The Integration Of Traumatic Memories Versus Abreaction: Clarification Of Terminology

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Some years ago, our respective children used to watch a TV cartoon program, *The Smurfs*, about those blue gnome-like characters, and subsequently the children incessantly used the verb *to smurf.* As parents, we feared for the development of language poverty. Something of this nature has occurred in the professional discourse on traumatic memories, particularly in the dissociative disorders field, regarding the word *abreaction*.

Reactivated traumatic memories are called *spontaneous abreactions*, the treatment or processing of traumatic memories referred to as *planned abreactions*, gradual and carefully paced work on trauma called *fractionated abreactions*, and patients are helped to *abreact* their trauma. It is striking that this usage is very rarely accompanied by a theoretical rationale. We, and others, have suggested that the field abandon the use of the catch-all phrase of *abreaction* and use more appropriate terminology that accurately reflects the wealth of knowledge available on the nature of traumatic memories (Brown, Scheflin & Hammond, 1996; Peterson, 1993; Van der Hart & Brown, 1992; Van der Hart, Steele, Boon & Brown, 1993).

First we will describe the nature of traumatic memories in order to clarify the phenomena that are at the heart of the confusion in terminology. Traumatic memories are hallucinatory and involuntary experiences consisting of dissociated sensorimotor phenomena, including visual images, sensations, emotions, and/or motor acts pertaining to past traumatic experiences that may engross the entire perceptual field (e.g., Van der Kolk & Fisler, 1995). These traumatic memories are usually reactivated by so-called triggers, i.e., conditioned stimuli that are saliently associated with the original traumatic experience. They exist either in dispositional or reactivated form. While the DID literature refers to reactivated traumatic memories as *spontaneous abreactions* (as if their main characteristic is the ventilation of intense or overwhelming affect), the PTSD field speaks of *flashbacks*. Although the word *flashback* emphasizes the visual dimension, authors have also acknowledged other dimensions of these sensorimotor phenomena (e.g., Blank, 1985; Bremner & Marmar, 1998; Van der Kolk & Fisler, 1995), as well as that these phenomena could be more or less encompassing. Thus, Sonnenberg (1985) defined *flashbacks* as"*altered states of consciousness in which the individual believes he or she is again experiencing the traumatic event. As dramatic as a full-blown flashback can be, it is but one point on a spectrum of more or less subtle alterations in consciousness experienced by those suffering from PTSD*." (p. 5)

In other words, when the word *flashback* is used, it is often unclear as to what form this pertains. In recent years the PTSD field has tended emphasize other descriptive terms, such as *intrusions*, *intrusive recall*, or *intrusive traumatic memories* (e.g., Van der Kolk, McFarlane & Weisaeth, 1996). However, regardless of the terminology used, traumatic memories are representations of experiences that are either not integrated or insufficiently integrated in consciousness, memory, and identity, and thus are clearly dissociative in nature. This state of affairs has implications for use of the term *abreaction*.

The American Psychiatric Association (1980) offered a definition of *abreaction* that we will use to demonstrate the problems with the concept as it is used in the dissociative disorders field: "*An emotional release or discharge after recalling a painful experience that has been repressed because it was consciously intolerable. A therapeutic effect sometimes occurs through partial discharge or desensitization of the painful emotions and increased insight*." (p. 1) *Abreaction* has been associated with idea of reliving or *revivifying* trauma in order to remember. However, clinical observations

have made it clear that the reliving of traumatic experiences in dissociative disorder patients without integrative mental action is merely retraumatizing. Instead, a much more modulated and controlled process should take place, in which the patient is helped to remain oriented in the present, i.e., to be certain that the current experience is a representation of a prior event, and to share his or her experiences with the therapist.

That "emotional release or discharge" could be, in itself, a therapeutic intervention for traumatic memory is contradicted by all that we now know about the nature of traumatic memories and the role of affect in trauma. It is well documented that dissociative patients often suffer from severe affective regulation problems and problems of chronic hyperarousal, thus becoming easily overwhelmed by the affects that accompany the reactivation of traumatic memory (cf., Herman, 1992; Van der Kolk, Van der Hart, & Marmar, 1996). Such feelings are experienced as affective storms that have no meaning, verbal narrative, or therapeutic value. It is also naïve to believe that mere affective discharge will alter the complex psychophysiological changes in functioning that can result from extreme trauma, including emotional, somatic, behavioral, characterological and attachment alterations (Cole & Putnam, 1992; Herman, 1992; Liotti, 1999; Van der Kolk, 1996).

More importantly, affect is not *pent-up* in dissociative patients, but rather is *unintegrated* with the rest of the personality, and *unregulated* in its expression. Cure, then, requires not ventilation, but therapeutically controlled and gradual *integration* of dissociated psychological phenomena, involving not just affect, but also behavior, sensation, perceptions, intentions, functions, and knowledge, into conscious awareness**,** memory, and identity. The integration of traumatic memory may involve, as an accompanying phenomenon, the expression of intense emotion, but this expression is in no way the goal of treatment. This integration encompasses full *realization* of the personal meaning of the traumatic experience, and places such experiences in their proper place in one's life history.

The treatment, or processing, of traumatic memories aims at relieving the dissociative nature of these highly aversive experiential states and transforming them to into autobiographical narrative memories, which are an integrated part of the patient's autobiographical self. We have divided this process into three major stages (Van der Hart et al., 1993): (1) synthesis, (2) realization, and (3) integration.

The first stage, *synthesis*, refers to the component of treatment that various authors in the DID field have called *planned abreactions* or *abreactive work*. The term *synthesis* (i.e., the combination of parts so as to form a whole) was borrowed from World War I psychologists (c.f., Van der Hart & Brown, 1992), and emphasizes that the goal of therapeutic reactivation of a traumatic memory is the resolution of its dissociative nature. The therapist guides the patient to associate elementary psychological phenomena into more complex mental structures, which yield meaningful and coherent experiences. Thus not only affects, but also behaviors, sensations and knowledge must be combined within a unitary consciousness to form a whole experience

Successful synthesis sets the stage for the next step in the integrative process called *realization*, i.e., the process of developing conscious awareness of and assigning meaning to the past traumatic experience, of becoming aware that the trauma is indeed over and not occurring in the present, and that it has definite implications for one's past, current, and future existence. In contemporary neuropsychological language, realization refers to the development of *autonoetic awareness* of one's past traumatic experience (Siegel, 1999; Wheeler, Stuss & Tulving, 1997). Realization is accompanied by the patient's increased ability to give autobiographical accounts of his or her past trauma rather than sensorimotor and

behavioral re-enactments of it. Thus, *synthesis* and *realization*, respectively, can be seen as parts of an overall process of *integratio*n. But this integration does not stop at the level of realization of traumatic experiences. It is actually an ongoing process, in which the patient time and again returns to various aspects of the trauma and its consequences, in order to redefine it meanings within one's evolving autobiographical self.

So, now, as the dissociative disorders field is entering its adulthood--like our respective children--we have the possibility of outgrowing incorrect language and using more accurately descriptive terms that reflect a deeper and more mature understanding of our work with dissociative patients.

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