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

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(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…
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 Ablation 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 non 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
TABLE OF CONTENTS
Table of Contents

Acknowledgements

The Rationale for an Unconventional Approach to Clinical Skill-Building

Three Caveats for the Reader

Prologue of the Amanuensis

Autobiography, by The Fractionated Abreaction Technique (The FAT Man)

Providing Shelter from the Storm: The FAT Man at Work - My Complete Scenario-Based Format

The FAT Man “Lite” or “Mini-Me” Techniques

Pacing Trauma Work: A General Overview

Making Use of My Flexibility: Changing Gears to Match the Therapeutic Terrain

Attachment, Me, and Mini-Me: A Speculation

A Segue into Forensic Concerns

Fractionation and the Comprehensiveness of Trauma Processing

The Big Secret

The Fractionated Abreaction Technique and the Therapeutic Alliance: An Exploration of Selected Topics

Boundary Concerns: An Excellent Indication for Employing Me as a Probe or Test Drive

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

Opening Acts

FAT Man’s Crew

The FAT Man’s Crew Part I: Getting Trauma Processing Underway

The FAT Man’s Crew Part II - Closure, and Containment and Safety Between Sessions

Dissociation, Memory, and the Issue of “Historical Truth”

Reflections on Myself and My Role in the Context of a Trauma Therapy

Mixologist’s Afterword

List of the Appendices

Appendix I - An Overview of the Treatment of DID

Appendix II – Catherine G. Fine, Ph.D.’s BASK Approach to Fractionation

Appendix III – What You Need to Know About Hypnosis to Understand The Fractionated Abreaction Technique

Appendix IV – An Introduction to the Howard Alertness Scale

References
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 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 spurious 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