

**DESENSITIZATION FLOODING, ABREACTIONS AND PRIMALS:  
THE PROBLEM OF ACCESSING DISSOCIATED TRAUMATIC MATERIAL**

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**DESENSITIZATION, FLOODING, ABREACTIONS AND PRIMALS:  
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One of the most difficult problems in therapy is uncovering and safely processing dissociated traumatic material in clients with trauma induced dissociative disorders. This paper examines two methods of access, desensitization and flooding, and two responses, incomplete abreaction and complete abreaction.

Systematic desensitization, according to Wolpe (1973), begins with the induction of a physiological state that inhibits anxiety (relaxation). The client is exposed to a weak anxiety arousing stimulus for a few seconds. After a few exposures, the stimulus progressively loses its ability to evoke anxiety. Then successively stronger stimuli are introduced and similarly treated.

Shapiro (1989) has introduced a new form of desensitization using saccadic eye movement. The movement seems to induce reciprocal inhibition allowing the client to focus on visualizing traumatic scenes, rehearsing self-defeating indictments and concentrating on physical manifestations. She reports rapid and excellent results. Wolpe and Abrams (1991) have also used eye-movement desensitization to successfully treat post traumatic stress disorder (PTSD). With multiple personalities and the fixated ego states found in dissociative disorders, systematic desensitization may have to be abandoned in favor of using flexible desensitization with the present personality/personalities, and the material which arises in each therapy session.

Evoking strong responses by exposure to either real or imaginary situations is known as flooding. Wolpe reported the use of flooding to cure an automobile phobia. A teenage woman was put in the back of a car and driven around for four hours. After her initial panic, her fear subsided and she was thereafter free of her phobia.

Pitman, et al. (1991) noted that flooding may be effective in treating anxiety in PTSD but also noted that flooding increased sadness, anger, guilt and/or shame associated with the trauma. Anxiety in PTSD may be too interwoven with a complex of cognitions, emotions and habits to be directly targeted for extinction by flooding. Negative therapeutic outcome would be expected when using flooding in this type of situation.

King and Gullone (1990) found, in describing hypothetical fear reduction techniques concerning an animal phobia in a child, that both children and adults preferred, in order, systematic desensitization, modelling, contingency management, imagery and flooding. Potential adverse reactions and the confrontative nature of flooding contributed to its dislike as a technique. Flooding would seem to be dangerous for dissociated clients.

Unsuccessful use of flooding with trauma induced dissociation could produce a psychotic break or drive the client further back into denial.

Abreaction, or the re-evocation of a fearful past experience with strong emotional accompaniment, is sometimes followed by therapeutic change while sometimes it is not and may even leave clients worse off than before. Wolpe (1958) noted, however, that in some clients emotional responses have been conditioned to intricate stimulus compounds such that neither current nor contrived situations would work and abreaction may be indispensable.

Peebles (1989) treated a severe case of PTSD stemming from consciousness during surgery (with auditory and pain perceptions). The patient was treated with eight sessions of hypnosis. Abreaction and revisualization used alone initially retraumatized the patient and her symptoms worsened. Additional techniques were introduced and her symptoms abated.

Ross and Gahan (1988) describe a reaction they call a malignant abreaction in MPD. An aspect of the person is agitated, frightened, assaultive and self-abusive. These symptoms do not moderate with repeated abreactions. They state that malignant abreactions must be defined as destructive, necessitating limits by constraint, hypnosis, physical restraint or chemical suppression.

The unpredictable results of abreaction can be explained by the work of Janov (1975). He called a successful abreaction a Primal. In a Primal, a painful memory is fully confronted and the feelings connected to the memory are fully catharted. Post-primal measurement of various physiological indicators showed measurements consistent with being in a state of calmness and relaxation. In effect, the traumatic memory had become a neutral stimulus.

Holden (1976) has described the difference between Primals and Non-primals. In a completed Primal, pulse rate, diastolic blood pressure, systolic blood pressure, core body temperature, and integral of EEG alpha rise together and then fall to or below the baseline. In abreactions, vital signs do not change together. The defenses are not fully breached so the defended experiences are not fully processed. There is a reshuffling to avoid the pain. There remains a sympathetic, parasympathetic conflict so complete that parasympathetic calming does not happen.

Clinical experience indicates that there are many incomplete abreactions before something as liberating as a Primal occurs.

In the following section, we will describe a therapeutic method that brings about the neutralizing effect of a Primal in a regulated, safe and non-threatening way.

## RESPONSE SIDE THERAPY USING ACTIVE BIOFEEDBACK

Toomim and Toomim (1975) first reported the psychodynamic use of biofeedback using ENG and GSR. They found that biofeedback was an accurate guide to emotionally significant material. The GSR, which is usually reactive in an upward direction, will stay in the middle range when a client throws out an emotionally neutral "red herring." The therapist can then gently suggest that perhaps there is something else the client wants to talk about. This often sends the needle well into the upper range.

Toomim and Toomim also discovered that some clients would "paradoxically flatten" in response to stressful material. The GSR would register at the lowest end of the scale. Using the EMG to relax systemic tension will often allow the GSR to free itself and allow the material to come through.

M. Toomim (1978) introduced the concept of Active Biofeedback, using feedback instrumentation to access and process unconscious, painful material, "melt" the body armor, reduce the mind-body split and address the underlying psychodynamic issues of dependency, trust and control.

Smith (1987) described the use of Active Biofeedback in eliciting a traumatic memory of cult abuse.

R.K. Pitman, S.P. Orr, and G.S. Steketee (1989) found that PTSD combat veterans' heart rate, skin conductance response (GSR) and frontalis electromyogram (EMG) were significantly higher than control groups in reaction to reading instructional combat scripts and imagining the events.

Peripheral skin temperature is also a reliable indicator of stress (Toomim, 1978). It usually drops in response to stress, but as with the GSR, it sometimes paradoxically reverses itself and will rise during stress.

When both client and therapist come to recognize the client's response patterns, the biofeedback instrumentation becomes an invaluable tool for treating trauma-induced dissociation.

Response side therapy is so named because the emphasis is on extinguishing the learned instincts and conditioned responses that maintain dissociation. The goal is to remove the emotional valence from the external and internal stimuli that elicit these responses and to leave the client with the capacity for self-determination and internally located responding.

In an earlier paper (Smith, 1991), the idea of a minimum level of integrity was introduced. This refers to a threshold of cognitive, emotive and behavioral connection below which a person employs denial or distortion. Persons above this threshold have the ability for conscious, feeling, rational choice. People with trauma-induced dissociation have truncated neocortical capacity, are numb and alexethymic (unable to recognize or name a feeling)

and thus are irrational in that they continue in self-destructive choice-making.

Restoring the connection between cognitions, emotions and behavior needed for conscious, feeling, rational choice is the primary process followed in response side therapy.

The basic procedure in response side therapy is to encourage stressful or traumatic material to come into consciousness (including symbolic material), briefly acknowledge and empathically respond to the topic, point out the response measurements, then begin the process of soothing, comforting and instilling a sense of control in the client.

A large number of dissociated people do not recognize that there is any connection between what they think, what they do and how they feel. When the process of re-connection begins, they are often frightened because the prospect of self-determination brings up the expectation of being thwarted or punished for acting on their own behalf. Additionally, coming alive is painful. Thus the need for soothing and comfort.

One especially effective means for giving comfort is therapeutic touching which is used in conjunction with the biofeedback instruments. Mari Callings (1991), a survivor, relates the following about touch, "After a while,... not getting burned or raped or hit or humiliated or otherwise punished, the period of terrified trembling grew less frequent and less intense!" (p.9) She also writes, "Being supported with solid, compassionate, physical reassurance when I'm moving through a memory has literally catalyzed my healing!" (p.9)

Her therapist writes the following, "I could reassure her that, if she had to shatter for a short time to learn and experience a memory or programming, she could do this and I would be here,...." (ANON, 1991)(p.11)

Stardancer (1990) also wrote about therapeutic touch and noted that even if you have been physically violated, you still need to be able to receive loving touch.

Comstive (1991) emphasized the need for being touched by writing, "One multiple I recall came to me with a body like cement." (p.2)

Finally, Kramer (1990) found a significant difference in casual versus therapeutic touch in hospitalized children. The important finding of the study was that therapeutic touch reduced the time needed to calm children after stressful experiences.

Instilling control with biofeedback is accomplished by noting the stressful topic and instrument measurements, writing them down, using psycho-motor re-education to normalize the readings, re-introduce the topic, then seek to achieve even a small degree of measureable desensitization. It is important that response

extinction be done in close temporal proximity to the stimulus, otherwise the client may not see the connection and disconnection between stimulus and response.

#### CONCLUSION

Response side therapy seems to be a very effective method for treating PTSD and dissociation. Therapists using this method need to have a precise understanding of the therapeutic process with a clear idea of reconnection. They need to keep the therapy on track while remaining empathic, supportive, non-threatening and efficient.

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