Over the last few years increasing attention has been paid to the issue of child sexual abuse and those adults who have survived it.

However it has become all too evident that this is a subject about which many therapists, even those with extensive training, feel ill at ease, some avoiding it altogether.

Starting in this issue the EJCH is carrying a series of papers by an author who has specialised in the field for many years.

Her first article sets out to provide hypnotherapists with a basic understanding of some of the different theoretical approaches which can be followed.

Working with adult survivors of child sexual abuse

Theoretical approaches, long term effects and the therapeutic process

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After moving to England she trained in Bodywork and with the London College of Clinical Hypnosis and for seven years she has worked in private practice in London,with adult survivors. She facilitates therapeutic groups for abuse survivors employing a combination of counselling, Bodywork and hypnotherapy and supervises counsellors and hypnotherapists working with survivors of abuse.

For the last three years she has trained and lectured on "working with survivors" and is now in the process of writing a book.

In recent years clients seeking psychotherapy have increasingly reported not only a history of sexual abuse but also have presented symptoms and complaints which might be related to – or be direct consequences of – abuse during childhood.

This has led to a growing need for mental health professionals to learn more about the long term effects of childhood sexual abuse and to create effective treatment procedures.

Fortunately an increasing number of highly qualified and respected practitioners are now willing to describe the struggles they went through when confronted with clients revealing a history of sexual abuse to point out the lack of theoretical and practical understanding, to examine various errors made in those early stages and to acknowledge that their training did not prepare them appropriately. (e.g. Hunter 1995; Mayer Ph.D. 1995; Yapko Ph.D., 1994; Sanderson 1990 [1, 2, 3, 4]).

Unfortunately this last point still seems to apply although it should by now be common knowledge that today's mental health professionals, regardless of training, qualification and approach, deal on a fairly regular basis with the effects of child sexual abuse.

When in the early 1980s I was confronted with more and more clients disclosing abuse, more than once I felt entirely out of my depth and – despite my clinical knowledge and experience and my therapy training – professionally inadequate.

The author's aims and intentions for this series

I have used hypnosis – in a traditional sense as well as in the sense of utilising natural hypnotic phenomena – in the therapeutic process with survivors for a number of years and have found it effective and valuable for the healing process. Which is why I decided to write this series of articles on the issue of sexual abuse.

What I would like to achieve with this first article is to give interested hypnotherapists a basic insight into various theoretical approaches, because I do believe that treatment of trauma survivors ought to be based on some theoretical understanding of abuse and its effects.

My second article will outline the most common known long term-effect of sexual abuse and relate them to abuse during childhood.

The third article in the series aims to give hypnotherapists some basic ideas about an effective therapeutic process and about its pitfalls.

The articles will not only be based on my personal experiences and clinical observations but I will also reference whenever possible.

As well as passing on some basic knowledge and information I invite hypnotherapy practitioners to enter into an exchange of experiences and opinions in the European Journal of Clinical Hypnosis.

The focus of the EJCH – and maybe also the focus of hypnotherapists generally – seems to have shifted from the issue of sexual abuse, its consequences and therapeutic interventions to "False Memory Syndrome" provoking reactions of:

Angst – being accused of producing false memories.

Avoidance – not treating clients with a history of abuse.

Defence – *"I never use regression, I just treat symptoms."*

But I believe we should instead be seeking to enhance a sensible and professional debate on this important issue.

[1] Hunter, M.: (1995) Adult survivors of sexual abuse, Treatment innovations, Sage Publ., London

[2] Mayer, RS.: (1995) Treatment of the very difficult abuse survivor, in: Hunter 1995, sage Publ., London

[3] Yapko, M., PhD, (1994) Suggestibility and illusory memories in the therapeutic setting, The European Therapy Studies Institute, London

[4] Sanderson, Ch., (1995, 1990): Counselling adult survivors of child sexual abuse, Jessica Kingsley Publ., London

I had no clear understanding of sexual abuse and its effects, let alone the therapeutic process; the disclosed material would have an immense impact on me at times; I was not able to deal effectively with transference and counter transference during sessions, self-destructive behaviour provoked a lot of "unprofessional" fear, and being with a client in crisis left me depleted of all my energy.

Over the last two decades increased awareness of the existence of child sexual abuse, as well as increased clinical observation of its short and long term effects, have given rise to the reviews of existing theories as well as to the creation of new theoretical frameworks, to more research into immediate effects on the child and possible long term effects on the adult, as well as to various descriptions of treatment approaches and procedures.

Although all this has to be seen as a process which is on-going and far from finished I believe practitioners should be able to work on a level based on some knowledge and understanding. Major mistakes by therapists and counsellors (from negating the effects of sexual abuse to over or under-relating symptoms) cannot be blamed solely on a lack of information and training any more.

It is therefore in a way frightening to realise that some therapeutic interventions leave survivors feeling re-traumatised, misunderstood, denied – or, at best, not helped at all.

It is also alarming that ignorance – and unethical practice – of some counsellors, psychotherapists and hypnotherapists could create the so called "False Memory Syndrome," shifting the focus dangerously away from the real issue and discrediting mental health professionals in general and hypnotherapists in particular. I personally find it almost unbelievable that there are not only individual practitioners but schools and colleges of hypnotherapy and psychotherapy which seem to explain symptoms, or a combination of symptoms, solely on the basis of childhood sexual abuse, no matter if clients consciously remember any abuse or not.

Theoretical approaches to child sexual abuse and its effects

The following approaches have developed from different levels of clinical experience research and orientation. The development of theoretical approaches, as well as the expansion of existing frameworks, is an ongoing process with new data and insight emerging constantly. So far I have not come across one that covers all aspects of abuse.

These compressed descriptions of various, sometimes conflicting models are therefore only meant to give interested therapists an overview, to create some basic understanding of different concepts covering as many aspects of sexual abuse as is possible in the framework of this article.

[5] *Freud, S., (1933) The aetiology of hysteria, in: Strachey: The complete works of Sigmund Freud, Hogarth Press, London*

[6] *Rush, F., (1980) The Best Kept Secret: Sexual Abuse of Children, Mcgraw-Mill, NY*

[7] *Masson, J.M., (1984) Freud: the assault on truth. Freud's suppression of the seduction theory. Farrar, Strauss and Giroux, New York*

[8] *Miller, A., (1984) Thou shalt not be aware: Society's Betrayal of the Child. Strauss and Giroux, NY*

[9] *Herman, J., (1981) Father/Daughter Incest. Harvard Un. Press, Cambridge, Mass.*

Freud's Oedipal Theory and its implications

The earliest proposed theory was Freud's psychoanalytic formulation based on his clinical work on hysteria.

With a high percentage of his female patients disclosing sexually abusive experiences during childhood he developed his 'Seduction Theory', which basically postulated a causal relationship between trauma of early genital stimulation during abuse and psychological damage, mainly hysteria and neurosis (Freud 1896[5]).

The poor reception of the seduction theory by Freud's peers as well as Freud's own self-analysis, revealing sexual instructions by his nurse-maid and provoking strong denial, together with his own entangled and problematic relationship with his father and daughter might have contributed to the fact that Freud later, despite further disclosure of abuse by his patients, renounced the seduction theory and replaced it with the Oedipal Theory (see also Rush 1977; Masson 1984; Miller 1984 [6, 7, 8]).

According to the Oedipal Theory, reports of sexual abuse derive from fantasy: namely the fantasy of little girls being seduced by their fathers. These fantasies are based on the little girls 'penis envy' which makes girls shift their love from mothers to fathers in the hope of being given a penis. It is the daughter's 'penis-envy' and love for her father which creates the fantasy of sexual activity between father and daughter.

Freud's assumption, that disclosed abuse is lodged in the realms of fantasy, influenced most of the psychiatric literature and the clinical treatment of survivors of abuse up to late 1960's with – in my view – devastating implications:

It denied the reality of child sexual abuse generally reinforcing feelings of guilt, shame, isolation, badness and confusion in individual survivors through accusations of fabricated stories of abuse. It furthermore denied – and provided no explanation for – the existence of extra-familial abuse or male child sexual abuse.

If psychiatrists did acknowledge that the disclosed abuse was indeed lodged in reality the child was pictured as the seductress and therefore still in a way responsible for her own abuse.

Associated with the concept of the seductive daughter was the tendency to view mothers as responsible for the occurrence of incest, firstly through using their daughters to act out their own incestuous desires and secondly through being cold and unaffectionate and so leaving the daughter no choice other than to turn to her father.

By seeing fathers as weak, powerless males falling for their seductive daughters, the blame was firmly put on females, and real research into the incidence of abuse, into abuser profiles, into the effects of abuse and so on, did not take place.

Later on the psychoanalytical framework was reinterpreted towards a more active role of the father with Herman (1981 [9]) emphasising that while girls do try to develop a special relationship with the father in order to be elevated into the superior company of men, it is the father who actively chooses to eroticise the relationship. Alice Miller (1984 [8]) clearly shifts the fundamental responsibility in stating that the disturbance doesn't lie within the child but in a 'narcissistic abuse' of the child to satisfy the father's needs.

The therapeutic focus of family therapy which is still very widely accepted throughout the USA and Europe, is on changing family dynamics

10 *Rist, K., (1979), Incest: Theoretical and Clinical Views, Sage Publication, London*

The Family Dysfunction approach

The family dysfunction approach established itself as a major force of explanation of incest and sexual abuse as well as a basis for therapeutic intervention in the 1970s.

It argues that the disturbance does not lie within the individual psyche but that the incestuous family, as a unit, is pathological, so that abnormal behaviour, such as incest, is a symptom of an already disturbed, maladjusted family. Incest is described as a rationale for maintaining the family's pathology and keeping it a secret.

Dysfunctional families do not conform to socially approved goals and values, the normal hierarchies and boundaries are not in place, the parent's fears, fantasies and wishes – which could not be acted out outside without destroying the family unit – are acted out within the family in order to maintain homoeostasis and release tension (Rist 1979[10]).

Because the Family Dysfunction Theory proposes that the cause of incest is rooted in the dynamics of intra-familial relationships each family member is seen as equally culpable.

One can not avoid though, while scanning through some of the literature, realising that a lot of emphasis is placed on the 'failing mother', who allegedly is not fulfilling her role as sexual provider for the husband and as protector and nurturer for her children.

The 'failing mother' is seen as being too dependent and weak – or too independent – and so, by emotionally and physically absenting herself from father and daughter the 'emotionally starved' daughter turns to, and accepts, incestuous advances from her 'sexually starved' father. (for overview of literature see Sanderson 1990[4])

The therapeutic focus of family therapy within the framework of the family dysfunction model, which is widely accepted by agencies throughout the USA and Europe is on changing the family dynamics, establishing proper boundaries, hierarchies and functional relationships while the sexual abuse is seen as secondary.

The Family Dysfunction Theory has, in my view, some major shortcomings. Again it has no explanatory power for extra-familial abuse. As a therapeutic technique in family therapy it can only be used if the incest victim is a child still living with the family, not for adult survivors of abuse.

It detracts from the devastating and painful effects of incest on the child and, used as the only therapeutic intervention, can minimise the daughters experience as well as fail to provide therapeutic interventions for her. Furthermore, it places too much responsibility on the mother and dangerously denies that the actual perpetrator chose actively to respond to family dynamics by sexually abusing his daughter.

The Family Dysfunction Theory provides us with some very valid insights, though. If the sexual abuse survivor is an incest survivor it is necessary for the therapist to have some understanding of dysfunctional families and their dynamics.

Blurred boundaries and hierarchies, as well as internalised dysfunctional role models, have to be addressed and worked through to avoid incest survivors ending up creating dysfunctional families of their own.

The incest survivor also benefits from a conscious understanding of her own role in the original family dynamic: namely, very frequently, the role of keeping the family together.

And although it is now well established through research that most mothers, but unfortunately not all, do take action when discovering incest, incest survivors often feel betrayed and unprotected by their mothers and see their mothers either as weak and powerless when they needed their protection, or as cold and distant.

To work through these feelings, to achieve an understanding of the mother's role in the family dynamics, is part of therapy with survivors.

11 Finkelhor, D., (1979) Sexually Victimised Children, Free Press, NY

12 Finkelhor, D., (1984) Child sexual Abuse: New Theory and Research, Free Press, NY

13 Schwartz, 1,F., Galperin, L.D., Masters, W.H., (1995) Sexual Trauma Within the Context of Traumatic and Inescapable Stress, Neglect and Poisonous Pedagogy, in: Hunter (1995): Adult ..., Sage Publication, London

14 Herman, J., (1992) Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma, Journal of Traumatic Stress, (5), 2

The feminist approach

The feminist reinterpretation of child sexual abuse, although mainly sociological in its approach, focuses on two aspects worth mentioning: firstly the part that unequal power relationships in society and in the family plays in child sexual abuse: secondly on the distinct features of normal masculine sexual socialisation that predispose men towards initiating and maintaining abuse.

Examination of male power in the family shows that incestuous fathers are often 'family tyrants' (Finkelhor 1979; Sanderson 1990; Hunter 1995;[11,4, 1]) while really feeling sexually inadequate and socially isolated and powerless.

Within the family the incestuous father usually reconstructs the traditional patriarchal domination over wife and children by means of fear, threats or sexual coercion and expects not only to be obeyed but also to be sexually and emotionally serviced by females (Sanderson 1990[4,]).

Analysing furthermore the increasing role of child pornography as a stimulant for males as well as the common fear of women to experience rape, feminist theory concludes that the power structure of society and its family systems actively encourage and socialise males to assume and wield their power over weaker people (children and females), forcing them to be submissive, passive and compliant providers for male needs.

Sexual abuse is therefore, according to the feminist approach, firstly about power and control and only secondly about sexuality.

Feminist reinterpretation of power hierarchies also focuses on the victimisation of mothers in incestuous families and concludes that maternal collusion in incest is a measure of maternal (female) powerlessness.

There are, according to Finkelhor (1984[12]), some distinct features of normal masculine sexual socialisation that predispose men towards such abuse.

Firstly, men do not generally practise nurturing behaviour and they are socialised to express all kind of needs through sex. Needs (of children) for nurturing or physical contact can therefore be interpreted as sexual and so become sexualised by males.

Secondly, men tend to use sex to counter feelings of inadequacy and low self worth and in times of low self-esteem or stress availability of a sexual partner can become more important than appropriateness.

Thirdly, men are generally socialised to desire partners who are younger, smaller and less confident than themselves – sexually inadequate men may therefore prefer a child to an adult so as to in order bolster an inadequate adult ego.

In focusing on the power relationships between men and women in society and the difference in socialisation the feminist approach explains the fact that the vast majority of perpetrators are male, that sexual abuse happens both inside and outside the family and across all social levels of society.

The conclusion that exhibition of power plays a dominant role in certain male sexual behaviour such as abuse or rape seems to explain why abuse often stops or becomes brutal if the victim shows physical signs of response to the sexual stimulation. In fact there is no evidence of "sexual starvation" of perpetrators in most abuse and rape cases (indeed a high percentage of rapists had intercourse in the past 48 hours before committing rape) to explain the facts that helplessness and powerlessness are dominant feelings in survivors and that mothers and women in general are often seen as weak and powerless by survivors.

Feminist approaches did finally – and in my view rightly – place the responsibility for sexual abusive behaviour firmly where it belongs, on the grown-up perpetrator – a fact which is crucial to achieving healing in individual survivors as well as for preventing and targeting sexual abuse and rape in general.

Also feminist approaches have little explanation for exploitation of male children and none for the small number of female perpetrators. They furthermore minimise psychological factors and motivations and give little insight into the individual experience of and effects on the victim and therefore a restricted basis for therapeutic intervention.

Another shortcoming in the feminist approach is the fact that it sees all women and female children as socialised into being powerless, compliant and passive, giving us no insight into the psychological structure of the children who are able to resist abuse or able to tell, and negates the enormous strength, courage and resourcefulness that victims of abuse show in their survival strategies

Finkelhor's four precondition model of child sexual abuse

Finkelhor[12] proposed, after extensive research into the occurrence of and literature about child sexual abuse in 1984, a multi-factorial model which is partly sociological and partly psychological in its approach.

Finkelhor argues that there are four preconditions which need to be in place before sexual abuse can occur:

1. **Motivation:** The abuser has to be motivated to sexually abuse a child. Factors influencing motivation for abuse include arrested emotional development. the need to feel powerful and in control, re-enacting own abuse, the influence of child pornography, the male tendency to sexualise all emotional needs, fear of adult females, castration anxiety, misattribution of arousal cues and so on.

2. **Overcoming internal inhibitions:** The abuser has to overcome all the internal inhibitions which act against his motivation to interfere with a child. These inhibitions may be overcome by alcohol, psychosis, impulse disorders, failure of incest inhibition mechanisms in family dynamics, weak criminal sanctions against offenders, child pornography and eroticised advertising featuring children. patriarchal prerogatives for fathers, and so on.

3. **Overcoming external inhibitors:** The abuser has to find a way around external obstacles prior to abuse. These include mothers or other caretakers emotionally not close to child, absent or ill mothers, social isolation of family lack of supervision of the child, a powerless mother who is dominated or abused by the father and so on.

4. **Overcoming the child's resistance.** The abuser has to overcome the child's potential resistance. Factors influencing the level of resistance: child is emotionally insecure and deprived, isolated, lacks knowledge about sexual abuse, lacks parental emotional support, situation between abuser and child is one of trust, abuser uses coercion through force, threat or violence, general social powerless of children.

Finkelhor's model accounts for intra and extra familial abuse and in its general approach rids the subject of distinction between incest and other sexual abuse.

The most important finding of his research for clinicians working with abuse survivors seems to me that abuse only takes place if the abuser is already sexually motivated towards abusing children in general. The behaviour of mothers or caretakers, the set-up of the environment, the child's behaviour and so on are relevant, but only in a supportive or deterrent way, or as a response to the manifestation of the abusers sexual interest.

The finding of a general sexual motivation towards abuse in abusers corresponds with the fact that most adult survivors of abuse I worked with did sooner or later come across people (siblings, children in the neighbourhood, girls of the same youth club) who were interfered with by the same perpetrator.

The realisation *"I was not the only one"* can be of immense value in the therapeutic process by taking away a portion of the guilt and responsibility internalised by every survivor.

Addressing the preconditions 3 and 4, finding out which ones were in place (e.g. powerless mother, distant mother, neglect, emotionally insecure and unsupported child) and working through all the implications is essential during the healing process.

The shortcoming of the model lies in its restricted value for clinicians who work with adult survivors of abuse in respect of the long term effects of sexual abuse. It does not address the issues of short and long term effects of abuse and so provides us with no understanding about processing strategies for abuse victims.

Schwatz, Gaperin and Masters' DES model

Schwatz, Gaperin and Masters (1995[13]) provide a psychological theory for understanding the effects – in the form of survival strategies and mental processing – of child sexual abuse, using an extreme stress response model.

Their basis is the assumption that one-off trauma (e.g. rape, natural disaster, one-off abuse) produces post-traumatic stress disorder (PTSD), which is characterised by cycles of numbing and intrusion.

The numbing part of the cycle occurs when the traumatised person disconnects, feels like an object, acts without emotions. It results in restriction, isolation and disconnection from the self and from others.

The intrusive part of the cycle is characterised by the breaking through or flooding of cognition or affect which threatens to overwhelm the individual.

Intrusion can be coded as nightmares and flashbacks, but also often in the more disguised form of depression, anxiety and symptomatic complaints.

Usually, during the intrusive phase of the cycle compulsive behaviour (e.g. purge eating, children's compulsive acting out with dolls, consumption of alcohol, bingeing etc.) is employed to numb again. If the numbing becomes too strong and the person feels completely disconnected, inhuman compulsive or ritualised behaviour (e.g. self–mutilation) is used to re-establish feelings.

The authors point out that without "finishing and working through the trauma" those cycles can go on for ever. If the environment of the trauma victim does not allow of resolution of the trauma because of the absence of caring, nurturing, understanding and facilitation of the expression of trauma related emotions, then the cycles can reach pathological intensity and result in mental disorder.

Disorders of extreme prolonged distress

A child who is sexually abused in a small or extended family may not only experience PTSD but is highly likely to develop disorders of chronic extreme inescapable distress.

The distorted survival strategies in humans that result from inescapable stress include on-going cycles of numbing and intrusion with manifestations of flashbacks, nightmares, depression, anxiety and somatic symptoms as well as dissociative symptoms, compulsive re-enacting, susceptibility to re-victimisation, intimacy and relationship disorders and personality adaptations in the borderline, narcissistic, antisocial or schizoid realm (Herman 1992; Schwartz, Galperin, Masters; 1995 [14, 13,]).

A child living in an abusive family environment not only suffers on-going stress through sexual abuse but has to cope with dependency, intimidation, disorientation, great confusion, isolation and neglect. If the abuse is violent, committed by people the child totally depends on, it creates feelings of profound powerlessness and hopelessness, forcing resilient children to reframe their environment in a way which restores hope, so that they can go on living.

The only power children have in such circumstances is to change themselves. Their instinctive conclusion therefore is they must be bad, and will be loved and cared for if they change.

These dynamics of internalising guilt are reinforced by the 'secrecy' of sexual abuse and by the extremely confusing messages the child gets from abusers. Confusing messages range from: *"I love you, but if anybody, and especially your mother, knew they would hate you"* to conflicting body language messages like a kiss followed by a pillow over the head which almost suffocates the child. Often these confusing messages occur together at the same time as overwhelming stimulation and excruciating pain of the abusive situation, leaving the child confused, disorientated, isolated in a bubble of terror, fear, hurt and badness.

The longer the abuse continues without respite the more the child feels unworthy of being saved, unloved, abandoned, disorientated, helpless, confused, bad, ashamed, isolated, and dependent on the abuser for cessation of the suffering.

Dissociation

To survive on-going sexual abuse most children need to dissociate. **Dissociation** is the separation and non-integration of trauma-related emotions, thoughts, sensations and behaviours. It enables children to deflect the traumatic abuse into a separate consciousness, making normal functioning possible and preventing direct experience of the pain, fear, helplessness, shame, disgust, terror. But it also prevents the expression of rage and grief which would complete the stress cycle.

The cost of dissociation is fixation of the child's development, each experience a new block of un-integrated material and a further break in the continuity of consciousness. The child is encapsulated and fixated in a bubble; feeling dirty, bad, damaged, helpless, frightened, isolated, different and defective. And although normal development goes on, so that the abuse survivor becomes an adult, learns new skills and experiences, has a job and creates a family the bubble stays untouched. But, as in PTSD, the stress response cycle strives for completion. Unexpressed emotions in the bubble break through, mostly as intense rage, often directed by survivors against themselves, as sudden unbearable feelings of terror or anxiety, as depression, as somatic symptoms, as flashbacks, introducing again cycles of numbing and intrusion helplessness.

Repetition

Or it can come as **Repetition**, which is another way for survivors of trauma to complete the stress response cycle. Survivors may re-enact the trauma, often in disguised form, with accompanying numbness and intrusion throughout their lives. Compulsive re-enacting often revolve around themes of self-punishment, self-mutilation, hypersexuality, binge and purge eating, of repetitively very destructive and abusive relationships, getting into dangerous situations and so on.

Those compulsive behaviours are also used as a numbing device to fight intrusion or as means to create the capacity to feel. Re-enactment may over the years become part of an addictive cycle, living a life of its own without any connection to the original trauma, and the stress release it creates perpetuates and reinforces the habit.

Trauma Coding

Trauma Coding (which refers to the complex bonding with the abuser) as well as **Internalisation** and **Introjection** of negative role models (family members) and the very negative self-image shape the survivors life as victim. Survivors often have no self-nurturing abilities, no self-appreciation, little capacity to say 'no' and generally see themselves negatively.

They suffer from very low self-esteem, internalised guilt and shame. It is very difficult to let go of trauma, especially when abuse started early and was on-going, because primary needs and drives like the need for nurturing, affection, love and eroticism are paired with abuse and neglect leading to very complex double binds and to a bonding to – and internalising of – the abuser.

The most common emotions we encounter in adult survivors is a strong mixture of hate/love for the abuser and very strong fears of being and behaving like the perpetrator, which have their origins in re-enacting the experience in sexual and abusive fantasies and in natural identification with the perpetrator (mainly because he had all the power while the non-molesting parent is seen as weak and powerless and survivors know what can happen if somebody is weak and powerless.)

These strong fears of being like the perpetrator became reinforced through feelings in the bubble – especially of rage – and because of blocked identification mechanisms with the weak and powerless mother.

The model of Schwartz, Galperin and Masters provides therapists with a good deal of insight into the coping and survival mechanisms of survivors of ongoing abuse in an environment of neglect, as well as with some basic understanding for clinicians as to how those mechanisms lead to long term, often pathological, effects. Everybody working with survivors of abuse ought to make themselves familiar with their findings.

The most important lesson for the therapeutic process is that it is absolutely necessary as part of the healing process to work through the original trauma with abreactive and cathartic methods in order to release fixated emotions in the 'bubble' and so complete the stress cycle, this combining the child's terrors and fears with the understanding and the resources of the adult survivor and the therapist together in a safe therapeutic setting.