stop the abreaction at any point. They also can be given permission to remember only what they are ready to remember.

Affect may be titrated by asking the client to imagine his or her feelings during the abreaction on a scale of 1 to 10, with 1 indicating minimal intensity

of feeling and 10 indicating intolerable intensity. Prior to the abreactive work, the client can choose a point on this scale that will indicate the intensity of feeling that is subjectively intolerable. A client who has little tolerance for feeling may choose 3 as the point at which he or she needs to stop, but another client may be able to tolerate 9. Then, during the abreaction, when the client indicates (by raising a finger or by saying the number) that the feeling level has reached the predetermined point, the therapist can assist the client in moving away from the feeling and memory while inducing a deep relaxation. Once the client is relaxed, he or she can move back into the memory. This is basically a desensitization process and will allow the client to gain mastery in a stepwise fashion.

Clues to the dissociated aspects of traumatic experiences will be contained in the client's verbalized memories, affects, and somatic manifestations; in phobias, compulsions, and hallucinations; in dreams and nightmares; in nonverbal modalities; and even in the client's metaphors (Braun 1988a, 1988b; Comstock 1986; Grove 1987, 1988; van der Kolk 1987; van der Kolk and Kadish 1987).

BASK indicators of dissociation are listed in table 1–2. These clues will assist the therapist in determining the missing dimensions of experience within a given abreaction and will give the therapist an entry point into an abreaction. For example, in the process of talking about her adolescence, a client reported to her therapist that she used to push the bureau in front of her bedroom door each night. She also reported that she did not know why she had done that. In addition, until telling her therapist about it, it had never occurred to her that it was an unusual behavior. In this instance, the client had knowledge of a behavior that was disconnected from any cognitive understanding of the origin of the behavior.

To initiate an abreaction, the therapist asked the client whether she wanted to pursue the memory at that time. Once a contract was made with the client, she was asked to draw her bedroom, showing the bureau in front of the door. This elicited some anxiety. She was then asked to find a way to act out the behavior by pushing the bureau. The client chose to push a chair across the room to the door. As soon as she began pushing the chair, she began to reexperience the full affective dimension (terror) of the past experience. Once she had accessed the affect, she immediately gained the cognitive component and said. "Oh, I pushed the dresser against the door to keep my father out!"

Affective and sensory clues present in the client during the session may be used to initiate an abreaction. One of the most common ways to do this is to ask, "When have you felt that before?" or "Do you remember the first time you felt that feeling?" An affect or sensory bridge also can be hypnotically created (Watkins 1971). Once the client has entered the abreaction, the next phase may begin.

Alleviating the Existential Crisis (Resolution Phase)

During an abreaction, the client is in an altered state of consciousness, and contact with the present reality fades. The client loses a sense of chronological time as he or she moves into a state-bound experience. Prior to abreactive work, the client has been unexpectedly and chaotically thrown back in history during flashbacks and other intrusion phenomena. A planned abreaction must add a sense of continuity and finiteness that flashbacks have not provided. A time line of the trauma must be provided for the client so that he or she experiences the beginning and the end of the trauma (Putnam 1989). The client with dissociated traumatic memories does not have a sense of past and present relative to the trauma, so the abuse has a sense of timelessness. Flashbacks typically take a client back into the middle of an experience or provide only a fragmentary piece that is reexperienced over and over, thus making it seem interminable.

A time line can be provided by asking the client to go back in time to just before the trauma happened. This direction need not be specific (for example, telling a client to go back to 9:50 P.M. if the trauma happened at 10:00 P.M.). It is rare for the client to have a literal sense of the exact time of abuse, especially when it occurred over a period of years. Yet the unconscious of the client will consistently be able to provide a point in time from which to begin the abreaction. Once the abreaction has begun, the therapist can continue to provide a linear frame by asking, "And after that, what happened next?" (Grove 1987).

Abreactions typically follow a curve of intensity (Ross 1989). The peak of the curve will correlate with the most intense moments of the episode for the client. The traumatic triad of anxiety, helplessness, and meaninglessness will be found at the apex of the curve, and the existential crisis will manifest itself at this point.

The therapist can recognize the peak of the curve through verbal and nonverbal communications from the client. Existential crises often can be detected through themes the client will verbalize (Steele 1989a). Typical examples include the following:

- Death—"I am going to die"; "I wish to die"; "I can't stand the pain."
- Meaninglessness—"Why is this happening?"; "Why me?"; "No, it can't be my dad doing this to me!"
- Isolation—"I am alone; there is no one who can/will help"; "I am bad/dirty/guilty/different and can't be with others in a meaningful way"; Nobody could ever love me after this."
- Freedom and responsibility—"Could I have stopped it?"; "I *should* have stopped it!"; "It shouldn't have felt good; I must have wanted it"; "If I

hadn't stayed home that day it wouldn't have happened"; "I should have fought harder."

Nonverbal clues to the peaking of the experience will be related primarily to the client's increasing affective response to the memory. Behavioral manifestations such as curling up, holding the crotch, sitting in the corner, and other behaviors generated by the client in a protective effort may be evident.

A wish on the part of the therapist to stop the abreaction and comfort the client often is a countertransferential clue that the abreaction is reaching its peak intensity. It is not easy to be with a human being who is suffering so intensely, and the therapist's wish to rescue may rise along with the intensity of the abreaction. Rescuing the client before he or she has achieved resolution, however, will result only in the abreaction having to be repeated again at another time. The fact remains that the client was not rescued from the abuse, and any attempt by the therapist to correct for that prior to resolution of the "stuck point" will be ineffective and obstructive to the client's progress.

It is, however, a positive and humane response to feel discomfort and empathy in the presence of such intense anguish. This response can be used in many constructive ways with the client and should not be suppressed. The client will not progress very far unless the therapist is caring and empathic. The empathic presence of the therapist creates a continuous experience during the abreaction, and his or her effective guidance of the abreaction is, in itself, a different and healing experience for the client. It is crucial that the therapist learn to distinguish between times when an abreaction ought to be titrated or stopped for the benefit of the client and times when there is a temptation to do so for the therapist's personal comfort.

As the abreaction reaches its peak, clients often stop the experience themselves. Or they may avoid the worst moment, focusing instead on an image or feeling that was experienced just prior to or after the worst moment. If the therapist feels that the client is missing a piece of the memory, it is sometimes helpful to ask the client whether there is anything else about the memory that he or she needs to have. The client then can review the entire memory as though it were a movie. Suggestions to view it from different angles may be helpful (Putnam 1989). This will continue to add small (and sometimes surprisingly large) pieces of experience to the abreaction in order to complete it.

The client must gain enough information from the memory, and be able to transfer enough knowledge from the present, to resolve the existential issues. For instance, the client must discover that he or she did not actually die. This will be, in the peak moment of an abreaction, quite a revelation. It is at such a moment of realization that a new imprint is formed. The knowledge and experience gained at this moment lay a foundation for further cognitive restructuring after the abreaction. For instance, clients must learn that the isolation imposed by the trauma does not last forever, that there is some

subjective meaning to their experiences, that choices are now available to them, and that the responsibility for the abuse is placed with the perpetrators rather than with the victims.

As the intensity of the abreaction increases, the client should be able to release the accompanying affects in a cathartic experience. Often, the affect has been too intense to allow for adequate processing, and the client simply avoids anything that triggers it. Therefore, titrating it to a manageable level will enhance the client's ability to release it. Some techniques to modulate affect are discussed in the section on containment of spontaneous abreactions, and Kluft (1989) has described additional techniques.

Issues in the management of intense rage reactions often emerge during the course of abreactive work. Rage responses are common and can be frightening to both the client and the unprepared therapist. It is the therapist's responsibility to provide an environment conducive to the safe and appropriate expression of rage. The client cannot heal without processing such intense affect. If the client has difficulty with impulse controls, therapeutic work on building controls should precede intense abreactive work. Even in clients who generally have good impulse control, however, the memory of extreme injustices and pain can evoke powerful rage reactions.

It is useful to assess the ways in which the client generally manages anger within the context of his or her life and to build on appropriate management skills. If the client has a history of violence, the therapist should be aware that rage reactions may be especially intense, and issues that trigger anger should be approached slowly and with caution.

Clients often fear their own anger; it feels overwhelming and bad. These issues must be addressed cognitively as well as experientially in the context of the therapeutic relationship. The therapist must give permission for the client to be angry, while setting limits on destructive behavior toward self, others, or property. Appropriate limit-setting will be reassuring to clients who fear their own rage.

There are numerous techniques to manage such reactions without shutting them down. Young (1986) and Sachs, Braun, and Shepp (1988) have advocated the judicious inpatient use of voluntary physical restraints with the informed consent of the client during intense abreactions in which the client may be acutely suicidal or homicidal. This method is used primarily with severely dissociated clients who have experienced extreme abuse. Watkins (1980) has described a silent abreaction in which rage work is done internally in a hypnotic state. The advantage of this technique is that it can provide release in a client when movement or noise cannot be supported by the environment and in a client who is unable to express intense emotion outwardly. Sachs and Hammond (1988) use a hypnotic technique in which the client is encouraged to scream, with the suggestion that as he or she screams, the body will become heavier and heavier. The more the client screams the less the body will move.

A similar hypnotic technique involves having the client imaginatively go to a "control room" where there is a lever or switch that suppresses physical movement. The client is allowed to express intense feeling, but whenever he or she senses that the anger is getting out of control, the client can pull the lever to suppress physical expression. The client ought to be taught to recognize physical sensations that precede impulsive physical expressions of rage; such signals will alert him or her to the need to add controls within an abreaction (as well as in other situations). This, in itself, is an experience of mastery for the client.

Schrader (1989) has described an innovative outpatient technique for rage release that integrates concepts from bioenergetics and gestalt and psychomotor therapies. She used a network to gather a number of therapists together to contain a client physically during a carefully planned, extended abreactive session. The session began and ended with cognitive framing for both the therapists and the client. The therapists served not only as containment figures but also as positive support figures for the client. This allowed for maximum motoric discharge of energy along with affective catharsis, a combination that is very effective in creating new imprints for the client. This technique had the added advantage of providing a support system and network for the participating therapists.

Once the client has reached and at least partially processed the existential crisis within a particular abreaction and has discharged the affect, the intensity of the experience will begin to decline naturally. When is a particular abreaction complete? As the therapist begins to notice the descending curve of the abreaction, the client's affect also will decrease. The whole story will have been told, the dissociated aspects will have been released, and the client will not have a phobic avoidance of the memory. The client will often experience a visible physical relaxation and display evidence that he or she is oriented to the present. There may be a verbal expression of a new insight, with relieved affect, crying, or laughing: "Oh, I didn't die"; "Somebody did come"; "It wasn't my fault." Once the curve of the abreaction returns to the baseline, the next phase of abreactive work can begin.

Creating a Gestalt (Assimilation Phase)

To create a complete experience from an abreaction, the knowledge and experience gained from resolution of the existential crisis must be assimilated into the client's cognitive context in the present. In the preparation phase, the therapist and client build a knowledge of the client's worldview and his or her understanding of family rules and messages. This body of knowledge is based first on the subjective experience of the child who lived in the family and then is broadended through more objective, detached, adult observations made by the client. It is helpful, when broadening this context, to be able to recognize

statements that come from the client's belief system and to clarify with the client the validity of such beliefs.

For instance, a client was talking about his relationship with his mother. He said that as a child, he never complained about anything to his mother because there were always others who were worse off in life than he. When questioned about that statement, he said that his mother spent most of her time doing volunteer work with the elderly and constantly told him how much they needed her. He had learned from experience that his problems could never match those of the people his mother tended and that he was selfish to feel any need. He generalized this belief to the point that any of his needs were unacceptable to him and he was unable to express needs within the context of a relationship.

Dysfunctional beliefs are formed not only by the client's perceptions of the sometimes confusing and chaotic world of his or her family but also by injunctions from the family or perpetrators. The assimilation phase focuses on cognitive restructuring of imprinted injunctions that are revealed in the abreactive work.

Injunctions are negative verbal and nonverbal commands or messages received during the trauma that are globally internalized and lived out. These injunctions are actually hypnotic in nature, since they are given in double-binding or abusive situations when the client is in a confused, suggestible, and dissociated state (Calof 1987) and thus are imprinted in the psyche. They are activated in the present by ANS activity in response to intrapsychic or environmental triggers. Since these imprints are usually encoded on an unconscious level, they are incorporated into the client's belief system without knowledge of their origin. To restructure the resulting cognitive distortions and behavioral concomitants, it is necessary to identify and bring to consciousness these injunctions (table 1–4).

Injunctions may be external or internal. *External injunctions* are those the victim receives from the abuser, such as "You're a bad boy; this is your fault." *Internal injunctions* are responses to abuse that occur as a result of the internal, subjective experience of the trauma. They are, in essence, messages reflecting the victim's understanding of the impact and meaning of the trauma. For instance, the victim may think to himself or herself during the abuse, "I am going to die. I will never get over this." Because these messages were received in a highly receptive hypnotic state, and because they were linked to powerful affects that were occurring simultaneously, they are deeply embedded. Injunctions are state-dependent phenomena and thus must be accessed in the state within which they were encoded. Once this state has been accessed within an abreaction and the associated affects released, the encoding is made available for restructuring. Old imprints can now be linked with new information gained from the abreaction and from imprints formed within therapy.

Table 1–4
Imprinted Injunctions and Resultant Cognitive Distortions

I:	You want this to happen, you love it.
C:	I wanted it, therefore I am bad.
I:	If you tell, Mother will hate you; Mother will kill herself; I will kill you; I will kill myself.
C:	I have the power to destroy my family; their survival depends on me. Telling the secret equals death.
I:	If you don't do this, I will do it to your sister or brother.
C:	I have the power to keep my family safe; it is my sole responsibility. I must sacrifice myself.
I:	You're disgusting, you're dirty; you're shit.
C:	I am bad to the core. This happened because I deserved it. I must never let anyone know me, or they will find out how bad I am. I don't deserve anything good in life. I deserve to be punished.
I:	Don't make a sound; don't let Father hear us.
C:	It's dangerous to speak, show feelings, or ask for help.
I:	You're so pretty (handsome) I can't help myself.
C:	I'm seductive and manipulative. I can't control myself. It's my fault that he lost control. I deserve to be punished. I must make myself unattractive.
I:	Come here and let me love on you. You know I love you.
C:	Love hurts. Sex and nurturance are the same.
I:	I'm going to teach you to be a man (woman).
C:	Being a man (woman) means being hurt or hurting someone else. Also, I'm not a man (woman).
I:	Don't cry or I'll give you something to cry about.
C:	What I experienced wasn't that bad. Showing my pain or fear is dangerous.
I:	Shut up! You know I'm not hurting you.
C:	I can't trust my own experience. Someone else must tell me what is real.
I:	If you say no again, I'll ask your brother to come in and help me.
C:	I have no power. I'm always outnumbered. I don't have the right to say no.
I:	We don't talk about our family with anybody else. It's none of their business.
C:	I have to look happy and be nice. I must never tell. This has never happened to anyone but me. It's so bad I can never tell.
I:	We take care of each other because no one else will.
C:	I cannot trust anyone outside the family.
I:	Don't say those things about your uncle.
C:	No one will ever believe me or help me. Maybe I just imagined it.
I:	You only have three A's on your report card; wait for me in your room. You're going to pay for this.
C:	If I'm good, maybe he won't hurt me. If I'm perfect, no one will see how bad I am inside.

Note: I = imprinted injunction (message from the abuser); C = resultant cognitive distortion.

For instance, many clients have the imprinted external injunction "If you tell, I'll hurt/kill you." The resultant cognitive distortion is "He will always know if I tell, and something bad will happen to me; therefore I must never tell" and "I am still vulnerable to being hurt by him." New information gained in an abreaction leads the client to the following constellation of restructured

beliefs: "I was very little and helpless then, and now I am an adult and can protect myself"; "The past is not the present"; "It is safe and important to tell."

These beliefs are encoded verbally (symbolically) and experientially as the story is told within the abreaction without the client's getting hurt. This experience occurs in the specific state in which the original imprints were encoded. Thus, new imprints are formed and linked with the old imprints. These new imprints can be activated each time old injunctions are triggered, so old imprints lose their potency and are gradually extinguished. New imprints must be reinforced over and over in the course of therapy in order for them to replace old injunctions completely.

This process frees the client to change behaviors that were previously dictated by internal injunctions. The following example illustrates a behavioral change that results from restructured beliefs. A client, as an adult, was very paranoid, lifted weights, and carried a knife (although he had never used it). He believed that he could have and should have fought off his uncle, who anally raped him when he was ten. He said that he could have hit the uncle with something or he could have escaped.

In the abreaction of that particular memory, he gained the knowledge that his uncle had locked the door, hidden the key, and held a knife to his throat. He reexperienced the terror of a small boy who was brutalized by a two-hundred-pound adult. Only when he had these pieces and the associated imprinted injunction ("If you fight me, I'll kill you") could he understand that there were good reasons why he could not fight back and begin to let go of the shame of submitting. He could understand his excessive need to defend himself as an adult in the context of having been terrorized as a helpless child. As this new information was gradually assimilated, he began to feel safer in the world. As he began to experience himself as a full-sized and quite powerful adult rather than a small "weakling," his weight lifting became less obsessive, he stopped carrying a knife, and he became less paranoid.

The belief that the victim should have resisted the perpetrator is one of the most difficult ones to restructure for male clients. In this society, men and boys are not supposed to be victims. If they are victimized, they are taught that it is because of their own inadequacy (Lew 1988).

A difficult internal injunction to restructure, for both males and females, is some variation of "It felt good, so I must be bad/responsible." When pleasure is paired with pain, survivors feel an intense mixture of confusion, shame, guilt, and a sense of betrayal by their own bodies. Abreactive work will usually reveal that the child did not want the abuse and was coerced, sometimes by verbal persuasion or bribery and sometimes by sadistic brutality. It is useful to allow clients to acknowledge their pleasure rather than reassuring them that they probably did not feel much pleasure. In fact, the physical sensations may have been quite pleasureable.

In addition to accepting their experience in a nonjudgmental way, the therapist needs to understand and be able to explain the physiological sexual response cycle. The body has a standardized response to stimulation that is natural and normal, regardless of the source of stimulation, and perpetrators often use this knowledge to make the child less resistive ("See, you really do like it"). The distinction can be made with clients between their body's automatic reactions and their wishes and psychological reactions.

Sometimes clients will report that they initiated sexual activity in a desperate attempt to get nurturance and affection. It is helpful for the client to hear that nurturance is a basic human need rather than an indulgence. (This fact will often come as a surprise to many survivors.) Children will seek nurturance in whatever ways are available to them. The responsibility for the abuse, regardless of the initiator, still remains with the one who is endowed with power and trust in the relationship.

Ending an Abreaction

To end an abreaction, the therapist must reorient and ground the client, process or contain residual affect, provide a healing experience, and solidify the learning that has occurred during the abreaction.

The client should be reoriented to the present. It is sometimes helpful to ask the client, "Are you here?" A dissociated client will readily understand this question. If the client answers negatively, the therapist may ask, "Where are you?" The client may still feel pulled into the past or may be having a dissociative response to the intensity of the abreaction. Bridging techniques into the present, as previously discussed, can be useful at this point. It is important to give the client ample "reentry" time, allowing him or her to sit in another room after the abreaction if needed.

Grounding the client may be useful to reduce the "spaceiness" related to dissociative tendencies after an intense abreaction. Clients may be asked to feel their feet on the floor, press their tongue to the roof of their mouth, feel the couch supporting them, and so on. It is especially useful to ask clients to keep their eyes open, providing a visual and perceptual grounding in the present. Clients can be asked to describe the room or clothes that they or the therapist is wearing.

Residual affect may indicate that the abreaction was not fully completed or affectively processed. Obviously, all affect regarding an intense memory will not be released in one session. Extremely intense affect should, however, have been released during the abreaction, and the residual should be much more moderate and manageable to the client. In addition, feelings of terror, shame, and humiliation and issues of helplessness and responsibility should be thoroughly processed within the abreaction so that they are not the major affective issues to be processed afterward. The feelings most likely to remain

following complete abreactions are grief and anger. Clients frequently need time after the abreaction to give expression to those feelings.

Positive healing experiences solidify learning and are an important part of the assimilation process. A healing experience also can help to reorient and ground the client. Asking the client to draw a picture of his or her inner child in a safe place can provide comfort and safety. Simply reading to a client a short children's story with a relevant therapeutic message can soothe and ground the client and add metaphoric cognitive content to the abreaction (Davis 1988; Ray and Lyn 1989). A guided visualization can be useful if the therapist has enough knowledge of the client's safe place or safe image (that is, an image that has been used successfully before or has been practiced by the client). The image also can originate with the client at the moment. The therapist may touch or hold the client to provide comfort and reassurance following intense abreactions.

The client remains in an altered state immediately after abreactive work, so when healing experiences are given at that time, they are especially powerful and can provide positive imprints in the present. Cognitive work often can continue during a healing experience. For instance, once a client is in a safe space and is feeling relaxed and comforted, the therapist may gently ask, "What have you learned, or what do you know that is different now?" Learning is a crucial part of abreactive work.

The new learning can be solidified by placing it on a time line that extends into the future (Comstock 1986). This encodes the possibility of choices and the ability to determine the direction of one's own life. The therapist can use age progression to reinforce the restructured imprints and beliefs by saying, "Now that you know (what was learned in the abreaction), go forward in time and see what your life will be like and how it can be different for you."

If an abreaction needs to be interrupted due to time constraints, give the client a fifteen- to twenty-minute warning, ask him or her to find a temporary stopping place, and use containment techniques, such as putting the memory in a box or time lock. The client needs to be given sufficient time in the session to reorient and, if necessary, should have a room in which to rest afterward. A follow-up session ought to be scheduled as soon as possible to complete the abreaction.

Once the abreactive event is completed, the client still has much work to do to assimilate the new learning and experiences gained in the abreaction into the context of his or her current life. This will occur gradually over the course of therapy.

Empowering the Client (Application Phase)

In the application phase, the client moves from the identity of victim to that of survivor and then gradually (for most individuals) to that of thriver. The

mastery gained by the successful navigation of abreactions will provide a base for the development of empowerment. The client is empowered by integrating dissociated elements (the missing cognition, affect, sensation, or behavior) and new imprints into present-day life. Clients can begin to rebuild shattered assumptions, developing a sense that their lives can be safe, predictable, and meaningful.

As abreactive work helps survivors distinguish between past and present, and as dissociated elements are reintegrated, clients slowly begin to live more in the present and are less restricted by unresolved aspects of the past. In addition, clients gradually will come to appreciate and accept themselves—including the disowned parts that were trapped in the past—as old feelings of shame, guilt, responsibility, and badness are defused and restructured. The inner-child aspects of the adult can become an integral part of the individual's life, adding spontaneity, playfulness, creativity, and a wide range of affective responses.

Behavioral change follows the cognitive restructuring and affective catharsis of abreaction. As clients begin to experience the truth of what happened to them as children and realize that they had no choices and no escape, no power and no blame, they can begin to act as powerful and self-nurturing adults in the world rather than as helpless, victimized children who blame themselves.

Clients are empowered as they learn that feelings are neither lethal nor omnipotent. With the release of fear, shame, rage, humiliation, isolation, and hopelessness comes the release of joy and creativity, as well as the capacity to love and be loved. Newfound hope and joy can be enhanced through involvement in hobbies or other activities. And as clients reestablish their identities, they may discover new hopes and buried dreams that they can now pursue. Many clients will change careers or return to school as the past becomes resolved and more of their psychic energy is freed to be invested in the present.

The client must learn to experience and express positive as well as negative affects. Postabreactive work involves intense grieving and rage about the irreplaceable losses of childhood. Issues of abandonment and loss may surface on many different levels over the course of therapy and will appear in the transference relationship with the therapist. The consistent caring and predictable boundaries of the therapist will provide a safe structure in which the client can work on such terrifying and painful issues.

It is important for the client to become familiar and comfortable with his or her body. Sexually abused clients often have a split between mind and body that must be healed. Their bodies have often been painfully abused. This pain is dissociated, as the client simply separates an awareness of his or her body from consciousness. Clients often report that they do not feel their bodies; they may ignore signals from the body such as hunger and pain. Many sex-

ually abused clients view the body as the enemy who has betrayed them and caused them great shame. As clients restructure beliefs about their current safety and about their physical responses during the abuse, they will gradually develop an awareness of their bodies and come to accept the responses of the body, sexual and otherwise, as an integral and important part of their lives.

As clients begin to acknowledge their physical selves, they become empowered to make healthy life choices. As they integrate the abreactive work and develop a respect for their bodies, they are able to make changes in eating and exercise habits, sleep patterns, and self-defeating work habits. Relaxation techniques and meditation can be used for ego strengthening and stress reduction (Flannery 1987).

Sexual issues must be resolved over the course of therapy (Maltz and Holman 1987). Phobic avoidance of sex or counterphobic promiscuity must be addressed. Clients may have disorders of desire, orgasmic difficulties, and other sexual disorders. Specific phobias that trigger memories should resolve as abreactive work resolves abuse issues. Clients must learn the difference between sexual and nurturing behaviors and how each can be asked for and given appropriately. Emphasis should be placed on sexual activity as pleasureable, respectful, and voluntary. Couples therapy can be a useful adjunct at this time, focusing on sexual and other relational issues.

Issues of spirituality often evolve during the course of treatment. For many clients, feelings of betrayal and abandonment by God may emerge. Clients may find spiritual awareness through nature, community, and other nontraditional avenues, as well as through more traditional means. The client may struggle with issues of sin, responsibility, forgiveness, good and evil, and the meaning of suffering, as well as others. It is important for the therapist to support clients in their search for healthy spirituality, regardless of the therapist's personal beliefs.

Clients will learn to cope with stress and fear in ways other than dissociating. As clients begin to believe they have needs and have a right to get their needs met, they can work on gaining assertiveness and limit-setting skills. Clients whose boundaries have been violated often do not have a sense of limits in relation to self or other. Abreactive work, and the therapeutic relationship, will help them learn to set appropriate limits and to be respectful of their own and others' boundaries. As they build a trusting relationship with the therapist and develop self-esteem, clients slowly learn to trust others, to build a support system of friends, and to develop a sense of community. As dissociative barriers erode, clients can more easily learn from experience and can develop good judgments about relationships. They can learn to discriminate between people who are safe and those who are not. Victim behaviors are reduced in intimate relationships as well as in the world.

It may be useful at this point to reiterate that the abreactive process is not linear. The application phase does not begin only when there is no more

abreactive work to be done. Each abreaction must be carried through to empowerment in whatever small way possible. At some point in the therapy, the major portion of the work will shift to empowerment issues, though some memories may still need to be abreacted.

A Clinical Example of the Abreactive Process

To illustrate the phases of abreaction and how they might be integrated within one abreactive session, we will describe a complete abreaction. This example was chosen because of its brevity and simplicity. It occurred with a client who had been in therapy for eighteen months. The general context for abreactive work had been established previously. The client came into session visibly upset and crying. She said that the previous night she had heard someone say something about "putting something big into something small." She immediately felt "awful, bad, and ugly—like I had black slime inside me." The client was asked if she could draw the black slime. She drew an orange outline of a person with no hands or feet and with hollow circles for eyes and mouth. Every other part of the inside was colored black. A cognitive frame was set by the therapist by gathering information about the picture. The client was asked to tell the therapist about the picture: How old was the person in the drawing? What was she doing? What was happening around her?

The client replied that the figure in the drawing was four years old. "She's pinned against the wall, feeling helpless. She's floating over her body." (This was a clear indication that a dissociative episode had occurred.) The therapist then began to define the parameters of the dissociative episode (when it began and ended, how much cognitive information the client was able to access, and which BASK components were missing).

The therapist asked, "What do you think was happening when she couldn't stay in her body?" The client did not know, indicating that the cognitive dimension of the experience was not yet accessible to her. The therapist then asked her if she would like to find out what happened. A contract was established for the abreactive work, and the abreaction proceeded. The client wanted to explore her feelings but was unsure about how much of the memory she wanted to know. It was agreed that she could stop the abreaction at any time by simply saying stop or by raising her finger.

The therapist initiated the abreaction by saying, "So, as you would like to find out why she's floating over her body, you can let yourself go back to the time when you were four and you felt pinned against the wall and helpless and felt like black slime inside. You can let yourself remember only what you are ready to remember. And notice that you are also here with me now as you go back and remember. You can know that you may stop anytime you wish."

The client began to cry and said, "She's against the wall because something bad happened." The therapist said, "What might have happened that

was bad?" The client was unable to answer. "Can you go back to the time just before she's against the wall and let yourself know what happened?" The client nodded affirmatively and, after a brief pause, said in a small voice, "I can't see anything." The therapist waited, and after another brief pause, the client exhibited overt signs of regression, which are common during abreactive work. She curled up on the sofa and began sobbing and mumbling like a young child. She then cried out in pain and put her hand to her crotch, having now gained a sensory component of the memory. The therapist reminded the client that she could be "here and there at the same time" and that the therapist was present with her.

At that point, the client sat up and said she wanted to stop. Her crying began to subside, and it was clear to the therapist that the client had accessed an experience that she was unable to process at that moment. The therapist respected the client's request to stop and gave her permission to distance herself from the memory by asking, "Can you tell me what's happening right now?" At the same time, the therapist was aware that the client had not yet completed the abreactive experience.

The client voluntarily returned to the memory and said, "I felt pressure on me. He was on top of me, and I couldn't breathe. And I was scared. He was smooshing me. And then it hurt, oh it hurt, like someone hit me with a hammer between my legs. And then I stopped because I felt like I was making it up." The therapist noted that the client had shifted from third person to first person. She was thus beginning to "own" the experience. The client also gave the therapist information about why she stopped the abreaction—because she feared she was making it up. A belief that the memory is "made up" is very common in survivors. Abuse memories often have a dreamlike or unreal quality due to the dissociative process. In addition, many clients defend against knowledge of the intolerable by not believing their memories. One of the hallmarks of dissociated clients is the remark "I think something awful happened to me, but maybe I'm making it up."

Responding to the client's first-person report of what happened to her, the therapist asked, "And who was it that was smooshing you?" The client began crying again. "My dad. It was my dad. I didn't want it to be true."

"What might happen if it were true."

"Then I'd be bad."

For this client, the existential crisis (the worst moment of the abuse) was contained in this statement. She had dissociated the memory in order not to believe she was bad, which involved the existential crises of isolation ("If I'm bad, no one will love me") and responsibility ("I'm bad because it's my fault").

"So what's it like when it's not true?"

"I feel crazy."

"So maybe feeling crazy, like you were making it up, is safer than feeling like you were bad?"

"Yeah, I don't want to be bad."

"And is there any part of you that doesn't want to be crazy?"

"Yes, right here." Without hesitation, she touched her heart.

With the client's "heart part," the therapist recognized the opportunity to offer the client a third option—something other than feeling bad or feeling crazy. "And what might the part that doesn't want to feel crazy do to comfort the four-year-old who does feel bad, like black slime inside?"

Again, without hesitation, she said, "It could be shiny and glow all through her body." The certainty in the voice of the client and her focus on what could be different were indications that the existential crisis was in the process of resolving and that a healing experience could thus be given without obstructing the process. The healing image came from the client, which made the experience more powerful and effective.

"It could be shiny and glow all through her body. Could you let that happen now? You can let that part be shiny and glow all through your body and comfort your four-year-old. And you can know that it was Dad and that you are neither bad nor crazy, but you shine and glow inside where black slime used to be."

The client was calm and relaxed. Her breathing slowed, and she began to smile a little, indicating that the abreaction was complete. The therapist said, "You can comfort that little four-year-old, and you can know that she isn't bad and she isn't crazy. She's just a little girl who got hurt very badly by her dad."

The client then drew a picture of the four-year-old with a yellow glow all though her body and took it home to hang in her room, reminding her that she no longer had black slime inside. After this particular abreaction, the client began to have other memories of more severe abuse. Her therapy at that point focused on containment outside of therapy and cognitive processing of the abuse memories. Although she had talked primarily about the abuse with metaphors in this abreaction, it was important later for her to verbalize what had actually happened in order to process fully her intense feelings of shame and badness.

Countertransference Issues

A final topic is the varied and intense feelings that arise in the therapist as a result of helping with abreactive work. Courtois (1988, 229–243) has offered a thorough discussion of typical countertransference responses to survivors. These include the following:

1. Dread and horror
2. Denial and avoidance
3. Shame, pity, or disgust

4. Guilt
5. Rage
6. Grief and mourning
7. Viewing the victim as exclusively needy or the survivor as exclusively self-sufficient
8. Believing that everyone is a victim
9. Language muting (that is, using euphemistic language to avoid the graphic details of the abuse ("the incident that happened" versus "the time your father raped you")
10. Contact victimization or secondary PTSD
11. Privileged voyeurism
12. Sexualization of the relationship

Unchecked countertransference issues may impede the progress of therapy in a number of ways. Some of these follow:

1. Stretching limits (taking too many midnight calls) and becoming resentful, withholding, or punitive
2. Ignoring interpersonal boundaries and thereby recreating boundary violation scenarios for the client
3. Expecting or needing the client to trust oneself and becoming resentful when he or she does not meet one's expectations
4. Ignoring gender issues that may have a powerful effect on the transference
5. Exhibiting caretaking behaviors that prevent empowerment of the client
6. Viewing the client as especially weak or strong, without consideration of the whole client, thus preventing the client from growing and developing
7. Viewing the client as especially strong and ennobled by the trauma, leading one to push the therapy too hard and fast
8. Colluding with the client's minimalization or denial, leading to a stalemate in therapy
9. Taking responsibility for the therapy and working harder than the client, engendering frustration and resentment in oneself and a more passive attitude by the client
10. Personalizing the client's projections rather than helping him or her sort out the confusion between the internal replay of abuse and the external trigger in the therapist-client relationship, thus resulting in one's resenting and dreading the therapy sessions

Progress in recovery for many survivors is made in small increments. Therapists who are new to this work often are impatient to "get to the mem-

ory work" and thus push the client into abreactive work, or they get frustrated because the client is "so resistant to therapy." When the therapist is not comfortable with the client's pacing, he or she may be ignoring some basic safety issues or a crucial transference or countertransference issue.

During many abreactions, the therapist must witness painful, wrenching affect and must hear intolerable, heinous abuses perpetrated upon children. The therapist is present in an intimate way with someone for whom he or she has a deep concern. This has to affect the psyche, if not the soul, of the therapist. The therapist's own existential crises will emerge, and he or she must deal with personal issues related to death/annihilation, meaninglessness, isolation, and freedom and responsibility. This personal struggle, which is universal, must be attended to outside the therapy hour. The therapist who is unable to deal with his or her own existential issues is not likely to be able to hear a client's deepest struggles. This may result in the therapist's avoiding abreactive work, consciously or unconsciously. Or the therapist may try to alleviate or fix the client's pain for his or her own comfort by prematurely bringing an abreaction to a close before the client has accessed the traumatic triad, thereby preventing any resolution for the client.

In addition to the emergence of the therapist's own existential crises, he or she also may have intrusive images or thoughts of a particular client's abuse outside the sessions (especially during sleep or sexual activity). And the therapist may be overwhelmed by the evil in the world, imagining an abuser behind every face at the supermarket. It is essential that the therapist hold on to his or her own ontological security—to be safely in a world that has meaning and hope. The hopelessness, cynical, or frightened therapist will be unable to hold any hope for the client's recovery—an essential, albeit intangible, part of the therapeutic process.

When working with survivors of childhood abuse, it is important for the therapist (regardless of theoretical orientation) to drop an analytic reserve and to be present for the client in a way that is genuinely responsive (as well as responsible) and empathic. At the same time, it is important that the therapist protect his or her own psyche by not overidentifying with, or absorbing all the pain of, the client. Some kind of protective visualization or ritual cleansing is often helpful. Some useful ways of releasing and renewing oneself after intense abreactive work with a client follow:

1. Listening to relaxing music
2. Using relaxation techniques, especially deep breathing, releasing affect and tension with each exhalation and breathing in comfort and relaxation
3. Exercising or taking a brief walk
4. Processing one's own feelings with an available colleague
5. Imagining a protective shield around oneself during abreactions so that

one does not "take in" the feelings of the client but is emotionally aware and available

6. Scheduling clients so that those who are doing abreactive work are spaced between "easier" clients
7. Scheduling breaks or time off immediately after abreactive sessions
8. Networking with other therapists who do similar work and are aware of the stresses
9. Carefully attending to one's own physical, emotional, and spiritual condition

Therapists must seek constantly to identify and separate their own issues from the client's issues through competent supervision or personal therapy. Therapists who are themselves survivors should be aware that new memories or feelings of their own may be unexpectedly triggered by the client's work. Such therapists should be adept at using for themselves some of the same containment measures that have been previously discussed, as well as receiving therapy to heal their own survivor issues.

Just as clients may have difficulty in distinguishing intimacy from sexual feelings, so can therapists. It can be especially difficult for some therapists to maintain clarity when the client (who may be covertly or overtly seductive) is having an erotic transference and when the therapy may, at times, focus on intense abusive experiences that were sexual in nature. It is crucial for the therapist to recognize and acknowledge to himself or herself (not to the client) the presence of any sexual feelings. Such feelings are to be processed in supervision or personal therapy.

As therapists, we cannot erase or compensate for the damages and losses of childhood our clients have incurred. Yet through the abreactive process, we can be present to validate their experiences, to alleviate their pain by helping them work through the trauma, and ultimately to empower them as healthy adults in the world. Perhaps the last word belongs to a former client:

> I never thought I'd make it through. I remembered stuff that was so awful and bad there were times I just didn't want to live. But during those times, my therapist hung in there with me. She kept telling me I'd make it, and she kept finding ways to help me get through the day. And I did, finally. Now I'm getting on with my life. Actually, for the first time, I have a life. What I've finally figured out is that it really is over, and I'm here now, and I'm very much alive.

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