

## DISSOCIATION AND INTERNAL MODELS OF PROTECTION: PSYCHOTHERAPY WITH CHILD ABUSE SURVIVORS

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*This article presents strategies for treating child abuse survivors based on a theory of interpersonal protection that integrates research in attachment, developmental psychopathology, trauma, dissociation, and experiential psychotherapy. The theory proposes that abused children do not form internal working models of an effective protector, with the result that they have difficulty defending themselves against interpersonal aggression and internal self-criticism; thus, a core psychotherapy task is to help survivors develop adequate representations of protection. The article provides case examples and describes interventions targeting the client–therapist relationship, other client relationships, client self-criticism, and traumatic memories. The author discusses dissociation as an intervention marker; client verbal and nonverbal feedback to therapist interventions; subselves and internal roles; the “inner critic”; guided imagery, role-plays, and dramatic enactment methods; and directions for future research.*

Child abuse is disturbingly frequent, and its victims often experience longstanding and damaging effects (Herman, 1997; National Research Council, 1993). Abused children may follow a

variety of developmental pathways, and a significant number are psychologically resilient (Cicchetti, 1996; McGloin & Widom, 2001). However, one well-conducted follow-up study of young adults who were abused or neglected as children found that almost 80% failed to meet criteria for successful psychosocial functioning (McGloin & Widom, 2001), and a longitudinal community study found approximately the same proportion of young adults who reported abuse histories meeting clinical criteria for one or more psychiatric disorders (Silverman, Reinherz, & Giaconia, 1996). Child abuse has been linked with many severe and intractable psychological and social problems, including borderline personality disorder, dissociative identity disorder, suicidality, substance abuse, sociopathy, and violence (Herman, Perry, & van der Kolk, 1989; Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Kluft, 1996; National Research Council, 1993). It is also strongly correlated with serious medical illness among adults (Fellitti et al., 1998).

In the past 2 decades, psychotherapists and survivors themselves have written extensively about treatment for the long-term effects of abuse (Herman, 1997; Williams & Sommer, 2002). However, there is little scientific data validating their methods (Ratiner, 2000; Solomon & Johnson, 2002; van der Kolk, McFarlane, & van der Hart, 1996). I have argued that research and treatment would benefit from greater theoretical clarity and proposed a model organized around the concept of interpersonal protection (Thomas, 2003). This model has multiple strengths: (a) it is consistent with research findings; (b) it offers a parsimonious explanation for a wide range of clinical phenomena; (c) it can be tested empirically; (d) it has the potential to align clinical research and practice with core scientific traditions (attachment theory in developmental psychology, as well as ethology, evolutionary biology, and general systems theory); and (e) it provides a clear focus for psychotherapy interventions.

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The present article focuses on the model's implications for psychotherapy. After summarizing the model, I provide case examples and describe psychotherapy interventions targeting (a) the client–therapist relationship, (b) other client relationships, (c) clients' internal criticism, and (d) traumatic memories. Finally, I consider directions for future research.

## **An Interpersonal Protection Model of Abuse**

### *Attachment and Representations of Protection*

Child abuse, a concept rooted in social policy developments of the past half-century, probably cannot be defined without reference to social norms (Garbarino, 1991). As the term is currently used in psychology, *child abuse* refers to acts of commission by caretakers that are considered, by a combination of community and professional standards, to be inappropriate and to endanger a child's health and development (National Research Council, 1993; Zuravin, 1991). Researchers distinguish physical abuse (severe corporal punishment or bodily injury), sexual abuse (intercourse or sexual fondling), and psychological abuse (e.g., terrorizing or systematic humiliation).

The interpersonal protection model proposes that abused children do not internalize adequate images of protection because their caregivers did not protect them at crucial moments. As a result, they lack a template for developing self-defense behaviors, and this deficit may underlie most if not all of the long-term effects of child abuse. It follows that a core treatment task is to help abuse survivors develop effective internal images of protection.

This model is consistent with Bowlby's (1982) attachment theory, currently the most widely accepted and validated approach in developmental psychology (Cassidy & Shaver, 1999; Thompson & Raikes, 2003). Bowlby defined *attachment* as a primary behavioral system that functions to keep infants close to their parents and argued (on the basis of animal behavior research) that attachment behaviors evolved to provide protection from predators. Recent studies of *disorganized attachment*, a breakdown in the coherence of the attachment system characteristic of children whose parents are dangerous or frightening, lend support to Bowlby's thesis that the attachment

system is organized around protection (Thomas, 2003).

According to Bowlby, attachment is crucial for psychological development because children form *internal working models* (mental representations) of themselves and their caregivers based on their attachment experiences. As they grow, they form expectations of the interpersonal world based on these models. They tend to select relationships, and act within those relationships, in ways that match their representations. Thus, attachment-based internal models can act as self-fulfilling prophecies throughout life. A substantial body of research now supports this hypothesis (Bretherton & Munholland, 1999; Hesse, 1999; Solomon & George, 1999).

Recent theorists have suggested that internal working models are dynamically related roles organizing children's experience and behavior (Blizard, 2001; Liotti, 1999; Lyons-Ruth, Bronfman, & Atwood, 1999). Furthermore, if attachment evolved for the purpose of protection, it seems likely that children's experiences of danger should crucially influence their internal models. I propose that (a) children form representations of three interacting roles on the basis of their experiences of caregiver protection and (b) these roles are activated and organize their thoughts, feelings, and actions in situations of threat. Children who are well protected form mental models of a safe child, a strong protector, and a contained or curbed aggressor (a *safe constellation*); abused children, on the other hand, form representations of an unsafe child, an inadequate protector, and an out-of-control, dangerous aggressor (an *unsafe constellation*). The inadequate protector representation is modeled on caregivers who were passive or ineffective but may also be contaminated by the aggressor role given that some caregivers are perpetrators.

The vast majority of clinical symptoms associated with abuse survivors correspond to roles in the unsafe constellation (for reviews of the long-term effects of abuse, see Briere, 1992; Browne & Finkelhor, 1986; van der Kolk, 1996). Anxiety, phobias, hypervigilance, excessive control needs, loneliness, mistrust, feelings of betrayal, and fear of intimacy characterize the unsafe child. Self-injury, suicide, victimization of others, and a grandiose sense of personal evil correspond to the uncontained aggressor. Passivity, difficulty setting limits, disregard for personal safety, and a

tendency to be revictimized reflect the inadequate protector. Patients with dissociative identity disorder, a condition linked to severe childhood abuse, demonstrate terrified children, violent persecutors, and confused protectors as their three most common alternate identity states (Putnam, 1989; Ross, 1997). Depression—a frequent problem among abuse survivors (Bifulco, Moran, Baines, Bunn, & Stanford, 2002; Briere, 1992)—can be seen as an internal interaction among all three roles: An abusive inner critic attacks a vulnerable child while the protector stands aside (Thomas, 2003).

Dissociative problems are also strongly correlated with abuse (Briere, 1992). Dissociation refers to a variety of phenomena, not well understood, that involve fragmentations of consciousness and a reduction of ordinary awareness (Lynn & Rhue, 1994; Michelson & Ray, 1996). Dissociative episodes include mild, everyday events (e.g., momentary confusion, memory lapses, and blank spells), more pronounced and unusual states (e.g., shock or hypnotic trance), and extreme manifestations (e.g., fugue states and alter personalities) that characterize clinical disorders (American Psychiatric Association, 2000). Many investigators regard dissociation as a defense mechanism protecting individuals from overwhelming experiences. Incest victims, for example, frequently report that they leave their bodies and feel numb while they are abused (Cardena, 1994; van der Kolk, van der Hart, & Marmar, 1996). I propose that individuals dissociate when their unsafe internal roles are activated (thus, dissociation functions as a kind of defender of last resort when individuals lack effective models of protection). If so, many dissociative events—even mild, fleeting episodes that fall within the range of “normal” experience—signal an immediate need for protection and can serve as valuable markers in psychotherapy.

### *Psychological Protection*

Bowlby argued that attachment relationships provide protection from bodily danger; however, the concept of interpersonal protection developed in this article has a wider application and includes the maintenance of psychological as well as physical integrity—what the professional and popular literature frequently refer to as “setting limits” or “maintaining boundaries” (La Llave & Commons, 1996; Popp, 1996). A person who

says “no” under pressure, stands her ground in a conflict, defends her privacy, and resists efforts to degrade, frighten, or exploit her is protecting herself in this psychological sense.

The current model assumes that the same or similar internal models govern safety in the physical and psychological realms. Thus, either type of violation in childhood tends to generate unsafe internal roles. This assumption is consistent with research findings that physical, sexual, and psychological abuse rarely occur in isolation from one another and that all three types of abuse have similar long-term effects (Bagley & Mallick, 2000; Bifulco et al., 2002; Briere, 1992; McGee, Wolfe, & Wilson, 1997). If the assumption is correct, individuals who were physically violated should have difficulty protecting themselves psychologically. In fact, this is widely reported in the literature (e.g., Briere, 1992). Herman (1997) noted that

the [physical or sexual abuse] survivor has great difficulty protecting herself in the context of intimate relationships. . . . The idea of saying no to the emotional demands of a parent, spouse, love, or authority figure may be practically inconceivable. (pp. 111–112)

The following description of the dynamics of psychological protection is a series of hypotheses, drawn from my clinical observations and consistent with the existing literature (e.g., Herman, 1997). In my experience, abuse survivors tend to see people who challenge their boundaries as dangerous aggressors, even when those people intend simply to make a request, strike a negotiating stance, or express disagreement. If survivors do not feel strong enough to counter effectively, they feel violated. This is especially likely when challengers occupy a social role with greater real or perceived power (e.g., male, employer, or psychotherapist).

I have observed that survivors who face boundary challenges simultaneously experience harsh criticism from an internal voice (e.g., “You have no right to say no”). Thus, survivors feel under attack at the same time from an outside challenger and an inner critic. Unable to defend themselves on either front, they feel overwhelmed and dissociate. Subjectively, they may feel blank, numb, confused, and/or paralyzed; outer signs include blunt affect, slowed reactions, dazed expression, slack jaw, and interruptions in eye contact. In severe cases, survivors may demonstrate clinical symptoms: amnesia, depersonal-

ization, or identity switching (American Psychiatric Association, 2000).

Even mild dissociation is disabling for survivors. At the best of times, their resources for protection are limited; when they are dissociating, even basic protective actions—such as leaving the situation to buy time—are impossible. As a result, they typically acquiesce, passively or superficially, to the challenge. Close examination reveals a more complex response: incongruent agreement signaled by a mixture of acquiescence and resistance messages. For example, a person may say “OK” with a muted and doubtful voice, a withdrawn body posture, and no eye contact.

Sometimes, challengers notice the mixed messages and ask for clarification or withdraw their request. More often, they overlook the incongruence and act as if they have received consent. Several factors tend to produce this outcome. First, challengers are usually motivated to obtain agreement. Second, survivors’ resistance signals are weak and easy to miss, because they are expressions of an inadequate protector. Third, incongruent messages tend to irritate receivers, which can lead them to become more aggressive (Mindell, 1987). Finally, challengers may be influenced by projective identification, a mechanism proposed by psychoanalytical theorists. According to the projective identification hypothesis, individuals disidentify with internal states that they find uncomfortable but communicate them nonverbally to people in their immediate environment, who resonate with the disowned states and are induced to experience them (Goldstein, 1991; for a related concept, see Mindell, 1985). Survivors, because of their trauma histories, are likely to disown the internal abuser role; thus, challengers who trigger this role in the survivor may be induced to enact it. The result of any or all of these factors is that survivors will feel violated, their unsafe role constellations will be confirmed, and the cycle of abuse will continue.

### **Intervention Strategies**

In summary, the interpersonal protection model proposes that most disturbances associated with child abuse histories are manifestations of an unsafe internal role constellation. These disturbances are either (a) manifestations of a single role; (b) manifestations of interactions among roles (e.g., depression, shame, and guilt); or (c)

dissociative symptoms triggered when the roles are activated. It should be emphasized that early experiences do not determine adult functioning in a linear fashion. Because of individual and environmental differences, abused children may follow a variety of developmental pathways, some leading toward competence and others toward dysfunction (Cicchetti, 1996; McGloin & Widom, 2001). The present model suggests that early abuse experiences increase the likelihood that children will follow a pathway in which inadequate models of protection constellate further abuse experiences, which in turn reinforce the models.

At the same time, later experiences of protection by supportive individuals may alter internal models. If so, new pathways can open in which adequate inner protectors and successful interpersonal experiences mutually support each other. According to Bowlby, people form attachment-based internal models during a critical period in early childhood but can modify those models or form competing models based on later experiences (Bowlby, 1973). Research findings generally support this argument (Berlin & Cassidy, 1999; Hesse, 1999).

In the remainder of this article, I describe psychotherapy interventions designed to modify or reduce the impact of unsafe roles by (a) providing clients in threatening situations with new models of protection and (b) improving clients’ access to effective images of protection they may already have internalized. These interventions are experiential in the sense described by Greenberg, Rice, and Elliott (1993), who argued that client difficulties are rooted in information processing problems and that effective interventions target moments in the therapy process (“markers”) when these problems are active. In terms of Greenberg et al.’s (1993) framework, dissociation is a marker for the information-processing problem represented by unsafe roles. Most of the methods recommended in this article use client dissociation as a signal to address interpersonal challenges while they are occurring and target unsafe roles when they are activated. Otherwise, the interventions engage information-processing systems as fully as possible by recreating past events through imagery and dramatic enactment, methods that have been used successfully with trauma victims (Foa, Keane, & Friedman, 2000). Because internal models appear to be stored in many sensory systems (Solomon & George,



1999), the interventions involve a wide range of information modalities, including language, paralinguistic signals, visual imagery, body sensations, and movement.

I discuss interventions and provide case examples (composites drawn from clinical practice) in four categories: (a) the client–therapist relationship; (b) other client relationships; (c) internal criticism; and (d) trauma memories. Interventions in the first 3 categories are especially useful in the early and middle stages of treatment, when clients test the therapy alliance for safety and develop coping skills. Interventions with trauma memories are generally appropriate later in treatment, when clients are better able to tolerate intense emotions (Herman, 1997; van der Kolk, McFarlane, & van der Hart, 1996). Space limitations prevent a full explanation of these interventions. The descriptions below are meant to stimulate thought and suggest directions for exploration, but therapists should use them in the context of knowledge about trauma treatment and its risks (see Foa et al., 2000; Herman, 1997; Pearlman & Saakvitne, 1995; and Pope & Brown, 1996), clinical experience with abuse victims, and professional sensitivity. Above all, clinicians should implement these interventions only when clients congruently agree, a point explored in the following section.

### *Working With the Client–Therapist Relationship*

*Case example.* Clara, a 27-year-old woman, sought treatment for recurrent bouts of depression. In one early session, she mentioned that her father had been “hard” on her when she was a child, and her therapist asked for an example.

“He was very strict. He didn’t believe in wasting anything. One time he blew up because I didn’t want to eat my vegetables. He said I’d finish every last one of them if I knew what was good for me.”

Clara had been looking more and more upset as she told the story. Now she was silent. Her therapist asked what was going on.

“I just remembered something. . . . I ate the vegetables, and they were horrible . . . and I threw up.” Clara was trembling. “He made me swallow them . . . again. I mean . . . eat my vomit.”

Clara looked overwhelmed and said she could not talk about it anymore. Her therapist commented that the memory was probably too painful

to talk about right now and agreed to change the subject. When the hour was over, Clara said she did not want to reschedule right away. The therapist replied, “I think you need to come back next week. We touched on something very painful, but very important. I know it’s difficult to talk about. But you’re going to have to face painful things if you want to feel better.”

Clara’s eyes glazed over, and she was still for a few seconds. Then she said, “Uh . . . OK, if you think so.” The therapist noticed her hesitation, her confused expression, and her flat voice tone. It suddenly occurred to him that he was acting like her abusive father, who insisted she eat all her vegetables “if she knew what was good for her.”

“Clara, you don’t sound convinced. I wonder if you’re just going along because you feel you should do what I say. Check it out again. I trust you to make the right decision.”

Clara took a deep breath and gave the therapist a grateful look. “You’re right, I don’t want to decide anything right now. I need to think about things.”

“Good for you for standing up for yourself. That’s not easy, with someone who’s supposed to be the expert. Listen, I’m sorry I told you what’s best for you. You’re the final judge of that. You don’t have to swallow anything if it’s not right for you.”

Clara looked happy as she left the room. The therapist was prepared to honor Clara’s decision if she discontinued therapy, although he weighed the option of phoning her to touch base if she did not contact him at all. Clara phoned 2 weeks later, however, and scheduled another appointment. In the following sessions, they discussed her relationship with her father, and Clara revealed a number of abusive incidents she had not thought about for many years.

*Therapy abuse.* Power in the therapy relationship is inherently unbalanced, because therapists’ perceptions and interventions carry the weight of authority. Clients who have been injured by their caregivers need reassurance that therapists will not use their authority to hurt them. The first stage of treatment often revolves around this issue, as clients test the therapy alliance for safety (Herman, 1997).

Pearlman and Saakvitne (1995) observed that “a therapist who sees her role as authoritarian may try to impose her perceptions, beliefs, and need for control on a client who may be strug-

gling to free herself from such control in the past” (pp. 270–271), and cited this type of imposition as a form of therapist abuse. Guggenbühl-Craig (1971) suggested, however, that this behavior is not limited to therapists who have an authoritarian frame of mind but is widespread and inherent in the psychology of the helper role.

I believe it is relatively common for therapists of survivors—without any intention of causing injury and on the basis of a sincere desire to be helpful—to impose their beliefs by persisting in interventions that their clients do not accept. Many abuse survivors, however, are exquisitely sensitive to boundary challenges and are impaired in their ability to protect themselves; therefore they are deeply vulnerable to reexperiencing abuse and trauma in social interactions in which they feel overpowered. They are likely to respond to therapist “overcertainty” as they do to other perceived challenges to their psychological integrity: They verbally acquiesce, weakly communicate their disagreement through nonverbal signals, and dissociate. Despite (or because of) their best intentions, therapists find themselves acting in a way that is likely to match the client’s internal abuser role. Even skillful and experienced practitioners are vulnerable, for several reasons: They want to help clients and are invested in the success of their interventions; they may not notice clients’ weak resistance signals; they may become anxious when clients dissociate and compensate by acting more definitively; they may be irritated by what seems to be client resistance, in the psychoanalytic sense; and they may enact the abuser role through projective identification.

A vicious cycle can set in. Clients superficially comply with therapists but feel mistrustful and disengage emotionally. Therapists sense this, become anxious, and compensate by taking a more authoritarian stance. In response, clients’ mixed signals and dissociation escalate (e.g., forgetting appointments) and the therapy alliance deteriorates further. Eventually, clients terminate; or worse, they remain in therapy and continue to be retraumatized. This cycle can occur when therapists urge their clients to review traumatic memories before they are ready, leave abusive relationships before they feel strong, or in some other way confront greater emotional intensity than clients can tolerate.

*Mixed feedback and dissociation.* In the case example, Clara’s therapist pressed her prema-

turely to commit to therapy. He did not recognize at first that her reluctance to reschedule was a valid effort to protect herself by regulating emotional intensity. Fortunately, he noticed her mixed feedback and drew a parallel between the current therapy interaction and Clara’s abuse memory. At that point, he reversed himself and affirmed her right to make her own decisions, paradoxically protecting Clara against himself. After she said congruently that she needed time to consider, he reinforced her for protecting herself. He used her feedback (verbal comments, breathing, eye contact, and facial expression) to confirm that he was proceeding in a useful direction.

To my knowledge, there has been no experimental study of clients’ nonverbal feedback to therapy interventions and almost no theoretical discussion of the subject (Mindell, 1985, is an exception; see below). It seems likely that experienced therapists register clients’ feedback even if they do not consciously think about the signals they are receiving and that they interpret client feedback correctly in many cases. Abuse survivors, however, pose a special challenge because their resistance signals are subtle and the consequences of overlooking them are serious. I recommend that therapists bring as much awareness as possible to the process of interpreting survivors’ feedback.

Mindell (1985; personal communication, May, 1986; see also Goodbread, 1997) analyzed client verbal and nonverbal feedback to psychotherapy interventions and encouraged therapists to honor clients’ feedback even when it runs counter to their own hypotheses and beliefs. The following discussion draws on his work as well as my clinical experience.

*Simple positive feedback* (clear agreement) and *simple negative feedback* (clear refusal) are characterized by strong communication signals and congruence (consistency) among verbal and nonverbal signals. (Congruence, of course, is an informed judgment because nonverbal communications are usually ambiguous). If a client smiles; says, “That is a good idea”; and immediately implements a therapist’s suggestion, his or her feedback is simple and positive. On the other hand, if the client shakes his or her head; says, “I do not think so” in a firm voice; and changes the subject, the client’s feedback is simple and negative. Because of their clarity, simple positive and negative feedback are easy to recognize.

Mixed feedback involves incongruent signals and is more difficult to interpret. In the case example, Clara gave mixed feedback when she agreed to reschedule but added a verbal qualifier (“if you think so”), spoke in a flat voice, and disengaged from the relationship by breaking eye contact. Mixed feedback carries two possible meanings: (a) The client doubts or disagrees with the intervention but lacks the internal resources to say so clearly; or (b) the client agrees with the intervention but finds it stressful. In the first case, the feedback is *mixed negative* and indicates superficial compliance without true “buy-in.” In the second case, the feedback is *mixed positive* and indicates “buy-in” despite anxiety—for example, when clients agree to take a significant risk.

Therapists can attempt to distinguish mixed negative and mixed positive feedback by clients’ level of energy and engagement. Muted signals, decreased energy, and reduced interpersonal contact (e.g., flat affect, low voice volume, movement slowing or stilling, averted eyes) are likely to indicate mixed negative feedback. On the other hand, increased physical energy, heightened emotional expressiveness, and strong interpersonal contact are likely to signal mixed positive feedback. For example, one therapist suggested that a shy client ask an attractive woman for a date; the client looked startled, stared at the therapist for a moment, then burst out laughing, fidgeted in his chair, and exclaimed, “You have got to be kidding!” His message was, “It’s scary, but I’m ready to go for it.”

I have found the guidelines described above to be useful, but it is important to remember that mixed feedback is necessarily ambiguous and interpretations are educated guesses at best. If in doubt, therapists should ask clients to clarify their feedback until the message is consistent. A useful question is, “You seem hesitant—perhaps that suggestion isn’t right for you?” Clients who have just given mixed negative feedback will usually agree and appear relieved. Clients who have given mixed positive feedback will say so clearly (“No, I want to do it, I’m just afraid”).

According to the interpersonal protection model, mixed negative feedback is closely associated with dissociation. Dissociation may be fleeting and subtle, indicated by signals such as immobility, silence, glazed eyes, and relaxed jaw. Identifying dissociation—and inferring that it is a response to an immediate interpersonal challenge—is a matter of clinical judgment, and

it is wise to confirm that judgment by asking clients directly. A helpful question is, “You seem a little bit in shock—is that right?” In my experience, clients who are dissociating easily relate to terms like “shock,” “trance,” or “fog” and express relief when their state is named.

After clarifying negative feedback, therapists must reverse direction and support clients for opposing them. I find it useful to reinforce clients (a) for making their negative feedback clear (“Congratulations for saying ‘no’ to me”) and (b) for having given negative, albeit mixed, feedback in the first place (“I’m glad you hesitated when I made that suggestion; that is a first step in standing up for yourself”). This intervention is a form of therapeutic judo and requires considerable flexibility and awareness, but it is likely to be highly impactful. Even highly skilled therapists can unintentionally act in ways that reinforce clients’ internal abuse schemas. By noticing the early warning signs (mixed negative feedback and dissociation), therapists have the opportunity to change course and provide clients with new and effective models of protection.

### *Working With Other Client Relationships*

*Case example.* Linda and Michael, a couple in their mid 30s, sought marital counseling. Linda was angry at what she called Michael’s “passive-aggressive behavior”—he frequently failed to follow through on agreements, and when she confronted him, he rationalized his behavior or said he “forgot.” When the therapist addressed him, Michael acknowledged that he was “probably difficult to live with” and added that he was “confused about the whole thing.”

The therapist asked Linda and Michael to show her how they make decisions. Linda offered an issue for discussion: Her brother and sister-in-law were coming soon for a long visit, and she wanted Michael’s help. “What do you think about refinishing the floor in the guest room before Jack and Sarah get here? It looks pretty awful, and you said you’re planning to do it.”

Michael sighed. “Look, I’d love to get it done, but you know it’s a terrible time right now.” He explained to the therapist that he had a major deadline approaching at work.

Linda was angry and her voice began to rise. “There’s always a good reason, isn’t there, Michael? That’s why you never do anything! You’ve been saying for months that you’re going

to do that floor, and you knew Jack and Sarah are coming!”

“I didn’t think I had to do it before they come. Can’t we put a rug down or something?”

Linda was furious now.

“I’m so fed up with you! I didn’t want to nag you, but I hoped you’d care enough about my family to think about it yourself. Maybe you’d be happier living alone, Michael! You wouldn’t have to consider anyone else. I’m sure we could arrange it!”

Michael looked stunned, his jaw dropped, and he stared at Linda for a moment. Then he looked down and muttered tonelessly, “OK, I guess you are right, I’ll try to do it.”

Linda looked at the therapist with a pleading expression. “That’s what he always says! But he won’t do it. He never does. I feel completely helpless!”

The therapist asked Michael what he was feeling. Michael seemed confused. “I don’t know. She’s right. Her family’s coming and she needs my help.”

“But you look a little dazed, almost like you’re in a trance, or in shock.”

Michael gave a wry smile. “Yeah, that’s exactly how I feel—like a deer in the headlights. She’s scary when she’s mad.”

“I don’t think you should agree to anything just now. You can’t know what you really want when you’re in shock. Does that happen a lot when Linda asks for things?”

“She’s so definite; she always knows what she wants. I almost never do.” He took a deep breath and seemed to relax. “Yeah, I think I *do* go into shock when she comes on strong.”

“Don’t decide anything when you are in a trance. Take as much time as you need, so you can find out what you really want. When you know, tell her. If you can’t figure it out, I’ll help.”

Michael seemed relieved, and asked Linda if they could discuss the issue later.

“That’s OK, but I’m afraid ‘later’ will never come. I don’t want to run after you.”

“You won’t have to run after me. Let’s talk about it next session.”

Linda agreed. Michael began the next session by speaking to the therapist.

“You were right that I needed time to think. Once I got away, I realized I’m really angry. She asked me if Jack and Sarah could visit, but she never said she expected me to do the floors by

then. Sure, I could have thought of it myself, but I have a lot on my plate. I’m not a mind reader.”

Michael added that he’d always had a hard time saying no.

“I think it has something to do with my mother. She was a single mom and she was always under a lot of stress. I was the oldest kid so she laid a lot on me. Sometimes she just blew up. One time she ran after me with the kitchen knife. After that I decided I’d better just do what she wanted.”

During the rest of the session, Linda and Michael reached a compromise about the guest room. She agreed to relieve him of his household chores and much of the child care over the next few weeks so he could focus on his deadline at work. In return, he agreed to refinish the floor before Jack and Sarah arrived. Both Linda and Michael kept their agreements. In following sessions, the therapist taught the couple how to recognize trances and negative feedback. She encouraged them to take time out from discussions when either of them noticed that Michael was in a trance and to arrange a specific time for continuing the conversation later. Michael explored ways to use the time out to become aware of his wishes. The therapist encouraged Linda to support Michael when he gave mixed feedback by helping him express all his reservations.

*Trances and time out.* This intervention begins by educating clients about dissociation, which is a relationship as well as a psychotherapy marker. The key message is that trances are “red flags” signaling that people do not feel strong enough to defend themselves at that moment. It can be helpful to frame dissociation positively. On one hand, trances leave individuals confused and, therefore, vulnerable to exploitation. On the other hand, trances are the beginning of a healthy process—withdrawing from an overwhelming situation in order to regroup. Clients learn to complete the process by consciously leaving the interaction so they can consider their feelings and wishes. Therapists and clients can explore strategies for using time out effectively. Options include relaxation techniques; silent reflection (e.g., walking in nature, journal writing, or meditating); accessing internal resources (e.g., talking to an “inner guide”); and seeking support (e.g., asking a friend’s advice, exploring the issue in therapy). Clients should continue reflecting until they feel renewed energy and clarity. At that point, they are ready to reengage.

When working with couples, it is helpful to



teach both members these skills. Partners can practice “relationship judo” by encouraging survivors who are dissociating to take time out and by helping survivors who give mixed feedback to express their opposition. Both parties should continue to express their feelings and negotiate until they congruently agree.

I noted earlier that survivors who feel overwhelmed by boundary challenges are usually under attack by a harsh inner critic. As they take time out to reflect, they may become more aware of the critic’s messages. Clients may find it helpful to write their internal dialogue as if it were the script of a play, with the critic presenting its accusations and an alternate voice responding. In some cases, writing the dialogue allows it to develop until the conflict spontaneously resolves. If not, clients can work on the dialogue in a therapy session. The following section describes a method for working with these dialogues, as well as with client self-criticisms that arise spontaneously in the therapy process.

### *Working With Internal Criticism*

*Case example.* Jim, 44 years old, was a successful businessman but suffered from chronic feelings of inadequacy in his work. During one therapy session, he said that he was “disgusted” with himself for pretending he was competent.

His therapist asked, “Do you feel that way completely?”

“No, part of me that feels I deserve to be successful—but it’s a pretty small part.”

The therapist suggested they role-play the internal conflict and Jim readily agreed. They identified two chairs to represent each side of the conflict, and the therapist suggested Jim play the critic because he identified most strongly with that part. However, Jim said he felt uncomfortable playing the critic (“it’s just too nasty”) and the therapist offered to take the role instead.

The therapist sat in the critic’s chair and imagined what to say. He was surprised how easily the role came to him and dismayed because harsh thoughts about Jim were spontaneously entering his mind. He reminded himself that he was probably sensing Jim’s internal state and decided to play the role strongly without censoring his thoughts.

“You disgust me! You know you’re a fake but you don’t have the guts to admit it. It’s only a

matter of time before everybody else finds out. You’re a failure, and you always were!”

Jim’s jaw dropped and he stared back from the other chair, motionless for a moment. “That’s just what he says to me. I ought to be mad as hell! But I can’t say anything back—it’s like he knocks the wind right out of me.”

The therapist noted Jim’s stillness, his dazed expression, and his metaphor. “You looked in shock there for a minute.”

Jim nodded. “That’s a good word for it.” The therapist asked Jim if he needed an advocate, and Jim nodded again—“Please!”

The therapist stood between Jim and the now-empty critic’s chair. He faced the chair and spoke as if the critic were still sitting there.

“Wait a moment! I won’t let you talk to Jim like that! You have no business telling him he’s disgusting, that he’s born to fail. I don’t know what you’re trying to do, but you’re crushing his spirit!”

Then the therapist turned around and saw that Jim’s eyes were full of tears. “What’s going on?”

“I . . . I never had anyone stand up for me before. When my dad lit into me, my mother just . . . tried to distract him. I think she was scared. She told me, don’t talk back to him, he’ll get more worked up.”

“So the critic sounds like your father?”

“Oh yeah, he was disgusted with me whenever I messed up. And also when I didn’t. He always found something wrong. I think I’ve been trying to prove myself to him for a long time.”

Over the next few weeks Jim reported that the inner critical voice was softer. Several sessions later, Jim role-played another internal conflict, and this time he defended himself against the critic strongly and congruently. In the following weeks, Jim became less anxious at work. Several months later, he decided to pursue a new career direction. “I’ve been wanting to do it for a long time, but I was always afraid I couldn’t pull it off. Now it seems crazy not to try.”

*Subselves and inner critics.* This therapist’s intervention was based on the metaphor—or reality—that personality consists of quasi-human *parts* or *subselves* that have distinct motivations and points of view and the capacity to interact among themselves. This idea has a long history, with proponents in clinical, cognitive, developmental, personality, social, and neurobiological psychology (Harter, Bresnick, Bouchey, & Whitesell, 1997; Rowan, 1990). Psychotherapists

from a wide range of theoretical traditions have embraced the concept (Assagioli, 1965; Horowitz, Eells, Singer, & Salovey, 1995; Mahrer, 1996; Mindell, 1985; Moreno, 1964; Polster, 1995; Schwartz, 1995; Stone & Winkelman, 1989; Watkins, 1993).

Experiential therapists often address client self-esteem problems by directing a role-play between a client's inner critic and another, vulnerable personality part (Fagan & Shepherd, 1970; Greenberg et al., 1993). In my experience, clients find the concept of an inner critic extremely helpful, because it allows them to gain perspective on their self-criticism, identifying it as one viewpoint among many rather than an overarching truth.

Integrating concepts from attachment theory, complexity theory, and neuropsychology, Siegel (1999) argued that attachment-based internal representations are *subselves*. He suggested that subselves correspond to attractor states in the brain—that is, patterns of neural activity with a high probability of recurring over time—that have “relatively specialized and somewhat independent modes of processing information and achieving goals” (p. 231). I propose that (a) attachment-based aggressor, child, and protector roles are subselves; (b) the inner critic is a subself closely related to the aggressor; (c) the critic addresses its messages to the child; and (d) in safe constellations, the protector shields the child from abusive inner criticism, but in unsafe constellations, the protector fails to do so. This argument is consistent with research findings that survivors frequently experience low self-esteem and depression (Bifulco et al., 2002; Briere, 1992), which are associated with harsh internal criticism (Beck, 1967).

Inner criticism is not necessarily abusive. Critics perform valuable functions: They make discriminations, form value judgments, and provide “constructive criticism.” Constructive criticism is delivered compassionately, addresses specific behaviors, communicates hope for improvement, and offers practical suggestions for change. Not surprisingly, recipients prefer this type of feedback to criticism that is nonspecific, personalized, and pessimistic (Ilgen, Mitchell, & Fredrickson, 1981; Liden & Mitchell, 1985). I suggest that individuals with safe internal role constellations have generally constructive inner critics, whereas individuals with unsafe constellations have abusive critics whose attacks are vague, overgener-

alized, personal, and demeaning and that imply that the recipient has no capacity to improve. Abusive critics often add insult to injury: They erode clients' self-esteem and then shame them because they lack confidence, or they undermine their performance and then humiliate them for failing. (It is useful to draw clients' attention to these double binds.)

*Inner critic enactments.* Moreno (1964) and Perls (1969) pioneered dramatic enactment methods for resolving inner critic conflicts by encouraging internal roles to emerge and interact. Clarke and Greenberg (1986) found that inner critic enactments are effective in helping clients reduce anxiety, resolve inner conflicts, and achieve other therapy goals. Clinicians have recommended the use of these methods with trauma victims (e.g., Elliott, Davis, & Slatick, 1998).

In two-chair enactments, therapists specify separate spatial locations for the critic and the child and keep both roles distinct by confining them to their assigned locations (e.g., if a client in the child role begins to criticize herself, the therapist points out that she has changed roles and asks her to move to the critic's location). In the traditional method, clients play both roles themselves and the therapist functions strictly as a facilitator (Fagan, 1976; Greenberg et al., 1993). I have found, however, that clients are more comfortable entering the role-play when the therapist participates as well. In this model, client and therapist play both parts, exchanging roles and locations as the process unfolds. Therapists are free to improvise in either role, using what they know about clients together with informed guesses and their own emotional reactions. Spontaneous enactment of another person's internal role is often surprisingly accurate (Moreno, 1964); however, therapists need to stay alert to clients' feedback and instruct clients to correct their portrayals whenever necessary.

If clients have a strong internal protector, they will effectively defend themselves against the critic's abuse. Effective self-defense is congruent and emotionally impactful; clients will feel empowered and relieved, and therapists (in the critic role) will feel softened and convinced. Clients who lack an effective protector, on the other hand, may attempt to defend themselves, but their signals will be incongruent—for example, strong words in a tentative voice. Therapists (in the critic role) will remain unconvinced and may feel the impulse to mount another attack. The dia-

logue continues until clients (in the child role) dissociate—a signal that they need immediate protection. Therapists who assume the protector role at that moment, restraining the critic and advocating for the injured child, can provide an emotionally impactful, corrective experience.

*Enactment protocol.* Greenberg (1984; Greenberg et al., 1993) analyzed role-plays of internal critic conflicts and developed a detailed therapist protocol that provides much useful information I cannot include here. I recommend that therapists attempting this intervention use Greenberg's work to complement the following procedure (the major difference between the two methods is that therapists in the Greenberg protocol remain in the facilitator position and help clients defend themselves against critic attacks; they do not watch for client dissociation or enact the protector role themselves).

1. Help clients identify inner critic messages; suggest role-playing a dialogue with the inner critic; check for clients' congruent agreement.
2. Identify distinct spatial positions for each role; allow clients to decide which role they will take to begin the enactment. If clients start in the critic role, encourage them to present the critic's message fully, then reverse roles so the therapist can repeat the message and the client can respond. Therapists should play the critic role congruently and forcefully, speaking directly to the client without "pulling punches."
3. Exchange roles and locations when (a) clients spontaneously enter the opposite role, as evidenced by their assuming the mental state and behavior of that role or (b) therapists no longer have enough information to continue playing their role (e.g., client-child asks therapist-critic a question that the therapist is unable to answer with a reasonable guess, and the client must enter the child role to continue the interaction).
4. Carefully observe the client-child's responses to the critic.
  - a. If the client defends him or herself congruently, the client will feel resolved and the therapist-critic will feel persuaded. Reinforce client for protecting him or herself.

- b. If the client defends him or herself incongruently, the client will feel dissatisfied and the therapist-critic will feel unconvinced. Continue the role-play with therapist-critic mounting another attack.
- c. If the client-child verbally agrees with the critic, the child role has effectively gone underground. Encourage the child to reemerge and express itself (e.g., "Is there even a small part of you that disagrees?") and continue the role-play.
- d. If the client-child dissociates (e.g., looks stunned or is unable to respond), take the protector role. Stand beside the client (as an advocate) or between the client and critic (as a shield). Set limits for the critic, speaking firmly but respectfully. Be spontaneous and follow your genuine feelings of concern for the client (a sincere, passionate delivery is likely to have the most impact).

*Alliances with inner critics.* After setting limits, it is important to engage critics in a dialogue and elicit their concerns. In my experience, critics have agendas that are not immediately obvious and often include a desire to help the child (e.g., by keeping him or her from making mistakes.) This phenomenon makes sense if critics are internal representations of confused and immature caregivers, as I have argued. In fact, some researchers have suggested that abusive caregivers, nonhuman as well as human, are often misguided protectors (Crittenden, 1998; Fergusson, Lynskey, & Horwood, 1996; Maestripieri & Carroll, 2000).

After eliciting the critic's concerns, therapists should help the child negotiate with the critic on a basis of balanced power and mutual respect. Once contained, critics often make valuable contributions. In general, critics must learn to treat the client-child kindly, and the client-child must learn to honor the critic's legitimate concerns. Abuse survivors have been so traumatized by authority figures that they often reject their critics wholesale. They deny themselves access to the critic's strengths—structure, self-discipline, evaluation, and discrimination—and do not realize that these qualities can empower them to be more creative.

For example, a harsh inner critic degraded all the songwriting efforts of one client. In dialogue,

the critic eventually admitted he was afraid that the child would fail and be humiliated; and, furthermore, he was angry that the child ignored his creative advice. After negotiation, the critic agreed to be more supportive and the child agreed to listen to the critic's suggestions for improving his songs. Several weeks later, the client described the new arrangement as "brilliant." He had written two songs but was dissatisfied with both of them. "Before, I would have just thrown them away. This time I took another look and realized they both had good things in them. So I put those parts together and made a new song. It's great!"

### *Working With Trauma Memories*

*Case example.* Donna, a 52-year-old woman, was sexually molested by her uncle when she was 10. She had been in psychotherapy for 2 years and discussed her sexual abuse in some detail. However, she felt that it continued to interfere with her ability to feel safe in her intimate relationship. The therapist suggested that they "recreate" the abuse memory by introducing a protector. Donna was enthusiastic and agreed. The therapist invited Donna to make herself comfortable and notice what she was feeling in her body. After several minutes, Donna reported that she was more relaxed. "Now imagine someone who could have protected you."

"That's just it—there wasn't anybody. My parents didn't want to hear anything bad about my uncle. I told them I didn't want him to babysit, but they wouldn't listen."

"It doesn't have to be anybody you knew then, or even a real person. Maybe a character in a story, or a god or goddess."

Donna hesitated. "This is pretty silly . . . but I keep thinking about Wonder Woman."

"That's perfect! Go ahead and picture Wonder Woman; see exactly what she looks like." After a pause the therapist gave suggestions, leaving time after each one for Donna to amplify the image. "See what she's wearing . . . the way she moves . . . the expression on her face. . . . Is she saying anything? . . . How does her voice sound?"

"She's quick, like a dancer, but very strong. Her face . . . is fierce and kind at the same time. She's got a beautiful voice. She's telling me she'll be there if I need her."

"Good! Now go back to that night. This time it's going to be different because Wonder

Woman will help you. Imagine you're watching the whole scene on a movie screen. Start at the beginning, and notice everything that happens. . . . Tell me what you see.

Donna described the scene as it unfolded in her imagination. At the point when her uncle approached her sexually, the therapist instructed, "Now Wonder Woman is coming to protect you. She said she would be there if you needed her. See what happens, notice everything about it."

Donna spoke in a 10 year-old voice, with a touch of awe.

"There's a big crash, the window's breaking, and Wonder Woman is coming in! She's very strong. I've never seen anybody so mad! She's telling Uncle George to keep his hands off me, if he ever tries it again he's going to deal with her." Donna laughed. "He looks like a scared rabbit! He didn't know a woman could be so strong. He's mumbling something, like he's sorry, he won't do it again."

"That's wonderful! Keep watching. See what happens next."

"Uncle George is back in the living room, and Wonder Woman is sitting on my bed. She's going to stay with me until mom and dad get home. She's telling me stories about other people she saved, and what it was like for her when she was a girl. . . . Now my parents are coming home. Wonder Woman is telling them what happened, telling them they were very wrong not to believe me when I told them I didn't feel safe. . . . Mom is shocked, she ran into the bedroom, now she's hugging me. She says she's very, very sorry."

"How do you feel?"

"I feel . . . really cared for. I feel like it's OK to relax."

In the following weeks, Donna reported a new sense of confidence and strength. She stood up for herself easily and effectively during an incident at work when she felt exploited. She also reported that she felt safer being vulnerable with her partner, and their relationship was improving.

*Reconstruction of trauma memories.* Most clinicians agree that reviewing and transforming trauma memories is a critical step in the treatment of abuse survivors (Herman, 1997; van der Kolk, 2002). In their review of the literature, van der Kolk, McFarlane, and van der Hart (1996) concluded that

controlled exposure as a means of reactivating and modifying traumatic memories is a key aspect of the treatment. . . . The critical issue is to expose the patient to an experience that



contains elements that are sufficiently similar to the trauma to activate it, and at the same time contains aspects that are incompatible enough to change it. (p. 430)

The authors suggested that the most important “incompatible” element is the experience of safety provided by a relationship with a trusted therapist.

The therapist in the case example introduced an additional “incompatible” experience by asking Donna to visualize a protector who prevented the abuse. This intervention closely resembles two methods described in the clinical literature: *imagery rescripting and reprocessing* (Smucker & Dancu, 1999) and *imagery restructuring* (Greenberg, 2002, pp. 216–217). A technique with similar features, *imagery rehearsal therapy* (IRT), has been tested experimentally and appears to be effective in reducing sexual assault survivors’ symptoms (Krakow et al., 2001). However, IRT differs somewhat from the method I recommend here (clients suffering from chronic nightmares are instructed to “change your nightmares anyway you wish” and then visualize the reconstructed dreams for several minutes each day).

In my experience, some clients who visualize a protector, as in the case example, appear to internalize the image and report enduring benefits, whereas others experience only short-term relief; occasionally, clients report that they are unable to imagine a protector at all. It is unclear what factors account for the difference, although timing appears to be important. The method seems more effective, and clients are more likely to give positive feedback to undertaking the intervention, later in the therapy process. One hypothesis, consistent with attachment theory and the model outlined in this article, is that individuals are more likely to internalize a protector image after they have had relationship experiences (e.g., with a therapist) in which they felt protected. As always, it is critical to respect clients’ feedback when deciding whether to use this intervention. If clients refuse, reinforce them for protecting themselves and consider offering the intervention at a later time.

If clients are willing to proceed, help them prepare by relaxing and heightening body awareness. Invite them to identify a real or imaginary figure who would be able and willing to protect them; ask them to visualize that figure and help them amplify the image by asking about sensory details, as in the case example. Then, ask clients

to review the target incident, watching from a distance (for greater safety) and describing the scene in the present tense. Start at the beginning of the incident and continue up to the moment of the trauma. At that point, instruct clients to see their protector enter the scene and stop the abuse in whatever way they imagine. Encourage them to see the outcome in detail. Continue with the visualization until the scene reaches a natural conclusion.

As clients are ready, they may take further steps. For example, they can visualize the reconstructed scene again from the vantage point of the child rather than an observer. Finally, they can imagine themselves as the protector and review the scene from the protector’s point of view. Clients can also enact the incident in a group with other participants playing various roles (Kellermann & Hudgins, 2000). Initially, for maximum safety, clients should direct the scene, determining each detail of the enactment and watching it from the outside. In subsequent enactments, they can enter the drama and play the child and finally the protector. Dramatic enactments may have more therapeutic impact than visualizations because they engage a wider range of sensory modalities—vision, hearing, and movement—as well as the active support of peers. They are emotionally intense, however, and pose the risk that clients and other group members may become overwhelmed (Hudgins, 2000). For this reason, they should be used carefully, with prior training and ongoing professional support.

## Research Directions

The usefulness of these therapy strategies must be determined empirically. A significant limitation of the present work is that no existing research directly addresses the interpersonal protection model or the interventions presented here.

The first 3 therapy strategies use dissociation as an intervention marker. The theory predicts that when therapists offer protection to clients who are dissociating in the moment, (a) clients’ unsafe internal roles will be replaced by safe internal roles, and (b) these changes will lead to improved psychosocial functioning. Controlled studies in which raters review videotaped psychotherapy sessions and code client dissociation and therapist interventions could test these predictions. Client representations can be measured by projective methods (see Page, 2001) as well as

self-report, and client functioning can be assessed with a variety of outcome measures. Given that correlations alone cannot demonstrate causality, researchers would have to determine whether changes in representations precede changes in behavior.

A key assumption is that dissociation can be reliably identified and distinguished from other client behaviors. I know of no systematic research investigating this question. Recent studies of *disorganized attachment*, however, suggest that it is feasible. Between 80% and 90% of abused infants in research studies show a class of attachment behaviors that resemble dissociation and that predict (and may be precursors of) clinical dissociation (Carlson, 1998; Cicchetti, Toth, & Lynch, 1995; Liotti, 1999; Main & Morgan, 1996). These behaviors are varied and often subtle, but investigators have coded them reliably (Main & Solomon, 1990). Investigators of client dissociation would have an additional advantage because adults, unlike infants, can report their experience. I propose three necessary and sufficient conditions for identifying dissociation in psychotherapy and research: (a) Clients display a cluster of behaviors that, taken together, suggest a sudden and involuntary state change involving reduced activity and reduced environmental awareness; (b) this cluster occurs in immediate response to events that challenge clients' ability to assert themselves or set limits; and (c) clients give congruent agreement when asked if they are in "shock," "trance," or "fog."

The fourth therapy strategy—introducing an imaginary protector to modify trauma memories—can be tested in outcome studies using either visualization or dramatic enactment. Enactment is more challenging than visualization to implement and study but may generate stronger treatment effects because it engages a wider range of sensory experiences as well as peer support. Investigators can measure changes in internal representations and therapy outcomes using appropriate control groups. Again, it is important to determine whether changes in representations precede behavioral outcomes.

All strategies presented here are based on the hypothesis that unsafe internal roles mediate the long-term effects of abuse. Even if this is true, there are undoubtedly other mediating factors. Psychologists increasingly view human development as the product of complex and bidirectional influences among many physiological, psycho-

logical, and environmental variables (Cicchetti, 1990). Because there are no simple causes, Crittenden (1998) has suggested that we identify *critical causes*, those "aspects of functioning that, if changed, would lead to a concatenating set of changes throughout the set of factors supporting [a specific] behavior" (p. 14). In other words, we must determine which variables provide the greatest leverage for intervention. Outcome studies, if they are to be useful, should compare the interventions presented here with methods that target other variables known to be influential, including emotional regulation (Schorer, 2002; van der Kolk & Fisler, 1994), self-concept (Cole & Putnam, 1992), and sense of self-efficacy (Diehl & Prout, 2002; Janoff-Bulman, 1992). Because it is likely that internal representations interact with each of these other constructs, the key question is whether directly targeting internal roles is more effective than targeting other variables.

## Conclusion

Caregiver protection plays a central role in current conceptions of human evolution and development, yet protection as a psychological variable has received little systematic attention. This article argues that the concept of interpersonal protection deserves an important place in clinical theory, research, and practice. Preventing relationship trauma, and resolving its aftereffects, is an outstanding challenge of our time. Interventions that target internal images of protection may provide a valuable focus for psychotherapy with abuse survivors.

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