Journal of Heart-Centered Therapies, 2000, Vol. 3, No. 1, pp. 1-64

Hypnotic Psychotherapy in the Identification of Core Emotional Issues

by Constance Spencer, Ph.D.

ABSTRACT

Hypnotic Psychotherapy offers a client-centered model that integrates elements of intrapsychic, cognitive/behavioral, body oriented, and interactional approaches. Treatment effects can be rapid, and during an individual session the therapist may witness accelerated processing of information indicative of a shift of cognitive structures (assimilation of core issue and positive beliefs) and insight into behavioral patterns. Hypnotic psychotherapy may be used to ammeliorate the effects of earlier memories that contribute to dysfunctional beliefs. The dysfunctional beliefs often develop into human core issues of shame, abandonment, and guilt. These core issues are explored and a cognitive shift can be initiated in the therapeutic process. This study attempted to address the retention and integration of core issue awareness into daily patterns. Post-hypnotic narrative therapy was used to examine the resolution of initial core issue psyche injuries. This study sought 1) to assess the contribution of hypnotic psychotherapy (if any) to the identification of the core issues, 2) to assess the amelioration of dysfunctional negative cognitions, 3) to assess the integration and retention of positive cognitions utilizing post-hypnotic narrative therapy.

INTRODUCTION

Insight-oriented psychotherapy has historically been a lengthy process of uncovering core issues, or common themes in a person's life. Our culture believes that healing painful childhood memories requires years of psychotherapy (Myss, 1996) . However, if the client believes it to be possible, healing painful memories and resolving the old feelings and thoughts that no longer serve them can happen rapidly (Myss, 1996). Recent years have seen the advent of new forms of psychotherapy that are designed to shorten the process. This paper addresses one particular form of brief therapy; hypnotic psychotherapy which utilizes elements of Transactional Analysis (Adult, Parent, Child parts of one's psyche), Gestalt

*Doctoral Dissertation, The Professional School of Psychology, Sacramento, CA, 1998

therapy (i.e., the technique of talking to the empty chair) and Cognitive Behavioral therapy. This paper explores the impact of the post-hypnotic trance and the integration of the reprocessed memories**.** This will be explored through the use of case studies from a single hypnotic psychotherapy session. Integration and perceptual understanding derived from reprocessing will be assessed through the use of post-hypnotic narrative therapy.

The post-hypnotic behavior as a phenomenon was studied utilizing a follow-up questionnaire. Shifting from perceiving a memory as in the past, to sensing it as now located on the immediate stage of consciousness involves a change in the sense of tense (past, present, and future) or place of contemplation. Once the client is able to identify their core issue they are able to break future patterns of behavior based on responses. If the client chooses they can briefly suspend time (Antrobus, 1994). As reported in Laderman (1991), Ornstein (1977) believes that practices such as rituals that employ rhythms of singing, chanting, etc. evoke and place into preeminence the right hemisphere's functions and inhibit those of the left hemisphere, which accounts for the "timeless" quality of the trance experience (Laderman, 1991). The ten case illustrations will show the client shifting from subconscious to conscious, bringing memories and feelings into a new mature perception in the post-hypnotic trance state.

A constellation of emotional themes (shame, guilt, and abandonment) will be identified as human core issues that often have their beginning in the initial developmental stages of life. The core issues can be tightly entertwined as a result of the infant's initial experiential acquisition. This triad of feelings exists for many people and using catharsis and the post-hypnotic trance has been proposed as rapid way to bring about change, particularly in helping the client refame their current perceptions. Many authors have identified a relationship between guilt and shame (e.g., Piers, 1953; Lynd, 1958; Lewis, 1971; Throne, 1979). However, the constellation relationship of shame, guilt and abandonment, is relatively unexplored (Morrison, 1989). The intent is to show that the common core issues can be elicited and be identified in a single session and reprocessed in the post-hypnotic trance-state.

How do these core issues of shame, guilt and abandonment begin? Much like Erikson's concept of developmental stages, the first crisis being basic trust versus mistrust, I believe that this is where these core issues begin as well. "The central developmental task of infancy and childhood is learning how to modulate behavioral states" (Donovan & McIntyre, 1990).

Behavioral states in infancy are often abrupt, going from calm and serene to inconsolably enraged in a moment's time. Under normal conditions the primary caregiver, usually the mother, helps the infant to modulate these behavioral states (Donovan & McIntyre, 1990). For the most part this is accomplished simply by attending to the infant's momentary needs (Donovan & McIntyre, 1990). The dynamics of attachment are most prominent in the first several years of life (Swerdlow, 1982). Should early experiences involve significant maltreatment the result can include cognitive, affective, and posttraumatic symptoms, as well as dysfunctional self-perceptions and impaired self-reference (Briere, 1992). If an infant's needs are not met in a timely fashion, it is at risk for developing problems in one or all of the core issues as regulation of behavioral states develop. The end result is often internalized into feelings of shame, guilt and abandonment. This is manifested in the child who is disengaged from his feelings, emotions, or discomforts (Donovan &McIntyre, 1990), or a person who caries life-long vulnerabilities to re-experiencing these painful inner emotions.

As the self develops, first one newly-grown part of the ego-identity then another is tested by the environment and surmounts (or fails to surmount) its vulnerability (Haley, 1981). As the infant gathers up the important pieces of its experiences, a synthesis is formed, and the basic question of "will you accept this configuration of what I am?" arises. All or part of the constellation is experienced in this development of self. When the self-structure (Rogers, 1961) includes positive experience, especially appropriate parental responsiveness, the individual attains congruence (thoughts and feelings are harmonious); when the self structure excludes this healthy nurturing experience, incongruence is the result (Haley, 1981). When the term trauma is accepted in its broadest definition as being something hurtful (Donovan & Mcintyre, 1990), this onset of the constellation is easier to understand as the acquisitions of initial experiences are assimilated. "Regardless of form, all trauma is in some way unassimilable" (Donovan & McIntyre, 1990). Often trauma as perceived by the individual and internalized into one or all of the core issues can manifest into various areas such as Post-Traumatic Stress Disorder (PTSD), Dissociation, and Repression.

Developmentally, some authors believe that shame is more primitive, considered to be the earlier affect than guilt. Historically there has been confusion between guilt and shame. Research indicates that there is more personal power in the experience of guilt, which is associated with

behavioral wrongdoing. Guilt reflects a hurtful thought or action and was believed to be the result of activity, a transgression against the superego barrier (Morrison, 1989). Psychoanalysis emphasized the importance of guilt rather than shame as a central dysphoric affect (van der Kolk, 1991).

Shame had for a long time been viewed as superficial, less worthy of attention than guilt (Morrison, 1989). The evolution of shame is believed to occur independent of guilt (Morrison, 1989). I suggest, that the propensity for shame occurs very early in development. There is a regressive shame that can be evoked by the exercise of authority, a regressive idealization of the good parent, to the extent to which there are radical discontinuities in the behaviors of children and adults (Tomkins, 1963). Shame can be thought of as lying on a continuum beginning early in life and taking on several different variations of the same core issue which creates dis-ease.

Shame is an affective response to a perception of the self as flawed, frequently hidden behind defenses, (i.e.; certain depressions, mania, rage, envy, and contempt) (Morrison, 1989). Piers believed shame was a reflection of tension between the ego and ego ideal. Shame represented a failure to attain a goal of the ego ideal (Morrison, 1989). Morrison, like Freud, related shame to narcissism stating that shame is a crucial dysphoric affect in the narcissistic phenomena (Morrison, 1986). “Thrane examined shame, as did Sartre (1943), from the perspective of identity formation and the narcissistic construction of the self,” (Morrison, 1989). Both Thrane and Sartre noted the dual social and internal nature of shame. Shame has been related both to the sense of audience (facing others) and to the presence of internal ideas (Morrison 1989). Shame implies self-recognition and reflects failure not only to achieve parentally approved behavior, but also to attain the mastery or autonomy that represent internalized narcissistic expectations of the self (Morrison, 1989). Although shame implies self-recognition, abandonment may be the lack of self-recognition or a sense of self-negation.

Abandonment has most often been explored in the relationship to adoption issues. Abandonment by the parent is often identified in its literal physical sense. What is suggested in this work is that abandonment issues can begin as early attachment needs are left unmet in the infant’s experience. The infant experiences feelings that result from the experience of nurturance or the lack of nurturance. The negation of self and others can begin at this early phase in life due to perceived physical or emotional rejection. Abandonment, like shame, does not have to be related to the

physical. This can be seen on a continuum as well and can mean anything from emotional absence or disregard for the infant's needs to the death of a parent who will never return.

Many victims of emotional neglect identify potential abandonment issues in everyday actions of significant others (Briere, 1992). Pavlov and others coined the term defensive reaction for a cluster of innate reflexive responses to environmental threat (van der Kolk, 1991). Infants who are emotionally neglected may be hypersensitive to the first signs of rejection or abandonment and these emotions can result in behaviors later in life such as angry, panicked outbursts and, occasionally, suicidal threats or attempts in response to actual or potential abandonment (Briere, 1992). History of parental neglect or emotional unavailability has been shown to be common to people who are prone to chronic fears of abandonment, alienation, and perceived isolation in personal relationships, and who often simultaneously exhibit anxiety in the face of increasing interpersonal closeness (Briere, 1992). Many clients are compelled to seek treatment due to experiencing these above feelings or reacting in the above fashions or are urged to do so by significant others.

While traditional talk therapy may take years to uncover a client's primary underlying issues, hypnotic psychotherapy can, with certain types of clients, target disturbing habits, thoughts, and behaviors in a single session (Teyber, 1996). Resolution may not be total in a single session, but the overcoming of resistance is often quite successful and enlightening for clients.

The experiences of shame, guilt, and abandonment are commonly experienced sources of emotional suffering in many clients seeking psychotherapy. Thus, it is appropriate to consider these core issues as targets for psychological interventions. And, especially in recent times, it has become important for therapists to use approaches that lend themselves to brief treatment.

The hypnotic psychotherapy techniques explored in this study will be shown to access rapidly these core issues. The integration of the reprocessed memories was done utilizing the post-hypnotic interview process. The post-hypnotic interview process is a variation of narrative therapy and follows the hypnotic psychotherapy session within a 24-hour period of time. The client is asked to recall as completely as possible the contents of the hypnotic psychotherapy session, as if it is their story. Clients often reenter the hypnotic trance, in the post-hypnotic phase by recapturing the affect of the emotional experince as they relate the story,

which is illustrated in the narratives. Narrative therapy is a life story experience and therefore much more lengthy and yet quite often much less cathartic. “The study of mental processes and the patterns of behavior upon which post-hypnotic results are based has been neglected” (Erickson, 1980).

GLOSSARY

ABREACTION: The process of working through a repressed disagreeable experience by living through it again in speech and action in the presence of a psychotherapist. Called also psychocatharsis and catharsis.

ABUSIVE TRAUMA: is, by definition, an assault on the boundries of the self; physical, emotional, personal (Kepner, 1992).

AFFECT: (noun) A feeling of emotion, particularly a strong one.

AGE REGRESSION: The phenomenon of age regression is partly based on the mechanisms of amnesia and hypermnesa. In the context of hypnosis it allows the client to reexperience memories of an earlier period (Edgette&Edgette, 1995).

AMNESIA: Refers to a functional loss of the ability to recall or identify past experiences. Erickson believed amnesia to be a form of dynamic behavior quite different from ordinary forgetting.

Anchor: A stimulus which is linked to and triggers a physiological state. Positive visual anchor: favorite photo, negative auditory anchor: Police siren behind you.

CATALEPSY: A condition characterized by a waxy rigidity of the muscles so that the client tends to remain in any position he is placed.

CATHARSIS: Freud’s technique for the treatment of psychoneuroses by encouraging the patient to tell everything which often results in a significant emotional release, felt to purge the mind of the repressed material which is the cause of the symptoms.

CEREBELLUM: A brain mass lying in the back of the head underneath the posterior cerebral cortex and above the pons and medulla in the hindbrain. Like the neocortex, it has two hemispheres.

CONGRUENCE: (Rogers) the conscious integration of an experience to become a part of the self.

CONGRUENT ATTITUDE CHANGE: A change in an attitude in the direction of the attitude already held by the individual.

DISSOCIATION: An ongoing process in which certain information (such as feelings, memories, and physical sensations) is kept apart from other information with which it would normally be logically associated. Dissociation is a psychological defense mechanism that also has psychobiological components. Generally, it is thought to originate in " a normal process that is iniitially used defensively by an individual to handle traumatic experiences (that) evolves over time into a maladaptive or pathological process". (Putnam. 1989, pg. 9).

ELECTROENCEPHALOGRAPH (EEG): A device consisting of amplifiers and a pen automatically writing on a rotating drum, used for recording the electrical currents in the brain conducted to the device by electrodes attached to the surface of the head. It is useful for medical diagnosis and for studies of the function of the brain.

FIXATION: The cessation of the development of personality at a stage short of complete maturity.

HIPPOCAMPUS: A structure in the limbic system connected with memory.

HYPERMNESIA: Refers to an enhanced memory ability that transcends everyday recollection. This hypnotic phenomenon allows subjects to remember vividly earlier memories in all their sensory detail (Erickson, 1944b/1980).

HYPNOSIS: A sleeplike state induced artificially by a hypnotist and characterized by greatly heightened suggestibility.

HYPNOTHERAPY: The utilization of hypnosis as a means of physical or mental therapy.

INTEGRATION: To make whole or complete by adding or bringing together parts. It denotes an ongoing process in the tradition of psychoanalytic perspectives on structural change.

PRE-CONSCIOUS: Descriptive of processes of which the individual is not aware but which can be brought to consciousness.

REPRESSION: The thrusting back from consciousness into the unconscious sphere of ideas or perceptions of a disagreeable nature.

SUBCONSCIOUS: In Freudian nomenclature, a transition zone through which any repressed material must pass on its way from unconscious to subconscious.

UNCONSCIOUS: A state characterized by a lack of awareness of ongoing internal processes that proceed in an implicit manner outside of consciousness.

LITERATURE REVIEW

The present study explores the use of hypnotic psychotherapy as a way of modifying the memory of any traumatic incident/s. Utilizing hypnotic psychotherapy and prompting catharsis (abreaction), clients are often capable of retrieving and modifying feelings, memories, and behaviors. Defense mechanisms both conscious and subconscious can be identified and modified with this brief therapy. This approach is a modified version of techniques developed by Sigmund Freud and Joseph Breuer for what they called a "cathartic treatment" to eliminate the symptoms of hysterical patients by hypnotic retrieval.

The scientific debate regarding reports and recollections of childhood sexual abuse goes back to as early as 1896, when Freud argued that repression of early childhood seduction (sexual molestation) had etiological significance for adult hysteria (Freud 1954; Masson, 1984, 1985; Peters, 1976; Rush, 1980). Freud introduced the concept of repression, and although he used it differently at different times, it is now generally defined as the involuntary selective removal from consciousness of anxiety-provoking memories. Freud later recanted his childhood seduction hypothesis admitting his error about repression of actual experiences of child sexual abuse and said that it was fantasies which drove the hysteria about sexual contact with parents or other adults (Freud, 1954). Several studies now support Freud's earlier contention that some childhood sexual abuse victims have no recall of the abuse at an adult age, and experience high levels of psychological symptoms that may be traced to early traumatic experiences, at least in clinical samples (Briere, 1992).

When the initial experience (trauma, abuse) occurs in childhood, the adult client will often bring to the therapeutic process the old coping skills (Kepner, 1992). Pure abreaction can be harmful (and it can result in overwhelming re-experiencing of intense emotions) because the same modes of coping (numbing, dissociation, denial) can be reinacted as in the initial trauma. The abuse surviver comes to repress or dissociate the

memories of abuse because it was overwhelming (Kepner, 1992). With maturation, ego-strength (self-structure) may develop and clients may be able to successfully integrate into meaningful experience the insight from an adult perspective. Hypnotic psychotherapy, when used here, involves accepting, utilizing, pacing, and leading clients' behaviors in the direction of constructive change. Coping skills and defense mechanisms can be identified in this inter-personal process in a safe and contained environment. Contained (as used by Teyber 1996) means maintaining a steady presence in the face of the client's distress and pain. Validating the client's feelings, containment helps the client understand the reality-based reason why it has been difficult to approach some feelings (Edgette and Edgette, 1995). In this therapeutic relationship, when a traumatic event is disclosed, it is important to facilitate the client's ability to stay with the feelings by emphasizing that the event is past and the client has already survived it. This prompts the client's perceptual shift to a more mature state of ego functioning.

HYPNOSIS

Hypnosis is an artificially induced trance state characterized by heightened suggestibility. Hypnosis refers to altered states of consciousness; of which dreaming, day dreaming, prayer, and meditation are all considered variations of self hypnosis. Hypnosis is a concept that goes back to antiquity (Kroger,1977). Hypnotic phenomena have been reported in all cultures across the world and throughout all periods of recorded history (Wickramesekera, 1988).

Almost 200 years ago d'Eslon, the successor to Mesmer, discerned that conviction and imagination were responsible for what Mesmer (1734-1815) believed was his cure for mental illness. In the early 1800s Abbe' Foria claimed that hypnosis worked due to a state of positive expectancy and cooperation of the patient. Abbe' Foria's work influenced James Braid to create a doctrine of suggestions. Emile Coue' (1923) polarized the laws of concentrated attention and of dominant effect. He was specific regarding the end result of a hypnotic suggestion. (Kroger, 1977). The initial premise for the laws was based on the idea that a strong emotion tends to replace a weaker one. Coue' became famous when he had his patients repeat positive affirmations about getting better and better every day.

In spite of hypnosis falling into oblivion twice in the past century, it has re-emerged as an invaluable adjunctive psychotherapeutic tool for medicine (Kroger, 1977). Hypnosis recognizes and utilizes direct and

indirect suggestions. Direct suggestions are, for example, assumptions that something will happen (Edgette & Edgette, 1995). Indirect suggestions allow more freedom for the client, (e.g., "as you begin to feel relaxed you can allow yourself to become aware of the air in the room.)" Suggestions can simulate sensory data input such as temperature and pressure sensations, and kinesthesia (Kroger, 1977). Persons in a trance state tend to narrowly focus their attention. As a result of this focus they may be able to suspend critical judgment and can become highly suggestible (Kroger 1977). They perceive certain things vividly and filter out other stimuli such as background noise. When a headache is relieved using hypnosis, for example, the belief the patient has in the established technique influences them to believe the hypnotherapist's suggestions as true statements that somehow magically affected a cure. Several authors have stated there is a placebo effect with hypnosis. The faith and hope of the patient combined with the suggestion and persuasion on the part of the therapist constitute some of the universal factors operative in mental healing. There is a subtle placebo effect in many types of psychotherapy today, yet one seldom recognized. All faith is built up by personal conviction and the imagination. Faith healing also depends to a degree on cultural as well as psychosocial factors (Kroger, 1977).

Traditional hypnotherapists tend to see themselves as putting something into the client from outside. More contemporary views of hypnosis suggest that it is not a matter of the therapist doing something to the patient or compelling him to do things or even telling him to do things (Haley, 1973). Ericksonian techniques, for example, emphasize the resourcefulness within the client. This semitraditional approach emphasizes the tailoring of induction formats and suggestions to fit each client (Edgette, and Edgette, 1995). When trances are elicited, they are still a result of ideas, associations, mental processes, and understandings already existing and simply aroused within the client (Haley, 1973). In this study every effort was made to direct the clients' attention to processes within themselves, to their own body sensations, memories, emotions, thoughts, feelings, ideas, past learnings, past experiences, and past conditions, as well as to elicit current understandings and ideas.

The trance-state can be induced in many ways. One of the most commonly utilized in individual, guided, and group settings is the progressive muscle relaxation. The trance may be deepened by visual imagery: for example, **"**Imagine yourself on a mountain top overlooking the ocean. There are 10 levels to go down before you get to the beach".

Another method is to precede the imagery with an eye focusing technique utilizing the ceiling or an object suspended from the ceiling. Today's theories and fashion, however, generally favor a conversational manner, relaxation, and calming images to induce the trance (Murphy 1992). The induction of catelepsy (which is characterized by waxy rigidity of musculature) is one example of a direct suggestion usually given in a way such as; "When your hand lifts up, you will feel yourself go deeper into the trance," (Edgette & Edgette, 1995).

As reported in Murphy (1992) some researchers (Ludwig, Lyle) induced hypnotic effects through spinning movements, knee bends, and verbal instructions designed to increase alertness, sensorimotor stimulation, and cognitive activity. These studies indicated that patients were more suggestible, spontaneous, and active in hyper-alert trance than in ordinary relaxing procedures (Murphy, 1992). For some subjects, what is needed is to chant or to repeat a few words over and over such as "relax, focus, float."

People in a trance state may feel as if their reactions are involuntary. Their suggestibility makes them highly responsive to guidance and particularly inclined to comply with direction and requests from the hypnotic guide, but hypnosis is neither mind control nor truth serum. People in a trance state cannot be forced to make unwanted self-revelations, but they are quite capable of deliberately or unconsciously lying. Memories brought to light through hypnotic age regression are not necessarily more accurate or reliable than other memories (Murphy, 1992). According to Murphy, the hypnotic intervention techniques are more rapid in accessing traumatic events than traditional talk therapy. The session develops as the therapist gives the client an open invitation to talk about what brought them into therapy, and what feels most important presently (Teyber, 1996).

The perceived traumatic incidents, due to their emotionality, can be retained in both the physical and the emotional aspects of the patient (Hay 1982). Dissociated material that has been repressed may be nothing more than information that is unavailable to awareness because it is stored in state-dependent form in an isolated neuro-network (Shapiro, 1995). Through cathartic flooding in the trance-state, immediate access to the identified problem can be accomplished and resolution achieved after appropriate ego-strengthening of the self-structure. The task of the hypnotherapist is to validate the symptom phenomena and pave the way for the client's development of a more psychologically adaptive solution

(Edgette, Edgette 1995). Therapists have found that by targeting the clients' current symptoms many clients (50%) are more easily able to reexperience visual images of the dissociated event (Shapiro, 1995). This entails reprocessing the client's perceptual orientation, coming from a place of disempowerment and despair to a different level of trust in one's own self and resourcefulness, and a different self-evaluation. Through age regression and reprocessng previous decisions about oneself seen as a child's, the client can adopt powerful choices about self-perception during the trance. The clients can nurture themselves from their imagined parent self or adult self with the mature coping skills they hold in the here and now. The shifting from their present ego state to the past childhood ego state is then utilized to reprocess and reframe the incident. The client is prompted to make statements to themselves regarding safety and control which empowers them to change the dominant affect of the here and now.

NEUROLOGICAL ASPECTS OF INFORMATION PROCESSING, MEMORY, AND HYPNOSIS

Humans continually construct an overall model or schema of the world around them (Antrobus, 1970). Memory provides more than interpretation for the sensory input; it provides prefabricated analogs that, when utilized, are the perceptual experience. Believed to be state dependent, as previously mentioned, memories are subjective in nature and questionable as to accuracy. Although people believe they are generally correct in their recall, memory is not based solely on their cognitive abilities. Rather, memory is a neurological process that everyone creates unconsciously.

The human eye is much like a camera taking snapshots all the time. One simply sees whatever image is formed on the retina. The human eye moves rapidly in jumps called saccades, several times a second. A momentary image fixated on the retina has no psychological existence and is not seen as a whole meaningful object, rather a composite based on the bits and pieces accumulated is seen (Swerdlow, 1995). The necessary information is preserved in a schematic way (Antrobus, 1970). We use information from each successive fixation (retinal) to form a construction. This construction is uniquely our own version of environment and experience. In the same way that fingerprints are unique, so too are memories and the construction of memories.

No one knows what memories are, but it is believed that all memories are more or less accurate cognitive reconstructions of past experiences (Swerdlow, 1995). Listening and smelling are active processes of

construction, just as vision is, and there are memories created from each which are unique to a specific individual. Similar processes are involved in dreaming and visual imagery (Swerdlow, 1995). Distortions of memory can and do arise due to its constructive nature (Schacter 1986). The constructed whole guides movements, often including the eye; when a patient is asked to describe their visual experience, it is a construction of what they see. This then is what is remembered and imagined (Neisser, 1967). The body receives information at the periphery and the brain encodes it as nerve impulses (van der Kolk, 1994). Memories range so far and vary so much that several areas of the brain are involved in the process of creating and storing.

Automatic processing and selectivity are necessary cognitive functions that keep us from overloading with too much information (Antrobus, 1970). From the early "Bottleneck Theory", (information processing approach-selectivity occurs at a bottleneck-a stage that could process only one message at a time), to the "Filter " theory (Broadbent's theory of attention, learning, and memory) there is a large research movement in cognitive psychology. Whether the "bottleneck" of information occurs before conscious recognition (Broadbent's) or after (Deutsch & Deutsch) there is most certainly a point of automatic processing that is both conscious and subconscious. Most processing of sensory input occurs outside of normal consciousness, with only novel, significant, or threatening information being selectively passed on to the neocortex for further attention (van der Kolk, 1991) . Studies reveal that priming of old, pre-existing knowledge appears to occur relatively automatically, while implicit memory for new association requires active processing at the time of encoding (Schacter & Graf, 1986; Schacter & McGlynn, 1989).

Extreme stress is accompanied by the release of endogenous neurohormones, such as epinephrine and norepinephrine, oxytocin, and endogenous opioids (van der Kolk, 1991). When humans are in stressful situations they secrete endogenus stress hormones that affect the strength of memory consolidation (van der Kolk,1985, Charney, 1993). The principle hormone considered in this phenomenon is norepinephrine which is involved in producing long-term potentiation, while other neurohormones secreted under stressful circumstances (endorphines, glucocorticoids and oxytocin, for example) actually may inhibit memory consolidation (Zager 1985). Both very high and very low levels of norepinephrine activity in the central nervous system (CNS) interfere with memory storage (van der Kolk, 1994). The limbic system is believed to be

the part of the CNS that maintains and guides the emotions and resulting behavior necessary for self-preservation (MacLean, 1985). The hypothalamus and pituitary gland are intimately connected to the limbic system and influence other glands and dominate the endocrine system. The limbic system is the area of the brain that is critically involved in storage and retrieval of memories (van der Kolk, 1991). The mood-altering qualities of endocrine imbalances give us an important hint about the connection of the limbic system with states of mind (Sagan, 1977).

Two areas, the amygdala and the hippocampus, are the areas thought most responsible for memory. The amygdala is most clearly implicated in the evaluation of the emotional meaning of new information, and incoming stimuli (van der Kolk, 1991). Initially attention was drawn to the hippocampal region. However, research indicates that conjoint damage to the hippocampus and amygdala is required for severe amnesia (Squire, 1991). The thalamus, amygdala, and hippocampus are all involved in the interpretation and integration of incoming sensory information (van der Kolk, 1991;Pitman, 1993;McGaugh, 1985;Adamec, 1978). The components of the medial temporal lobe memory system perform a crucial function at the time of learning in establishing long-term declarative memory (Squire, 1991). The process of long-term (permanent) memory storage is gradually assumed by the neocortex and this assures that the medial temporal lobe system is always available for the acquisition of new information (Squire, 1991). When the amygdala is moderately activated there is an enhancement of the long-term potentiation of declarative memory that is mediated by the hippocampus which accounts for hypermnesias for stressful experiences (van der Kolk, 1991). The amygdala is thought to integrate internal representations of the external world in the form of memory images with emotional experiences associated with those memories. The amygdala then guides emotional behavior by projections to the hypothalamus, hippocampus, and basal forebrain (van der Kolk, 1991).

Once neuronal impulses reach the brain, they trigger the release of messenger chemicals such as glutamate, which then induce impulses that travel from one neuron to another. This electrochemical process sometimes stimulates growth of new dendrites. Brain imaging studies suggest that dendrite production rises rapidly after birth and remains at a peak level from approximately age four to age ten (Swerdlow, 1995). During the first few years of life the brain has many more connections than later in life as an adult, and uses twice as much energy. Connections in the brain at birth

are widespread and over time become tailored or pruned. The important connections are activated and those rarely used atrophy. The way the local environment makes demands on certain connections in the brain affects how the brain works and, in a way, how a person perceives the world (Burke & Ornstein, 1997). The flexibility of the brain can, at this early stage of development, compensate for deficits allowing a transference of information to occur from one hemisphere (side) of the brain to the other. The ability to transfer from one hemisphere to the other is highest before adolescence, during the years of peak dendrite growth (according to Ben Carson, a pediatric neurosurgeon at Johns Hopkins Hospital). This same process of transference also occurs when strokes damage portions of an adult brain (Swerdlow, 1995). Further evidence of transfer comes after amputations. The brain attempts to make up for the deficit (Lemonick, 1995), possibly by sprouting new sets of connections. Neurons can resprout dendrites throughout life, so hard work and encouragement could restore much brain dysfunction such as stroke victims suffer.

Powerful new techniques (MRI, PET) have provided a window into the human brain. Different patterns of activation can be viewed under different circumstances. The amygdala is involved in both aggression and fear (Sagan, 1977). The ability to recall information depends on a network of regions located mainly in the right hemisphere (Bower, 1996). Research now shows the hippocampus and cortical regions adjacent to it (specifically, the entorhinal and parahippocampal cortices) work together to support the development of representations in the neocortex (Squire, 1991). More specifically, research from the Institute of Neurology, London, indicates that part of the right frontal cortex aids in the retrieval of personal memories (Bower, 1996). Many findings according to Endel Tulving, Rotman Research Institute, indicate that predominately the right cortical activation takes place during autobiographical memory retrieval (Bower, 1996). Comparisons of blood-flow data under several conditions revealed that the right brain regions predominate. However, the frontal cortex and temporal lobes are also activated during autobiographical memory retrieval (Bower, 1996). Neuroimaging techniques have revealed data regarding brain activities under two circumstances: the recall of actual events, and the remembering of "false memories." Accurately and falsely remembered words stimulate cellular activity in different areas. Genuine memories are believed to trigger a sensory reaction in the brain. False memories, on the other hand, elicited elevated activity in frontal brain areas involved in conscious attempts to remember information. At the time

of the trauma, the excessive release of norepinephrine, as well as other stress hormones such as endogenous opioids, oxytocin, cortisol, and vasopressin probably play a role in creating the hypermnesias and amnesias that are a essential part of PTSD (van der Kolk, 1991). The hypermnesia and amnesia existing for the client suffering PTSD symptoms are also considered to be similar to hypnotic phenomenon (Edgette & Edgette, 1995).

Hypnotic phenomena that are common automatic responses in traumatized people include amnesia, hypermnesia, dissociation. (Edgette & Edgette, 1995). These hypnotic phenomena can be described as natural experiential manifestations of the trance-state but can also be induced during hypnosis. These phenomena are believed (Edgette & Edgette, 1995) to be the result of trance-eliciting communication patterns and concentrated internal attention, and not of physical differences between normal waking states and trance.

Almost certainly, the experience of a hypnotic trance involves some alteration of neurochemical functioning in the brain. And since people are often able to access certain memories more readily when in a hypnotic trance, it is likely that many of these limbic structures are involved in hypnotic retrieval.

HYPNOSIS AS A TREATMENT

There is a divergence of opinion as to the role of hypnosis in on-going psychotherapy. Hypnosis is used to control anxiety, generate emotional reactions for later examination, liberate fantasies and associations, retrieve memories, and accelerate the formation and resolution of the transference in the client/therapist relationship that facilitates the recall of childhood experiences. Because the hypnotic trance is both emotionally and physically relaxing, it can be quite a successful technique for overcoming apprehension, anxiety, and phobias (Briere, 1992, Murphy 1992). Hypnotic imagery can be used to treat many physical illnesses including asthma and gastrointestinal disorders. Hypnosis is said to alter several body functions including the secretion of stomach acid and other involuntary movements, and even slow bleeding in hemophiliacs. It has been used to relieve side effects of radiation and chemotherapy in cancer patients and to reduce the rapidity of this and other disease processes along with reducing the pain, depression, and anxiety in dying patients. Most believe these techniques are useful in the retrieval of memories. Because of the relative vulnerability of people in a trance-state, and probable dissociative amnesia

for part or for all the hypnotic session, it is important that the individual enter the state only in a trusting, nurturing environment. The retrieval of painful childhood memories is rooted in extreme emotion, and is an on-going process in the therapy of PTSD (Teyber, 1996). Because the hypnotic trance gives people a heightened awareness to their own bodies and what the therapist says and does, it can be helpful in treating a wide variety of physical conditions.

In the context of cognitive behavior therapy, hypnosis has been used to enhance relaxation, generate imagery, heighten expectation of success, change self-defeating thoughts, and initiate new behaviors. Hypnosis facilitates reinforcement, in which the client imagines a reward after imagining the desired action, and desensitization, in which relaxation and imagery are used to eliminate phobias. Hypnosis has been used for almost all psychological disturbances from phobias to sexual problems, psychosomatic illness, bedwetting, and nail biting in children. Guided imagry is a common aspect of hypnotic psychotherapy. This intervention allows the client to experience a thought and assess their reaction and perception.

A few of the perceptual changes reported by hypnotized patients are; hallucinations, visual illusions, improved visual and auditory acuity (Murphy, 1992). Hypnosis recognizes these images as hallucinations, whereas other theories do not consider imagry to be hallucinatory. Hypnotic researchers are still unsure of the nature of hypnotic illusions and hallucinations. One researcher (Nicholal Spanos) has provided evidence that hypnotically induced color-blindness does not mimic congenital color-blindness which casts doubt upon the authenticity of some hallucinations (Murphy, 1992). Experimentally manipulated functional paralysis was analyzed and differences between organic and functional paralysis were studied for years by Charcot, 1886.

Several advantages can be achieved through the use of guided imagry, some of which include relaxation of one's mind and body after gaining the ability to consciously focus fully on an image. This is something everyone does while engaged in certain activities that require total attendance, such as reading. Once learned this can be quite helpful to reduce stress.

Hypnotic techniques can be useful in crisis management to help clients suffering from PTSD and/or DID (dissociated identity disorder) to stop flashbacks and reorient themselves to external reality when these altered states occur. Hypnotic techniques are useful in ego strengthening and for supporting patients during crises. Access to previously unconscious ego, to

self statements or beliefs about oneself, is often gained in hypnosis and aids the client in properly assimilating any insights. The emphasis is on bringing into focus any instinctualized elements that have to some degree succeeded in becoming conscious. The effectiveness in making the unconscious area of the ego more accessible grows as one becomes more familiar with the complexity of functions oftened lumped together under the label of memory (Antrobus, 1994). As the therapeutic relationship unfolds therapists continually listen to the clients and deal with manifestations of the function of memory in a variety of contexts or forms (Antrobus, 1994). One of the complex functions grouped under the heading of memory is the capacity to transform something first thought of as referring to another time and place--the past--into awareness. That the event exists as an internal image in the present is what is identified and confronted by the client. One of the aim**s** of hypnotic psychotherapy is to guide the healthy interpersonal transformation of the client.

One of the goals of psychotherapy is to aid in a client's interpersonal growth. Hypnotherapy (the version used in this study) is used as well to facilitate healing by allowing the client to identify the central affect that the current issue has aroused and link it to the original wound. Hypnosis can be used as a brief approach to therapy that promotes a rapid interpersonal relationship with the therapist. For instance, if the client recalls an early experience of extreme emotion, the therapist can remind them they are able to say whatever they needed to at that time in this new instance of experience.

Age regression is one aspect of some forms of hypnosis. The process of age regression involves inducing a trance, and while in this state, the client is encouraged to remember and to reexperience certain events, emotions, or reactions experienced as a child; (i.e., to get in touch with inner recollections of important past experiences). As used in this study, age regression refers to reexperiencing (whereas hypermnesia refers to intense remembering). The use of the term age regression in hypnosis may also be referred to as inducing a "child ego state" or as a "transference reaction" in other therapeutic models (Edgette & Edgette, 1995). Because the client brings to the age regression experience greater wisdom, psychological maturity, and broader coping skills, than when the traumatic events were originally experienced**,** these strengths are incorporated as the trust of self grows through reframing. Once the client understands they are currently in the control role they can choose to reframe (modify) the painful conflict any way they want (Teyber, 1996). This is done by

allowing the client to say what they needed to say at the time of the initial trauma, but could not. Through ego-strengthening techniques (e.g., assuring the client that they lived through the experience and can access their own parent or adult self to rescue, nurture this vulnerable often scared inner child), in hypnotherapy the client can express and experience congruence and trust in themselves. This type of reparenting when used in age regression allows the client to empower themselves in a protective way they may never have experienced before.

Hypnotherapeutic ego-strengthening, through the use of reparenting and regression, allows the client to reframe (perceive differently by changing the script), the painful conflict (Schiff, 1975). Using hypnotic psychotherapy, regressing from one incident to another, the client quickly adapts to maintaining a comfort and trust from within.

A demonstration of understanding between the client and therapist will be illustrated to be on a different experiential level than the more traditional psychotherapy session. The client will have identified and experienced at least one recurrent theme. A theme is a behavior that results from an emotion such as withdrawal caused by shame or anger due to abandonment. The ability to identify the repetitive interpersonal themes, pathogenic beliefs, and primary affects that link together the client's experience and problems will allow the client to feel the therapist understands in a way no one else does (Teyber, 1996).

People enter into therapy in pain asking for help with something they have been unable to resolve within themselves. At times clients are reluctant to work with the conflicted emotions that emerge in treatment. The client simultaneously seeks to avoid re-experiencing painful conflicts and to find a new and more satisfying response to them. In dysfuctional alcoholic, abusive, or authoritarian families, when the client's subjective experience has been denied repeatedly, they may not be able to differentiate their feelings or values. While growing up most clients have certain developmental experiences that are painful, confusing, or disempowering, because the caregivers were unable to provide a safe and understanding context to allow the child to contain these emotional reactions. As a result the client is unable to form confident perceptions, and they retain a vague and painful feeling of internal dissonance (Teyber, 1996).

One essential component of the internal focus in the interpersonal process inherent in hypnotherapy is to help the client look within and become aware of their reactions and responses. A collaborative

relationship accepts the client's need for comfort, understanding, and guidance, yet equally encourages the client's own initiative and autonomy. When the therapist captures and expresses understanding of the client's level of distress by helping them focus emotionally and physically release, through various expressions, catharsis can take place (Teyber, 1996).

Emotional containment is also provided using hypnotherapy in a way that may have never been provided for the client. Using this supportive context allows the client to experience their feelings, progress through their natural course, and come to a more congruent close. With abuse victims the initial coping strategies are broken down and brain and body work together toward clarity of feelings. According to Teyber, clients can improve quickly when the therapy provides a holding environment that allows them to contain feelings that have been too painful to integrate or to resolve (1997).

CLINICAL PHENOMENA

POST TRAUMATIC STRESS DISORDER

Childhood abuse is at an all time high. One in three girls and two in nine boys are abused sexually or physically (Briere, 1992). Many adults who have a personality disorder and nearly all those diagnosed with DID were seriously maltreated as children (Famularo, 1997). These individuals may initially be misdiagnosed (bipolar, avoidant, or overanxious) only to eventually be recognized as suffering from PTSD (Briere, 1992).

Both causes and symptoms of PTSD are similar in adults and children. The childhood form of PTSD is like the adult in that it can be a severe and debilitating mental illness (Famularo, 1997). PTSD is not only an emotional response to troubling events, it is thought to be the expression of a persistent disregulation of body and brain chemistry (Butler 1996). The experience of a traumatic event, whether it is sexual, physical or psychological it is generally followed by recurrent nightmares, rumination on thoughts around the event, and intense reactions to symbolic reminders of the trauma (Briere, 1992). The severity (course and duration) of the trauma and the age at the time of occurance as well as developmental and biological predisposition all influence the severity of PTSD (Briere, 1992).

In the late 1800s Pierre Janet postulated that intense emotional reactions make events traumatic by interfering with the integraton of the experience into existing memory schemas (van der Kolk, 1991). Freud (1919) considered the tendency to fixate on the trauma to be biologically based (van der Kolk, 1991). Physical trauma which elicits an unconscious

physiological response is believed to distort memory by temporarily inhibiting all or part of one of the memory processing structures (Charney, 1993). The information stored in the neuro network can be manifested by all elements of the event: physical sensations, all the senses, images, affect, and such cognitions as assessment and belief statements (Shapiro, 1995). In this state of dissociation there is a lack of integration of knowledge, memory, and voluntary control which is expressed as a feeling of unreality and a change in the sense of self (Holmes, 1994). Shapiro (1995) believes when trauma occurs it appears to get locked into the nervous system and often gets triggered by a variety of reminders and is responsible for the clients' frequent feelings of helplessness, fear, hopelessness, etc. PTSD sufferers have an inability to integrate memories of the trauma and tend to get mired in a continuous reliving of the past, which is mirrored perceptually by the misinterpretation of innocuous stimuli, such as unexpected noises, as potential threats (van der Kolk, 1991). Research as far back as Kardiner (1941) has shown that the trauma response is bimodal: hypermnesia, hyperreactivity to stimuli, and traumatic re-experiencing coexist with psychic numbing, avoidance, amnesia, and anhedonia (van der Kolk, 1991). People who are thought of as traumatized, including rape victims, battered individuals, and abused children, do not respond to subsequent stress the way that other people do because of their experiences and memory construction (van der Kolk, 1991).

Memories (somatic or symbolic) related to trauma are elicited by heightened arousal (Solomon, 1985). Memory retrieval has been recognized as state dependent and emotionally charged. However, in PTSD failure of declarative memory may lead to organization of the trauma on a somatosensory level that is relatively unchangeable (van der Kolk, 1989,1991). This state-dependent memory retrieval may be involved in the dissociative phenomena in which traumatized persons may be totally or partially amnestic for memories or behaviors enacted while in altered states of consciousness (van der Kolk, 1989, 1991, Putnam, 1989). Body memories can manifest themselves in symptoms which include, but are not l limited to, asthma, heart disease, and kidney disease. Body memories are a separate yet connected type of memory which is subconsciously stored and elicited once triggered through some type of stimuli, (Lemonick, 1995).

The abnormal acoustic startle response (ASR) is seen as a cardinal feature of the trauma response (Davis, 1991). There are many triggers not directly related to the traumatic experience that precipitate extreme

reactions (van der Kolk, 1991). The ASR is mediated by excitatory amino acids such as glutamate and aspartate and is modulated by a number of neurotransmitters and second messengers at both the supraspinal and spinal levels (Davis, 1991). Inability to habituate to acoustic startle suggest that traumatized people have difficulty assessing sensory stimuli and mobilizing appropriate levels of physiological arousal (van der Kolk, 1991). Chronic and persistent stress inhibits the effectiveness of the stress response and induces a desensitization of the person (Axelrod, et al. 1984). Much as a chronic pain client may eventually adapt a higher pain threshhold, the chronic stress response can also be elevated. In many people who have endured severe stress, the post-traumatic response fades over time, whereas in others it persists (van der Kolk, 1991). Research has shown that over time memory for events can be changed or reinterpreted to make the memory more consistent to the person's present knowledge and/or expectations (Wickramasekera, 1995). Often change occurs due to one's pathogenic belief changing. An adult traumatized due to abuse as a child may reflect back and minimalize the experiences. Due to multiple defense mechanisms that are difficult to control or discontinue, a person's perception continually shifts as they mature.

Dissociative amnesia is a defense mechanism used by many people, and it may be the most common among the abuse victims (Briere, 1992). The association found between no recall and trauma (as measured by violence or injury) and the lack of association between no recall and conflict (as measured by guilt, shame, and enjoyment), fits better with the process of dissociation (Briere, 1992). Dissociation characterizes not only PTSD, but many other altered states of consciousness, including hypnosis and dreaming.

DISSOCIATION

Dissociation is a natural part of our daily lives (Edgette & Edgette, 1995). Dissociation is a mental mechanism that can be used productively as well as counterproductively. The important thing to remember is that if we were fully alert and attending to every move at all times we would not be able to function beyond focusing on each motion (Edgette & Edgette 1995). Dissociation refers to one part of a person's experience (mental or physical) functioning distinctly and independently from another part (Edgette & Edgette, 1995). In a sense the state of dissociation is an altered state similar to dreaming in that one can see oneself performing various activities (Kroger, 1977). All altered states of consciousness are related,

especially the various types of meditative states and the relaxation response.

One way to explain the sum of the powerful effects of hypnosis is to regard the hypnotic trance-state as one of dissociation. "Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviors or movements that are experienced as being beyond one's control" (American Psychological Association: Diagnostic and Statistical Manual of mental disorders, (4th ed., 1994). Washington D.C. (herafter referred to as: DSM IV). In this state there is a lack of integration of knowledge, memory, and voluntary control which is expressed as a feeling of unreality and a change in the sense of self. The cognitive process is suspended as the subconscious comes to dominate the focus. In a threatening situation a person automatically shifts into the utilization of defense mechanisms as a self-preservation takes place. Hypnosis too, is a shifting back and forth between the conscious and the subconscious mind, a natural process that occurs during much of our day (Holmes, 1994).

Dissociation refers to the inherent ability of a person to detach from the here and now immediate environment (Kroger, 1977). It is possible for a person to be totally dissociated and still retain the capacity to function adequately (Kroger, 1977). The children who are ritualistically abused or continuously terrorized may in fact have gone beyond the defense mechanism of repression or typical dissociation, and may have split off from themselves into a separate personality/ies; an extreme form of dissociation (Briere, 1992). Over time, these individuals may be able to integrate the separate personalities into one and hypnosis is especially successful with these patients. This is the extreme on the continuum of dissociation, which also includes Dissociative Amnesia, Depersonalization Disorders, and Dissociative Disorder not otherwise specified. Dissociative Identity Disorder (DID) is the presence of two or more distinct identities or personality states, with at least two of these states recurrently taking control of the person's behavior (APA, 1994). Depersonalization Disorder is a persistent or recurrent experience of feeling detached from, as if one is an outside observer of one's mental processes or body (APA, 1994). During the depersonalization experience, reality testing remains intact. Dissociative Disorder not otherwise specified is included for disorders that don't meet the above criteria specifically enough. Experts agree that autohypnotic phenomena may play an important role in the etiology and structure of this disorder. They also agree these patients frequently enter

trance states even when the therapist has not performed any hypnotic induction procedure (APA, 1980).

Some child developmental specialists theorize that children start life with an experience of self, similar to that described by those with Multiple Personality Disorder (MPD). DID individuals experience the self not as one entity moving through time, but as a collection of reactions to the world. Behavioral characteristics are believed by some to only develop after an infant has acquired enough memories to construct them, generally around age four (Schrof, 1997). The self can be seen as a large reservoir of behavioral patterns that in most cases eventually form one personality with its own characteristic traits. These behavioral patterns are formed as a result of one's perception based on subjective experience and memories**.** If a child is severely traumatized and comes to rely on a significant amount of dissociation prior to learning to integrate moods (happy, sad), they may never achieve a unified identity (Schrof, 1997).

BEHAVIOR

Accuracy then, based on their life experience, becomes a valid consideration and diagnosis should therefore be based on the patient's recall of their life experience which may have resulted in a characterological style. For patients, core emotional issues may be discovered through the technique of hypnotic age regression. Such core issues often include fear of abandonment (both physical and emotional), guilt, and shame. These common core issues can and do encompass numerous dysfunctional habits both physically and emotionally leading to a set of cognitive behavioral styles. Characterological outcomes from histories of abuse can be identified using the framework by S. Johnson in *Character Styles* (1994).

CHARACTER STYLES:

The children that are severely abused are often the Personality Disorders, such as the hated child would be the Schizoid character, the exploited child would be the Historionic personality, the disciplined child would be the Obsessive-Compulsive, the defeated child the Masochist. When comparing the body types there are both similarities and differences. The Oral/Dependent and the Schizoid are both weak and vulnerable due to the insufficient nurturing and acceptance in their infancy. These two are both dealing with strong, negative emotions based in their childhoods, and both harbor fearful expectations of their environment. They are both prone to illness, psychosomatic or otherwise. There is a lack of firm grounding and both have weakness and stiffness in the legs and feet. The oral character's musculature tends to be more flaccid and less defined then the Schizoids' which can appear contracted and stiff. The hated child's eye to eye contact is withdrawn, whereas the orals' eye contact is more attainable or contactable. The Schizoid is less present than the

> oral, who has a posture that is markedly thrust forward from the waist up. These body types can then clearly reflect the mind-set or constructs of the person, the way they think, what they think is who they are, totally. The energetic Narcissist (psychopathic character), has an under developed or weak lower half of the body and accompanying over developed upper half- (puffed up) appearance. This body type is thought to reflect the ungrounded base supporting exaggerated power, willfulness, and achievement. The individual may not realize they are what they think but they in fact are what they think and feel and the body interprets and incorporates to accommodate.

There are three types of dissociative behaviors that relate to alterations in thoughts, feelings, or awareness, each of which is considered common among abuse survivors: disengagement, detachment/numbing, and observation (Briere, 1992). Traumatized children are often faced with terror and cope using the same mechanisms as anyone else in a life-threatening situation, utilizing dissociative behaviors (Briere, 1992). These early experiences of maltreatment can produce cognitive, affective, and posttraumatic symptoms, as well as dysfunctional self-perceptions and impaired self-reference (Briere, 1992).

Disengagement consists of withdrawal into a state of affective and cognitive neutrality with the external locus of control being secondary to the internal locus of control**.** These episodes are generally very brief and the depth of dissociation is usually shallow (Briere, 1992). Detachment/ numbing occurs when the dissociating client weakens the negative feelings associated with specific thoughts, memories, or ongoing events so they can function in their necessary daily activities without being distracted or immobilized by psychological pain (Briere, 1992). Observation is commonly associated with out-of-body experiences and depersonalization, in which the traumatic event is treated as if it were not real (Briere, 1992). The abuse victims may experience themselves as outside looking in (Briere, 1992).

Studies support the theory that if a child is sexually abused by a caregiver at a very young age the child is more likely to forget the incident due to the essential relationship with the caregiver (Schrof, 1997). Whether abuse occurred, or an incident traumatic enough to the child/person for them to block it out, the process of repression often occurs and is quite common. Any behavior which produced regret of any kind, which was later choked off before it could be integrated and progressively attenuated, is a candidate for sudden retrieval of guilt and shame feelings which can be overwhelming (Tomkins, 1963). A similar process occurs with abused children and accident victims in that they both block out trauma as an unconscious defense mechanism, a behavior sometimes referred to as

dissociative amnesia (Schrof, 1997). People commonly utilize the defense mechanism of dissociation in response to a traumatic event, distancing themselves from the experience or separating perceptions from feeling (Briere, 1992). Pathogenic beliefs resulting from early childhood traumatic events are maintained in psychological symptoms which inhibit the client's pursuit of normal desirable goals such as success in love and work. The traumatic experiences of childhood often involve abuse inflicted by parents, relatives, or other caregivers: rarely is the perpetrator a stranger (Briere, 1992). The result is a loss of trust, a sense of betrayal, an overwhelming sense of helplessness which can be associated with the masochistic traits.

Masochism or self-punishment also can result due to strong feelings of guilt; is a common form of unconsciously motivated damaging behavior (Cheek and LeCron, 1968). Masochism is a self disorder; this person doesn't have much of a self because they conformed to the environment which they perceived needed them to be more or less than they were (Johnson, 1994). The masochist is the person that is on self-destruct and won't let anyone in (Johnson, 1994). "Extreme masochism can bring suicide or fatal illness" (Cheek and LeCron, 1968). In painful psychosomatic illness, masochism frequently will be a factor in the etiology. Often masochism can be uncovered by questioning underlying emotional issues in such conditions as migraines, chronic headaches, arthritis, bursitis, slipped disc, dysmenorrhea, and other painful conditions (Cheek and LeCron, 1968).

SOMATIZATION

Material from several sources (Rhue, Lynn & Kirsch, 1993; Fromm & Nash, 1992; Wickramasekera, 1988) suggests that the hypnotic ability and hypnotic procedures significantly contribute to the explanation, prediction, and therapy of both mental and somatic disorders (Fromm, 1992).

The link between emotions and health has been indicated by many researchers in the past decade (Moser, 1996). Cathartic effects of abreaction in the healing of psychological trauma and psychosomatic pain have been attested to in many studies (Laderman, 1991). It is becoming clear today that many diseases are psychophysiological illnesses including cancer and cardiovascular disease (Fromm, 1992). Scientific boundries have become blurred, due to new findings in the basic sciences of immunology and neuroendocrinology, between mental symptoms like anxiety and depression on one hand, and physical disorders like cancer,

cardiovascular disease, allergies, even the common cold on the other hand (Cohen, Tyrrell & Smith, 1991). These illnesses apparently have psychological factors that can influence their progress**.** Depression is generally thought of as an emotional and mental disorder; if prolonged, it often develops into a physical illness, such as chronic exhaustion (Myss, 1996). Illnesses develop as a consequence of behavioral patterns and attitudes that we do not realize are biologically toxic until they have already become so. To create disease, negative emotions have to be dominant and what accelerates the process is knowing the negative thought to be toxic but giving it permission to thrive in our consciousness regardless (Myss, 1996). Clients suffering from severe anxiety disorders, for example, have been shown to be at greater risk for angina, heart spasms, heart attacks, or death due to cardiac arrest (Moser, 1996). Symptoms of somataform disorder are often the client's presenting problems.

Somatization is something that many people have experienced from time to time, in brief episodes of pain**.** Some researchers view this as simple somatization which implies the temporary nature of the symptom (Taylor, 1982) . Somatization Disorder generally begins before age thirty and evolves over a period of several years. This is why it is understandable that a client can complain of various symptoms which have become a way of life.

The criteria for somatization is well defined (APA, 1994), and must have been met, with individual symptoms occurring at some time during the duration of the disturbance: four pain symptoms; two gastrointestinal symptoms; one sexual symptom; one pseudoneurological symptom (APA, 1994). Quite often abuse patients who have attempted to repress abusive incidents will present with these specific complaints in variations. Hypnosis can be used to treat somatization disorder by helping the patient to make the connection between their symptoms and the underlying cause, enabling them to begin addressing the core issues (initial trauma unconsciously suppressed and translated into the bodily symptoms and types).

One theory is that people subconsciously turn emotional metaphors into physical sensations; the feeling that someone is a "pain in the neck" becomes a neck pain, back pain equals perceived lack of support, choking or asthma is perceived emotional smothering (Hay, 1982). Dramatic relief of asthma, specifically, has been observed following catharsis. The motor expressions of emotion, (i.e., laughing, weeping, and the acting out of

anger) proved to reduce symptoms and remove the oxygen deprivation which characterizes these clients (Laderman, 1991). This association can then become persistent and chronic. Anxiety can be understood in a sense as the emotional equivalent of physical pain. Several physical problems have been commonly associated with child abuse histories and include stomach pain, asthma, anorexia, muscle spasms, elevated blood pressure, and other complaints that have no identifiable biological etiology (Briere, 1992).

REPRESSION

The repression of memories has been a controversial subject for several years. As previously mentioned, memories are uniquely constructed by each individual based on their perception and life experiences. Memories are therefore not considered facts but truths for the individual. If the memories are not authentic, they could be due to fantasy, illusion, confabulation, or hallucination-mediated screen memories, internally derived as a defense mechanism making them very real for the person (Briere, 1992). Repression is thought to be the most basic defense mechanism because it is involved in all the other defense mechanisms. Repression is often referred to as psychogenic or dissociative amnesia. This defense mechanism is an unconscious avoidance of anxiety and distress resulting from a painful memory (Briere, 1992). Although reported amnesia is more likely in cases in which there is a history of early molestation onset, chronic long term abuse, and greater current symptomology, amnesia for abuse is a common phenomenon, as is childhood dissociation (Briere, 1992). The dissociative amnesia patient suffers from the inability to recall important personal information, usually of a traumatic or stressful nature (APA, 1994). Memories are repressed for many reasons as a defensive measure to protect the individual at the time of the incident**.** Severe memory problems are most likely in cases of abuse that began early in childhood and ended before adolescence (Briere, 1992). Cases of sadistic and/or violent abuse are most likely to be associated with massive repression as a defense (Briere, 1992). Repressed memories, or dissociative amnesia, is a confusing situation for the client. Repressed memories, like those which have not been repressed, are generally thought of as an individual's perception of an experience which may or may not be completely accurate or factual (Kepner, 1992).

Studies have shown that people abused by someone close to them, such as a family member, are more likely to forget the abusive episode/s.

These are the types of traumatic events that are most confusing for the client. In particular, sexual abuse by a stranger is more likely to be remembered (especially by a child) because it may have been a highly salient event--easily remembered because of its one-time occurrence, its frightening aspects, its novelty, and the probable family support one will gain after the assault. Abuse by a perpetrator known to the child is likely to combine elements of fear, betrayal, and conflict, which may cause confusion about the nature of the abuse and the client to experience difficulty with the memory of it (Briere, 1992). Abuse by a perpetrator known by the child is more likely to have occurred repeatedly and routinely, and memory may be hazy (Briere, 1992). For some of the abuse victims, having no recall of the abuse is based on more than just ordinary forgetting associated with the passage of time, their young age when abused, or lack of salience of the event (Briere, 1992). There are certain psychological mechanisms such as repression, dissociation, and depersonalization which are utilized as coping strategies by these victims. Current literature on adult survivors of child sexual abuse suggests that the aversiveness of the experience may lead some victims to engage in active strategies to avoid reminders of the traumatic events, and ultimately, memories of the event (Briere, 1992) . The passage of time can affect the strength and organization of memories (Wickramasekera, 1995).

Clients who perceived themselves as victims, whether in childhood or as an adult, quite often have no coping skills to resolve the feelings they hold onto or hold in. When they come to therapy it is important to identify the defense mechanisms most prominent in their past and present. When clients present with (subjectively perceived) abusive backgrounds, they commonly bring to therapy those same defense mechanisms. The core issues of shame, guilt, and abandonment can be elicited and then traced methodically back to early childhood (if not infantile) experiences.

Humans are creatures of habit and often seek the path of least resistance (homeostasis) in coping with daily life. It is much easier and safer to remain the same than to change any part of oneself or one's environment. Repetitive interpersonal themes may be repressed out of one's conscious awareness until a seemingly recurrent problem is identified. Core issues are an integral part of one's perceptual adaptation. Defense mechanisms, resulting from one's perception, can be traced back to the core issue initiation.

Core issue themes identified in single hypnotic psychotherapy sessions are illustrated in the following chapter. These themes are identified by the

subject and are recurring throughout their lives. Reprocessing and integration are achieved in the final narrative portion of the study.

METHOD

PARTICIPANTS

All participants are psychotherapists at the Masters' level. All participants enrolled in either a six day intensive training in hypnosis, or were engaged in the second year of a two year internship in hypnosis, all affiliated with the Wellness Institute, Seattle Washington**.** All participants had therefore accomplished the educational requirement of 40-50 hours of personal psychotherapy. None of the participants had undergone any hypnotic psychotherapy prior to this specific training. Participants were asked to volunteer in this research study and were fully informed as to what participation included. The study reported here relied on a sample of 10 subjects who underwent a previous hypnotic psychotherapy session. Within a 24 hour period of time after the session each was interviewed in a narrative therapy fashion regarding their total recall of the session. All ten participants presented different types of resistance, different backgrounds, and different types of problems.

The population utilized in this study consisted of 5 subjects from various areas in the United States and 5 subjects from South Africa. Total population consisted of 5 men and 5 women ranging in age from 40-53. Each subject completed a Release of Information Statement, and signed a Confidentiality agreement. Participation agreement and reporting was limited to the post-hypnotic recall of the previous hypnotic session which as we shall see**,** included direct illustrations of the common core issues shame, guilt, and abandonment. All ten of these patients were then interviewed in a Narrative Therapy style of telling their individual story and experience of the previous hypnotic psychotherapy session.

The length of time the clients were previously engaged in hypnosis classified them either as novice (0-2 previous sessions), or experienced (5 or more). A standardized script was used to induce hypnotic trances, although it was varied/customized somewhat to meet unique needs. Hypnotic psychotherapy is not a fixed therapeutic model, but one that is easily tailored to suit the clients' objective.

PROCEDURE

BASIC QUESTIONS:

This study asks the questions: (a) Are common core issues of abandonment, guilt and shame identified in a single hypnotherapy session? (b) Are core issues identified and associated with early childhood trauma ? (c) Is post-hypnotic trance successful in confirming the integration of decisions regarding the trance state material?

The client is informed of a safety signal that will allow them to both consciously and subconsciously stop (contain) the feelings they are experiencing if they want to. They are taught to put their hand up in the motion of a stop sign. If they would rather they can use a verbal signal saying "one, two, three, stop". These are added measures of support and safety for the therapeutic relationship. If the clients want, they can imagine viewing the scene on a movie screen which places as much distance as is needed to keep a safety barrier around their psyche a technique which is similar to techniques used in EMDR.

The hypnotic psychotherapy process generally takes an hour and a half because it is necessary first to interview the client and target the work to be done**.** The hypnotic psychotherapy process has several steps, including induction, generally an eye fixation exercise which then results in the patient gently closing their eyes as they begin to experience relaxation through their body as they continually scan themselves for physiological feelings. This then is followed by progressive muscle relaxation which is a deepening technique. This type of a technique results in an enhanced physiological awareness on a level they may not have cognitively experienced before. In using the induction technique one can individually tailor it to the patient's core, or problem area. If the patient presents with psychosomatic symptomology the progressive muscle technique might be more suitable than alternative induction techniques such as imagry. The deepening technique allows the patient to progressively release all their thoughts and cares, clearing their minds so that once they reach the lowest, or ground level they are as relaxed as they can be. This technique, when used regularly, will allow the patient to experience deeper levels of relaxation each time they practice it. This is the point in which experienced dissociative disordered clients begin to meld the mind and body so they can tell their bodies that they are not there at all and focus solely on the relaxation.

The client is initially interviewed and the focus of the therapy is discussed and chosen. The technique of associating is begun at this point: the reconstruction of the clients' memories beginning with the most recent time they felt the chief complaint, be it the urge to smoke a cigarette or the

panic and terror of being beaten or molested. The recognition and identification of the feeling that triggers the memory (anger, fear, guilt, shame, loneliness, hurt,) is then re-experienced. Similar to the procedure used in EMDR, it can be useful to direct the client to physically press a finger into the location of the body sensation. These sensations may be associated to the emotional tension the client holds onto or holds in such as the pain in the neck, the gut feeling, or increased blood pressure. Prounounced physical sensations can be associated with negative cognitions. Commonly a person will experience a sinking feeling in their stomach, or a tightness in their chest. People generally locate an uneasy feeling in the torso area of their body while assessing physiologically**.** Increased pressure will often cause the emergence of an image or thought about an associated memory, which should then be targeted (Shapiro, 1995). The patient is then encouraged to describe the situation they are experiencing and will be able to locate a point in their body (often the stomach) from which the feeling stems. They can at this point evaluate the strength of the feeling and begin to narrow the focus to the maximum feeling experience. In keeping with the progressive style of hypnosis, if the client evaluates the feeling at or below the mid-point of the scale (1-10 the latter being the greatest), they can be guided to increase the target emotion using a correlated counting technique. This is referred to as a Subjective Unit of Disturbance (SUD) created by Wolpe, (1991). As the therapist counts from one up, the feeling increases until the patient experiences what will be their maximum at that time. The client is then directed to release and express the feeling using various techniques such as yelling or speaking into a pillow, punching outward, or hitting a punching bag with a small piece of rubber hose. This cathartic flooding of emotion brings an insight as to the strength and location of the feeling which has been denied, repressed, or masked. This technique narrows the focus to the "here and now" and the awareness of the unconscious progressive retention of the feeling, thus the thought or psychosomatic symptom. The client is directed to focus their awareness "on" the feeling and assess its strength. Once this has taken place the client is then guided progressively backward through similar situations until they reach the earliest time they experienced the feeling. This reoccurring abreacting or catharting allows the client to identify the origin of the feeling and express it in various ways. As the catharsis occurs the ego strengthening can be progressively increased by exchanging negative beliefs for positive beliefs**.** The negative belief/cognition represents the client's present self interpretation such as; I

am bad/ I won't ever succeed. Positive belief/cognition would ideally be the opposite of the negative; I am a good person and deserve to be successful. This will allow the client to gain a more adaptive mature perceptual self interpretation. The client is then readily able to reprocess the situation and challenge their past belief about being victimized and shift the responsibility for the act or trauma to the appropriate place or person. They are directed through progressive extinction to release the intense feeling and replace it with a feeling of love, relaxation, and positive affirmations. Intense feelings are experienced when triggered by a memory and anchored.

"A stimulus which is linked to and triggers a physiological state is called an anchor in Neuro-Linguistic Programing" (NLP), (O'Connor & Seymour, 1990). Our minds automatically link experiences, it is the way we give meaning to what we do. There are several types of sensory triggers that anchor feelings. A positive visual trigger would be a favorite photo which has anchored a specific feeling. A negative auditory trigger might be a police siren behind you. An anchor can be anything that accesses an emotional state.

The client is taught to anchor this positive feeling (similar to NLP) in the final step as a replacement for the initial negative feeling/belief. This is done by bringing together a finger and thumb or by making a fist in a specific way. The client should be given positive affirmations such as "Whenever you experience this feeling you can automatically come back to this peaceful state just by," using the anchoring technique. This process of cathartic flooding may bring insight into the core issue, initial experience.

New, more adaptive coping is experienced by the client as they reprocess their core issue/s, and then utilized upon completion of the initial session. The client is able to acknowledge their feelings and beliefs and re-evaluate the rationale behind them. The ego strengthening at various stages throughout the session enables the client to consciously adopt new personality constructs while challenging the old. The progressive emergence of the adult perspective replaces the earliler, often childhood perspective. Several therapeutic interventions are utilized during the hypno-behavioral session and they include: Gestalt (to experience how it is to relate with the present mature adult ego strength), Transactional Analysis (Adult, Parent, Child), Guided imagery (induction), relaxation, and Cognitive Behavioral (affirmation suggestions).

Hypnotic psychotherapy used in this study has been performed using one standard script and incorporating three specific traditional

(Transactional Analysis, Gestalt, Cognitive/Behavioral) psychotherapeutic interventions. Following specific steps, varying somewhat from one client to the next, can provide a safe, quick, and controllable approach to the core issues most common to these clients. The script for the therapy sessions' has approximately one dozen steps that are performed in a sequential fashion as follows: 1). Hypnosis induction utilizing an eye fixation on the ceiling or the wall. This technique utilizes the direct suggestion after fixation of: "Just allow your eyelids to close down now and let yourself go deeper and deeper into relaxation." 2). Deepening technique: This step is an indirect suggestion. Most hypnotherapists (as done here) give the client an open personal choice. The suggestion is as follows: "Imagine yourself now on the top of a gently rolling hill overlooking the ocean or a meadow, or perhaps you are at the top of a staircase with ten levels to reach the ground. Just allow yourself to create and experience a safe place. A safe place is, in a sense, elicitation of dissociation. The safe place is a personal fantasy refuge that creates a feeling of calm and safety.

Occasionally a client will have difficulties imagining a safe place and can be prompted to imagine their own "Garden of Eden". Once the person accesses an image they are directed to anchor the feeling by touching two fingers on one hand together. The direct suggestion is given "Anytime you feel scared or alone you can once again come to this place; this will be your favorite place". Just touch these two fingers together and close your eyes and get in touch with this feeling." The client then goes on to describe their scene and is prompted to smell the smells, hear the sounds, feel the breeze or mist which allows them to incorporate all senses, making it as vivid as possible. The client is then guided deeper into the trance-state by descending one level at a time until they reach the last level. At each level sensory guidance is given, i.e., "You're on the eighth level now, almost down, and once you get to the last level you will be completely relaxed. The mist is thicker now, or the leaves on the trees are clearer now." 3). The third step is a direct suggestion of: "Go back to the most recent time you felt _____ (anxiety, fear, panic) and get in touch with that situation or image." This is the initial target and reason the client sought treatment**.** The client is then asked to raise a finger when something comes to them, a feeling or an image. 4). This fourth step is the description by the client of the feeling produced from the image. The client is asked to describe the situation and what the feeling is. 5). The client is asked if there are physical sensations accompanying the emotions and if so to please locate where they experience the sensations with the indirect suggestion of "Possibly it

is in your stomach, or back." 6). The client is then asked to assess the strength of the feeling on a SUD's from 1-10, the latter being the greatest. 7). Depending on the strength of the feeling the client is then directed either through a strengthening exercise or an expression exercise. If the feeling is 5 or less, the therapist uses a counting step-wise exercise guiding the client through sensory imagery to evoke state-dependant memories. With each number 1-5 as the client progresses up, the feeling increases until they have moved up into the top 3 (8-10). The client is then given the direct suggestion of "Give the feeling a voice, or a color or shape." If they give the feeling a voice it is helpful to allow them to verbally express their feelings into a pillow (therapist places small pillow in client's hands). This gives the client an opportunity to induce the cathartic experience. The client is allowed to express all these powerful feelings and say whatever they needed to and could not at the time of the initial traumatic incident. This particular step may include the use of either a hitting device (a small piece of hose or a pillow) to hit either a small punching bag placed in front of them or hit the floor or couch with the pillow. The client is asked to kneel, with eyes closed, and are guided through the exercise initially. This allows the client to move the feeling out of their body, work through it in a holistic fashion. 9). The client is then primed for age regressions to similar situations that elicit the same feeling. The client is then given the direct suggestion (upon lying back down on the mat or couch) to return to (in their mind) an earlier time when they felt___powerless (generally abuse related). The client is progressed back with indirect suggestions such as, "Feel yourself getting younger and younger, allow yourself to go back to one of the first times in your life you felt___powerless." When the client accesses an image or feeling they raise a finger for the therapist to see. 10). This action indicates the client is hallucinating and helps confirm the trance state**.** After two or three regressions to state-dependent experiences, catharting each time**,** the client is asked to return to the initial source of the feeling, the first time they felt___powerless. 11). Once again the client is asked to express the feeling by hitting or yelling and taking the power of the situation into their own control, which often includes crying during this abreaction. The client is generally feeling younger and powerless, and the therapist should validate their feelings. They are then given the direct suggestion to see how they were at that place and to say or do whatever they needed to then at this time. This is the exchange of negative cognitive affect for positive powerful cognitive affect. They can have a conversation if they want and tell the person now how they felt. By using their voice and

speaking what feels true for them, the client is able to emote old feelings while establishing new ego strength**.** This type of ego-strengthening enables them to begin reframing painful feelings, thoughts, and beliefs. 12). An indirect suggestion is given for the client to get in touch with any person in their life that exemplifies a strong, competent, healthy adult. This may be a grandparent, teacher or minister, "You don't have to think about it, just allow an image of the person to come to you". If there were no role models for them to imagine they are guided to utilize their own internal parent or adult self. The client is now given direct suggestions to allow the person to nurture them the way they would have liked it at the time. They are then given the indirect suggestion to feel or sense or visualize the adult within in them. They are provided a small stuffed toy as a surrogate (inner child) self and they are directed to parent it or tell it that it is now safe and will never have to feel that way again. Extinguishing the old feeling and replacing it with love and understanding the client can experience the new feeling. They are then given an affirmation statement, (i.e., I am a wonderful, lovable person and deserve to be loved)**.** This new feeling is then anchored by directing the client to touch their fingers together or place a hand on one of their thighs. The negative feeling is reduced using the same progressive counting procedure of increasing with each number the feeling will progressively decrease. 13). This then becomes the reorientation phase bringing the client back to the here and now as they begin to hear the sounds around them, and the therapist count up to number five when they are wide awake, refreshed, and relaxed.

SETTING

Settings are Seattle, Washington, and Cape Town, South Africa. Total number of subjects in Cape Town, South Africa were 8, five of whom were randomly selected. Total number of subjects in Seattle, Washington were 16, five of whom were selected. All subjects had initially applied and were accepted for a six-day training or a two-year internship in hypnotherapy.

Post-hypnotic narrative therapy sessions are individual with the client and the researcher only in a secluded therapeutic setting utilizing the same narrative therapeutic style. All clients were engaged in the post-trance within a 24-hour period of time after the session and some were interviewed within an hour. This allows the client to access more readily the previous hypnotic psychotherapy session. Continued processing can take place for several days to weeks after the session. The client, not unlike

those in more traditional psychotherapy, continues to assess and challenge their beliefs.

APPARATUS

All hypnotherapy sessions utilized the same tools and equipment which consisted of a mat or couch to lay on, two pillows, one blanket and a stuffed toy for inner child nurturing work. A large throw pillow or small punching bag is placed at the client's head, which may be struck by an 8" hose if and when the client moves into that particular healing area. Background instrumental music is played on one small tape recorder at the beginning of the sessions as an induction aid. Auditory recording of this initial induction and of the closing affirmative portion of the session can be done as an aid to both therapist and client. Positive affirmation ("I am better and happier every day") closing is the rule for each session, similar to Coue, (1923), and with each client so that they can then take the recording from the session and review it at their convenience. The tape will have the beginning of the session and the closing only. This enables the client to review the exchange of the negative for the positive and reflect on their newly anchored feelings.

ANALYSIS OF RESULTS

MULTIPLE CASE STUDY APPROACH

The following case material is presented since it so clearly offers a modus operandi in hypnotherapy with a type of client who has had a long experience in failing to derive desired results from traditionally-oriented therapy. In each instance post-hypnotic narrative therapy was used for the specific purpose of allowing the client to further integrate the previous hypnotic insights and positive cognitions. The subject relates their Hypno-Behavioral therapy session story as completely as they can.

The induction of hypnotic states and phenomena is primarily a matter of communication of ideas and the elicitation of trains of thought and associations within the client with consequent behavior responses. To judge the depth of the trance and hypnotic responses, consideration must be given not only to average responses but also to the deviations from the average that may have been manifested by an individual (Haley 1973). Some clients can develop dissociation and depersonalization states rapidly while others take several sessions (Haley, 1973). This was seen in the narrations of the participants, as was dissociative amnesia. All participants in this research identified areas where there was a lack of memory and

displayed dissociative traits in their search for recall. All participants identified emotional core issues of abandonment, guilt, and/or shame in the post-hypnotic narrative therapy recall. Coping strategy of dissociative amnesia was observed in the post-hypnotic narrative therapy session for part of the session by each participant. The state-dependent memory retrieval may have been involved in the reconstruction/recall. This dissociative phenomena is common amongst traumatized persons as reported by van der Kolk,(1989).

The individual cases had similarities in the target approach, script, and therapeutic techniques. There were differences in sessions that included in-vivo (tub) setting, and variations in the procedure (one session involving a couple). The narrative therapy recall sessions were conducted exactly alike and were all audio recorded verbatim within a 24 hour period after their hypnotic psychotherapy session.

RESULTS

CASE ILLUSTRATIONS

Case Illustration #1: Ms. M. is a 52 year old single white female from the U.S. Ms. M was a participant in a two year Hypno-Behavioral Internship.

Presenting Problem/Chief Complaint:

Ms. M. presented with severe anxiety to immersing her face in water which prevents her from participating in numerous activities. The onset of problem upon presentation was not known and prior panic attacks were of a similar theme. Ms. M. requested to undergo a regression session to her birthing process utilizing a hot tub self-hypnosis technique whereby she uses a snorkel, and a nasal blocker fitting over the bridge of her nose. It was decided to use hypnosis along with in vivo exposure to water. Ms. M. had experienced a severe car accident in which she underwent numerous emergency life saving procedures one of which resulted in trauma to her head and mouth area.

Specifics Regarding the Induction Technique:

Ms. M. was directed into the hot tub accompanied by this researcher for this study. Ms. M. entered the hot tub without any notable anxiety and was without hesitation in donning the equipment. Ms. M. began to experience panic and anxiety as she initially bent at the waist and submerged her face while focusing on attaining a trance state. Ms. M. immediately began experiencing panic as her trance state depened. Ms. M. was able to achieve a level of 8 on the SUD scale within a three-minute

period of time in which she immersed her face five times. Ms. M.s' initial memory (while in trance) was of being in a hospital crisis and experiencing the noise of the pumps and life support equipment that had surrounded her at the time. She underwent sensory flooding which brought the immediate recall and body memories of the trauma of the car accident.

Verbatum Narrative Therapy Post-Hypnotic Interview :

"I was having a hard time with closing my mouth tight enough around the snorkel and it tasted like blood and I clamped down tighter and felt pain. I tried to take a deeper breath and I felt the restriction of the nose plug. Everytime I tried to desensitize it, it became a stronger and stronger sensation. At one point I was being flooded by the pieces in my throat, (recall of her teeth being broken during the emergency procedure) pain of being suffocated. What flashed for me was kind of like I'm all alone, Oh God, and then I hear a ' yes' and that was the entire piece." Ms. M. then described a feeling of being dissociated into a floating state, and finally reached a state of release and relaxation. "I felt my face back in the water and I took a breath, I was trying to count on my fingers and regulate the breath. I thought if I was talking it would interrupt, I began to feel comfortable and safe and I began to hear my mother laugh. I had some sensation of a comfort zone and accomplishment and then my jaws relaxed and I heard my mother laughing and her voice saying that will teach you a lesson. And after that I was not interested in putting my face in the water anymore. The memory and the experience was complete just to the point of choking, I can't remember if she picked me up or not. I was throwing a temper tantrum in the kitchen sink getting a bath and my face went under I must have inhaled water, so obviously I cried. I couldn't get up out of it so my sitting-up skills must not have been too good. She quit caring for me at 9 months old, I was hospitalized for failure to thrive because I had quit eating due to being stubborn. The fear of punishment is always there, asking to have my needs met, and me caring for myself ".

Discussion:

The client demonstrated dissociation as she realized the experiences of panic in and around the choking issue, but was unable to recall the remaining content of the session. She was able to get in touch with her abandonment and shame issues regarding her mother and an experience she had in the sink in the presence of her mother who let her slip into the water and accidentally gulp a mouthful down. The insight due to cathartic flooding regarding the car accident at the initial onset of the trance enabled Ms. M. to recreate and reframe her phobic reaction to water. Ms. M.

displayed dissociative amnesia which may have resulted from her traumatic experiences (subjectively perceived). She was successful in evoking possibly the initial trauma at 9 months old, which likely contributed to her core emotional issues of abandonment, and shame. Ms. M. was clear as to her cognitive integration of the material in the post-hypnotic narrative therapy session. The one statement in the post session that confirmed this was: "The fear of punishment is always there, asking to have my needs met, and me caring for myself." Ms. M. is continually aware of the core issues at this point and consciously identifies them.

Case Illustration #2: Ms. R. is a 51 year-old married white female from the U.S. Ms. R. was a participant in the two-year Hypno-Behavioral Internship and was experienced (5 or more previous hypnosis sessions).

Presenting Problem/Chief Complaint:

Ms. R. initially came in knowing she had a phobia to water which made her uncomfortable. She was unsure why she had a phobia to water and wanted to explore any possible causes to include regression to the earliest trauma issue regarding water. It was decided to use hypnosis with in-vivo exposure to water due to her previous experience.

Specifics Regarding the Induction Techniques:

Ms. R. chose to do her work in a bathtub, with a target of regressing back to her birth state. She began with a mild panic because she did not want her face in the water. She utilized a snorkel two or three times for brief periods. However, she chose simply to lay on her back with the water covering her ears for stimulus control.

Verbatum Narrative Therapy Post-Hypnotic Interview:

"I allowed myself to float in the water and it began to feel like the amniotic fluid, and I began to relax. My first feeling was that I was aware of a sadness, an emptiness, and a darkness about it. I was in a sad state for some time, I don't know how long, when I had an urge to get out of the amniotic fluid and be born. I felt my mother's feelings of just seeing me but not being happy to have me, and her shame. At first I saw my father, he had a little smile on his face out of the corner of his mouth. This is the man that later told me that I was an accident and then he spent the rest of his life drinking to get numb. They counted my fingers and my toes to see if they were all there, that seemed like a big deal to them. I had more feelings of sadness, isolation and emptiness, and tears. Never realizing my mother's love, her nonexistent love rather, her shame. After being born I felt a sense of release of relaxation and then felt sadness again at the fact nobody

wanted to hold me. I can't remember for certain how the session ended. I think after I was born and experienced those feelings I described I was done, and born but I don't remember the end. When I emerged from the womb the therapist was there with a warm towel and comforted me. It was at that time that I realized that I was separate from my mother and that her shame in getting pregnant before getting married and being in the predicament as a Catholic girl belonged to her not me. Words are inadequate in describing the feeling of separation. It is my belief that the experience of being in a wet birthing situation provided a barrier between my mother and I that I could psychologically feel and experience. Before I was feeling isolated and lonely because of leaving the group setting early, and later rejoining along with other group involvement I was unsure of. And now I feel very much at peace, re-connected to myself and the others even though my experience of re-birthing (regression through hypnosis backwards to the birth state) in the bathtub isolated me from the others. The feeling at this point is peace, tranquillity, and relaxation".

Discussion:

Ms. R. was able to identify abandonment, guilt and shame regarding her birth as a result of her cathartic flooding in the bathtub. Through yelling into the water, Ms. R. was able to release the anger she was carrying toward her parents. Ms. R. was able to feel pleasure at being born and recognized the role she feels she plays in life. Ms. R. was able to reframe the initial trauma using Gestalt (hitting and yelling), Transactional Analysis (re-parenting), and Cognitive Behavioral (exchanging negative for positive cognitions) techniques. Ms. R. was successful in identifying her initial core issue development issues and identifies the recurrent theme in her present living. Her integration was presented in a clear statement of "I feel very much at peace, re-connected to myself and the others."

Case Illustration #3: Ms. S. is a 52 year-old single white female from the U.S. Ms. S. was a participant in the two-year hypnosis internship and had had 5 or more previous sessions.

Presenting Problem/Chief Complaint:

Ms. S. initially came in for relationship problems with her present boyfriend, also from the U.S. Although the two lived apart they were at the time seeing each other on a regular basis. Mr. A is a single 48- year old Asian American who presented with the initial complaint/problem of Ms. S cutting up food on his counter beside his sink. Ms. S presented with the concern that Mr. A. would not allow her to care for him in the nurturing

fashion she would like. She claimed he would not let her do his dishes or fold his clothes. The two could not understand why these seemingly small issues had such an impact on their relationship or if they were even issues that needed to be explored. They specifically requested a couple's hypnotic psychotherapy session which was conducted by the instructor of the training in front of the intern group.

Specifics Regarding the Induction Techniques:

The induction was approximately five minutes long utilizing the image of an elevator going down to the bottom floor. The researcher observed the therapist sitting between Ms. S. and Mr. A. who were lying on mats on the floor approximately one arm length away from the therapist. Once the induction was complete both people were asked to imagine themselves in the most peaceful place they could imagine and experience it as fully as possible using every sense. The therapist then whispered in Ms. S' ear that she was to stay in her safe place while the focus was on Mr. A. Mr. A. was then guided through the most recent time he got upset with Ms. S cutting up food on the specific counter. Mr. A. automatically began to experience the feeling and explained what he was experiencing. He was then guided back to a more distant, similar experience. He went through several cathartic flooding periods, and eventually went back to losing his best friend and feeling helpless and not receiving the understanding, support, and nurturing he needed at that time. He was then guided back to the earliest time he felt this feeling of helplessness and abandonment. He then experienced being quite young the first time he had these feelings. He was able to do some work on this using Gestalt therapy, using the hose to release anger. He was then guided to use Transactional Analysis and access his adult self to comfort his inner child. Once this was accomplished he was then guided back to his imaginary safe place and asked to remain there while the focus switched to Ms. S.

Ms. S. was then asked to experience the most recent time she wanted to do something for Mr. A. and was not allowed to. She was able to regress back to experience and release some of the anger using Gestalt therapy (hitting the hose on the punching bag). She then was progressively regressed through several similar experiences and was guided in releasing anger and hurt. Ms. S. was able to regress all the way back to her early childhood when her mother removed her from her little brother due to the fact that she had whooping cough. "My mother took away my earliest male love object." Ms. S. was able to make the connection that she wanted to nurture her little brother and was denied the opportunity and it felt much

the same as the present relationship experience. She felt that Mr. A. was blocking her need to nurture and care for him and she was experiencing a loss of a part of herself, an emotional cutoff to a certain extent. She felt emotionally cut-off due to never processing her feelings with her family members. Ms. S. continually expelled unwanted defense mechanisms through this cathartic flooding and was able to reparent herself utilizing Transactional-Analysis techniques. She was then guided into her safe place and for a few minutes of further relaxation was guided. The two were then asked to allow the energy to build and fill themselves and come slowly back to the room and acknowledge on a sensory level the here and now. They upon return embraced each other and discussed the session and the closeness of their issues. Mr. A. stated that he had apparently chosen, subconsciously at that time to stop needing, and not to expect or allow anyone to help him. Approximately an hour later Ms. S. and this researcher conducted the Narrative Therapy post-hypnotic interview.

Verbatum Narrative Therapy Post-Hypnotic Interview:

" I wish the induction had lasted a little longer and been a little slower. It was an elevator going down but there wasn't enough calm and relax statements. I didn't get to go where I wanted to and I found it distracting. I held on to some of the anxiety about doing the session and I was distracted by some outside stimulation as well. I must have gotten past that but I don't remember what was the button that got me to the place of the relationship issue and I remembered that I may never get another chance like this. Interestingly I had the memory of my brother. Maybe Freudian, the connection between my being threatened by Mr. A's ex-wife and how he described her as very critical, he could never please her, and tried continually, like my mother. She was in a kind of anxiety fear situation and that was why she took away my earliest male love object, my little brother. She took him away when I got whooping cough. This was where I had the feeling of Mr. A blocking my need to nurture him and feeling that loss again, and with my son when he died. Part of it may be connected to Mr. A's expectation of the relationship and formalizing it. It probably ties in with his fear about possible loss, our losses interplay with each other. I remember hearing him cry, but it didn't seem like very much or very long. I remember him saying that using the hose felt violent to him and I honestly can't remember where it went from there. I remember holding his hand as we returned but I can't remember why I was holding his hand. I really don't remember the session ending, other than a sense of the anxiety

never went away, I carried it in my body all through the session. Then sitting there when Mr. A. and I hugged each other I was able to release it".

Discussion:

Ms. S. was able to identify the core issues of abandonment and shame regarding a period of time in her early childhood when she was denied the opportunity to nurture her younger brother. Ms. S. was able to reframe the feelings into a cognitive understanding and was able to identify the abandonment feelings and further integrate her knew insight in the post-hypnotic trance. Ms. S. was successful in identifying a recurrent theme in her present living. She was successful in regressing back to her early childhood to identify the onset of the initial core emotional issues of abandonment and shame.

Case Illustration #4: Mr. G. 37 year-old South African white male. Mr. G. is considered a transient (0-2 previous hypnotic sessions) participant.

Presenting Problem/Chief Complaint:

Mr. G. had been taking an anti-depressant medication for his adjustment difficulties with his wife. He missed being with his family and did not understand what he could do.

Verbatum Narrative Therapy Post-Hypnotic Interview:

"The induction was good, I kept wondering if I was really under hypnosis. Once I went deeper and found my favorite place a bright vision of a place came to me, it took some relaxation to really get there. The deepening did work to a certain extent. I started working on first feeling of my wife's reaction toward me and me feeling abandoned and alone, then we tried to deal with that but I felt that wasn't the point. In age regression at least we established the problem was I felt I had to keep performing (next to the bed) wondering if I'm good enough, and I regressed to about age one. My mother was putting on diapers for my brother and sister and I didn't need the diaper, I was without needs. This is linked to the fact that I was always trying to be better and stronger, you give all the time and become a rescuer. Some of the people around me grew to resent that. And it comes out in my marriage and my wife plays the victim game. I couldn't understand what this was, I know now where it started. I don't resent my parents, I can survive without fulfilling my needs. Had its positive effects but keeps causing me to land in the same situation, protect too much. I begin to lose out and feel inadequate. Extinguishing was great, getting in touch with the inner child inside, to be able to protect that child. One of the

things I'm doing is dissociating from the situation. I was not able to identify any core issues in regular talk therapy, but the victim had been identified in marriage therapy as my wife. I'm taking a medication for depression, I've been depressed for possibly two years. Now there is a major change, I don't need to continue the medication."

Discussion:

Mr. G. was able to revive his cathartic flooding regarding abandonment and guilt and was able to reframe them to his present circumstances. Mr. G. was able to reframe them in the post-hypnotic trance by reviewing the decisions he had made in the trance-state. Mr. G. admitted he was extremely tired after the hypnosis session and now the post-hypnotic processing. Mr. G. was successful in regressing to age one and identifying the onset of his emotional core issues of abandonment, shame, and guilt. His term "extinguishing" was the cognitive reprocessing of early childhood decisions and feelings of self from negative to positive.

Case Illustration #5: Ms. N. 35 year-old married white South African female. Ms. N. has had previous therapy for one year in college. Throughout her therapy she was unable to get in touch with her " core issues ". Ms. N. had one session of EMDR therapy two years ago with the same reported experience as hypnosis, that of cathartic flooding and insights. She is considered a novice (0-2 previous hypnosis sessions) participant.

Presenting Problem/Chief Complaint:

Ms. N. presented with the inability to tolerate hearing her own voice and continued to feel deformed and ugly since birth as she was born with a hair lip and cleft palate. Ms. N. self reported she was afraid of life. Ms. N. had a series of surgeries throughout her childhood beginning at age three and ending at age 16. She also underwent extensive speech therapy which began at age 1 and continued until she was 7. The maxillofacial surgeon removed a piece of her hip and some of her skin for grafting/reconstruction of her face. At this time she has good function except for one nostril which will never be functional but was constructed for cosmetic purposes. Ms. N. chose to work on her fragmented/dissociation and fear.

Verbatum Narrative Therapy Post-Hypnotic Interview:

" I was able to identify core issues in the first session, and I feel physically changed, more at peace, a relief, grounded at this time. The physical shame issue, got into touch with that. It was a good opportunity to take time off and I blocked out previous issues, I thought they were

resolved. We started off about my feelings and ability to say no and how tired and exhausted I was. I regressed to eight years-old when the kids laughed at me. I had dreamt about going to Japan and I thought it was real, and all the kids laughed at me and it made me angry and sad. I pushed one little boy down and he hurt his head, I didn't know I had that anger. Not quite sure why I was lying. I then regressed to about 3or 4 months old and grew to 3 or 4 years old. I was tied up to a hospital bed and hearing the babies and feeling scared and alone and the incredible pain and being so scared and so lonely. The physical side, I'm really scared of cars, speed, I'm scared of life. I think that where all that came from, the anger, lashing out, and I gave to people what I needed, tired, angry, sad, mixed feelings in one flow. The inner child was really good when I could calm down and do the inner child work. I believe I went through a lot of needing as a child, inside I still felt abnormal and I never integrated that turmoil. I had strong physical feelings, I felt my face, it was really so sore, I get quite anxious, it is so scary. My accident, my brother died in 1994 and one year later to the day I had a bad car accident, the car landed on me and I never cried out. I never speak, I never speak out. I don't like hearing my own voice, the good and bad from inside. I split myself on a physical level, good and bad. The Japan dream, I wanted to share that with my friends, even then I stopped talking to people so I'd rather not talk when I was little I had an imaginary friend. I met him studying in Pretoria alone in my flat where I could see him and experience him, I thought I was losing my head. I tend to go into my head and not with my emotions. Today's session, I'm scared to keep the intensity, I need to work on my fear and I'm not very comfortable with me. I know one session is not enough, I don't believe people telling me I'm beautiful, I still feel deformed. Core issues of guilt, shame, and abandonment, reoccurring all the time, I'm always fearful. No compassion during time of pain when I was young. I'd pray for the day my mom would come, I had separation anxiety, but she still went. She would give me a token, a hanky with her perfume, I could smell her. Since I was a little child I knew she'd come back. The age of my first surgery for hair lip and cleft palate was at 3 months of age and the final was at age 16, due to the development of the face bones they had to wait. The used part of my hip bone and skin to build up my face. I had extensive speech therapy, always struggling with school. I had speech twice a week began at age 1 to age 7. I developed an eating disorder as well that became anorexia in 1988, and went to bulimia without purging, I still eat when I'm anxious".

Discussion:

This woman was able to identify for herself a constellation of core issues which consists of abandonment, guilt, and shame. She was able, through hypnosis, to regress back to 3-4 months old and then to 3-4 years old. She had quit talking to people out of fear of abandonment and at that age she made the decision she did not feel she deserved the support and nurturing the other babies/children got. She was and still is to a certain extent dissociated from her inner most feelings. She was quite successful at imagining the perfect friend that would be there, comfort her, in her lowest times. She confided that she felt that God had abandoned her as well, and that she was unsure how to integrate the entire content of the session. This woman was then asked to re-assess her early decisions about people and God and to decide if they still served her. She was able to identify the anger and hurt she had felt toward her friends and mother and she was able to release it using Gestalt techniques (hitting down with the hose on the punching bag). She realized that she still felt shame for being born with a hair lip and cleft palate, which she thought prior to this session she had worked through. The one cathartic experience that was the most profound was her ability to recognize she never cried out for help, she never reached out, due to fear. This patient is now able to tolerate hearing her own voice, after the one session**,** and can ask for help from those she loves (husband and parents) when she needs to. She had become so accustomed to choking back her words and feelings that when she got in touch with them she was amazed**.** She was relieved to be able to re-parent her inner child and felt grounded due to the comfort she had obtained within herself. Ms. N. has recognized that she has a shadow self that is not uncommon, or different from other people. She realized that her splitting the good and bad was an early childhood coping mechanism.

Ms. N. still has work to be done on integrating the cognitive and physical conflict of her self-identity but she did gain insight that was helpful for her whole self.

Case Illustration #6: Mr. D. is a 45 year-old married white male, from the U.S. Mr. D. has had numerous previous hypnotherapy sessions (5-10) and was a participant in a two year Internship.

Presenting Problem/Chief Complaint:

Mr. D. chose to work on the feeling he has of being invisible, not being heard or understood. This was identified by Mr. D. as a recurrent theme is his life with his family of origin.

Verbatum Narrative Therapy Post-Hypnotic Interview**:**

Recall conducted approximately 30 minutes after the hypnotic psychotherapy session.

"I told you about being/feeling invisible and the impostor syndrome I felt growing up in my family. I remember starting to rock back and forth on my knees and hands to get the energy going. I laid down and began screaming into the pillow, I remember looking for my feelings and not being able to locate what was happening right away. I remember then the feeling of my parents, especially my mother always telling me to turn my music off, and questioning my study habits. I remember yelling shut-up to her, what I had wanted to do all along. The session was more like a flooding of emotion, it brought me to another sense of watching myself and a sense of being outside looking in and experiencing it. Also facing the problem, allowing myself to be vulnerable with other people. The end part (role playing) was going from person to person telling them what I needed to tell people in original incidents, and making statements of affirmation in a sense. The energy release was very important because that was where I felt the discomfort, even after speaking to the people. My statements started out weak and ended up strong. I wanted from them to be heard. That was the therapeutic restructuring of it, a sense of not realizing anything you didn't already know, it's just familiar. A willing sense of being in control, having a new experience of asking is something I wouldn't normally ask for, or have an opportunity to ask for the safety of being understood and having it given. Normally I wouldn't be in the emotional state to request what was coming out of me. I began with the ideas to surrender to the process and to begin with having a trusting state".

Discussion**:**

Mr. D. was successful in identifying his emotional core issues of abandonment, guilt and shame. These issues regarding his family of origin resulted in a life-long theme that he emotionally carried with him of not being heard or understood. He was able to revive the cathartic feeling in the narration of the session and his seemingly increased self-esteem enabled him to want to be heard and understood. Mr.D. was successful in and was able through Transactional Analysis and Gestalt techniques to release the negative feelings and assume the positive as an adult fully capable of asking for what he needed.

Case Illustration #7: Ms. M. is a 32 year-old white female, born and raised in South Africa. She is considered a novice (0-2 previous sessions) participant.

Presenting Problem/Chief Complaint:

Ms. M. chose to work on her low self-esteem and continual comparison of self and others.

Verbatum Narrative Therapy Post-Hypnotic Interview:

"I started off feeling blocked, feeling different from others, and I moved back in regression. It came out that my first experience was at age 10 or 11 maybe younger. Three school-mates, young girls and they didn't want to play with me. I couldn't understand why and felt hurt surrounding that. I moved back to about three-years-old and saw myself and my two older sisters playing, one is eight-years-old and one is five-years-older. Not that much older. Playing together but I was always younger and they related to one another, forever. Pattern (theme**)** through my life. I kept forever trying to show them that I was just as big, on their level as they are. And that influenced my life, trying to be the best, I'm not satisfied. I'm always trying to be equal. I knew about the situations before but I felt I'd already dealt with it cognitively. I didn't know there was so much emotion. And since then I can see things falling into place, I still have to remind myself I don't have to try so hard now, it's not like I was rejected. I always got the message that; what would you know, you're too young. I had a lovely relationship with my parents. No problem, loving and accepting. I perceived it that we were loved the same, no competition for love. No other age regressions. It's okay I can stop running after them and when I reach the end they shift. And when I reach this point I got tired of running. I was the one that went different places and established myself. I always felt the youngest even in school. My birthday is November and that contributed to feeling the youngest. Just have to remind myself I'm not the youngest. I brought in my adult self to reassure me that I'm fine. So much pain involved it helped to console the child [her inner child]. I could see the script going through and it made so much sense. I held emotion in my shoulders and I did notice the difference when it lifted and I felt light as a feather. The effect of that emotion, I felt as if my arms were wings"

Discussion:

Ms. M. was able to confirm her feelings allowing further integration her accomplishments and the driving force behind them. She was able to identify the abandonment of her sisters and how it was a pattern in her life, although she failed to identify it as abandonment at the point of the feeling. She was further able to recognize the shame she felt for being small and the guilt coupled with it in her perception for not measuring up or being recognized as being equal. She was successful in identifying these early

childhood emotional core issues of abandonment, guilt, and shame and may be able to discontinue the theme in her present life.

Case Illustration #8: Ms. Y. is a 31-year-old white woman born and raised in South Africa. She is considered a novice (0-2 previous hypnosis sessions) participant. Her previous therapy consisted of two years utilizing Transactional Analysis.

Presenting Problem/Chief Complaint:

Ms. Y. was able to recognize that with a brother fourteen-years older and one four years younger and a couple of foster siblings she had some abandonment issues. She chose to work with the tension she held in her back and neck regarding her family of origin.

Verbatum Narrative Therapy Post-Hypnotic Interview:

"I was working with tension in my shoulders, neck, and soreness across my head. I was working with hurt, I regressed back to age 13 or 14 I ran away from home. My mom had passed out, she was drunk and my dad and brother were trying to stop me. I was feeling really lonely and then I got feelings around my mother and I felt cheap. Then I regressed to 8-years-old feelings about my mom. She had thrown things at my dad. Threw a vase at my dad and it hit my arm and cut me, I felt abandoned and betrayed, she was then loving me and bandaging my arm. I felt I couldn't move and realized I felt abandoned by my father and it hooks into my sexual stuff with my husband. I knew it was temporary, and when I moved out he didn't try to stop me and I felt abandoned and betrayed again. I married him because I felt he could protect me, he's very strong. His brother J. was nasty to me. Betrayal, I spoke to my husband and he understands it now. I actually abandon myself and people abandon me at times. I didn't realize that was one of my core issues. I move away from friendship, I don't think they mean it that it's not going to last. I feel very unsupported, doing everything on my own. Also felt betrayal by my foster father and mother, they rescued me but my foster father sexually abused me. He took porno pictures, fondled me, tried to get me to fondle my boyfriend in front of him. The mind/body feeling is starting to go. I seduced my older brother at age eleven or twelve, that went on for a period of about six months. I felt I betrayed him, also a pattern before marriage, I'd have sex and then I'd abandon my boyfriends. I was in charge, I was pushing my husband by not having a sex drive. I wasn't aware of this. I got in touch with the Victim Triangle (Zimberoff, 1989). He was smothered by his mom and I smothered him. We broke up a couple of times, we had a

good sex relationship, no pain or force, no abuse. Some relief in my shoulders, but it is starting to come back, but it's not overwhelming, all my life I've carried that around. I did get some issues around my mom in traditional therapy, but not my dad. I'd repressed it so much I didn't connect with the feelings. Intellectually but not physically. I want to do a combination with traditional therapy, and deal with my underlying fear of abandonment".

Discussion**:**

Ms. M. was successful in identifying her emotional core issues of abandonment, guilt , and shame in various areas of the post-hypnotic trance. She was able to further her cathartic flooding regarding her husband and was able to recognize the depth of pain she had carried around all her life. This theme was associated with early childhood issues**.** She readily made the connection between her emotions and her body and was continually working on resolving that as well as the pattern of leaving in her marriage.

Case Illustration #9. Ms. B. is a 43-year-old white woman born and raised in South Africa. She had completed two years of individual therapy, plus group therapy for six months in Germany. She is considered a novice (0-2 previous hypnosis sessions) participant.

Presenting Problem/Chief Complaint:

Ms. B. chose to work on the terror she felt regarding her children and her and her feelings of attachment for them.

Verbatum Narrative Therapy Post-Hypnotic Interview:

"I went straight to my safe place, I went down several levels, and I remember asking for help with dealing with my terror of losing what I love the most, my children. Then I'm blanking out again. Eventually I had a memory of age three or four. The experience was I could see the room, my mom and dad, and I knew they had been fighting. I was feeling hurt that he had taken a little toy locomotive and smashed it and couldn't believe he took one of my toys and smashed it and I had nothing to do with their fight. Why did he have a flip side, he was such a good father, then I did existential stuff, and next I went off into a state of being where my feet were connected with Mother Earth. Some blanking, it was about its been going on since beginning of time, femininity, primordial, primeval problem, battle of being able to release myself from the agony. I couldn't take the abuse the women take anymore. I'm very connected to abuse on the levels of femininity and ties in to Mother Earth. Then I went into a

rage, I did like hitting with the hose but I needed to get my claws into the pillow. Went in to struggle, couldn't say it was with the devil because that sounds mad. Fighting the inner force that flips inside me when I was in that I was starting to feel physical things. The fear of losing what I loved most, being hurt where I was the most sensitive, the heart, clear color and physical. From that I was given the guidance to talk into the pillow, that was what I needed, talking to God the Father, questioning why he couldn't be all loving. Then into the pillow I asked my dad, I said; I really need you to be consistently loving, continual flow stop disrupting the flow. Discounting I'm noticing it was very good and right and complete at that stage. I had a bit of a feeling another memory of my dad was when I was young I loved dancing, it was my life. It was therapeutic and good and I wanted it to be my career. My mouth felt bloody, as though when I say something coming from the real me I get smashed in the mouth. My father stood very erect and he became big in my child's eye, saying : "And you will not make this your career!" and he was smashing what I needed most, he knew where the core of my heart was and he stepped right in there. Going into the feeling it was like a dagger straight in to my heart nailing me down. I was limp with the dagger through, the sense of being, an experience like what Jesus might have had. Being pinned down and not enough goodness to receive. I remember holding the bear [stuffed toy provided for inner child work] it was very easy, a part of me that finds it easy to connect with the inner child, I love the teddy. I can play easily, lots of my defenses go down around children. Then I was given an affirmation, I'm not a religious person in that socialized restrictive level. I'm connected up to the fact that spirituality is there. I couldn't get the connection, asked God's presence to be there, fighting the flip side I was furious at it happening again. I still have that fury. I had a replay of my very problem and bringing it in to the present. I felt powerless around the mouth and ended with the feeling of being stuck and alone where I needed support the most, felt I needed to deal with guilt, don't know what that is about. I feel guilty even if I'm not guilty which is linked to a continuous fear and that I won't get what I need the most. I wasn't able to get rid of the guilt and I possibly intensified it. What I picked up on was a new decision, it's your fault not even God will come down there and help you out; you weren't good enough, I felt that, not thinking you sense it. He just wasn't there then and I felt like yelling at him because he didn't give me consistent flow of love like my father. I had a sense of going some place, and experiential connection. Very similar to my father, parallel. God and my father. I used

aloneness, abandonment for the first time, I really feel abandoned by God and find it shameful and when it all came out it felt like it slapped me in the face and like my lips were bleeding all over again. I also felt like I was not being received and connecting up, like being able to really flow and give, tied in to the feeling that what's most precious is being taken away. What's flowing from my heart is blocked. Also, after the session, in the middle of the night, I recalled my birth. The darkness, and that I couldn't, what I needed most was to come out but I was killing my mom, what I needed most I couldn't get".

Discussion:

Ms. B. was successful in recognizing her core issues of abandonment, guilt and shame and making some new decisions about them. She further identified this theme as initiating in early childhood. Ms. B. was able to integrate further the trance state material in the narrative session. She has begun to work on the resolution of the early decisions that she had about being abandoned. When the poem "Footprint" was pointed out to Ms. B. she was able to feel and acknowledge further integration**.** Ms. B. felt and expressed closure at the time of the narrative recall regarding her painful childhood memories.

Case Illustration #10. Mrs. B. is a 54-year-old white woman from the U.S. Mrs. B. is considered an experienced participant as she was a participant in a two-year internship in hypnosis.

Presenting Problem/ Chief Complaint:

Mrs. B. is a professor and a therapist and chose to address her maternal relationship in the hypnotic psychotherapy session. She had previously identified several issues between herself and her mother, through her work in the internship.

Verbatum Narrative Therapy Post-Hypnotic Interview:

"Primary memory was about my mother and she would be drunk and have to drive to Angeles National Forest, Indian Reservation. Conflict between my life and being okay in the family and not being heard. The idea that I have a right to live, to be, and to be angry. I remember my mother would deliberately swerve the car around the curves and I thought I would die. I had to be with her or she'd kill herself. I get very scared when inside me I want to protect myself. Protection is to belong, nothing can happen. Some decision was made that in that conflict people would look at me like I'm a Borderline Personality Disorder and their not seeing me and I'm expecting too much. I remember saying take care of yourself, be

careful, and you're gonna get it. Mom stop stop stop it, your gonna hurt your baby. I'm waiting for the crash, I need help. You're breaking the law, I want to kill her. I am a person, I am a person. I don't want you to touch me. Keep you're clothes on, please put on your clothes. Your drunk, you're drunk, keep your bathing suit on. She said I was fat. It is not the truth. I'm a person. I'm a person. You don't even remember in the morning, you can't even remember what you did. You did bad things to me, you broke a rule. Your not nice to me mommy, you shouldn't do that. You stop drinking, stop, just cut it out. You hurt me and you hurt brother. You get on the golf course and say everyone should obey the rules. You're a hypocrite. I wish I were thin like you, but I'm not. I have a right, and it's not a sin, to eat. I have a right to eat some food. I can't get over how cruel you are. I want to do the right thing, why do you hate me? I don't care if you were drinking, you still did it. I want her to stay away from me, if I'm in the bathroom. I have a right for it to be locked-it's my body, it's my body it belongs to me. I know she wants to be loved. It wasn't my job to meet her sexual needs, it's my job to live. I'm going to live and I don't care if you don't love me. I want you to be separate from me and you'll make it. I have a right to choose me and I won't be punished, when I choose me I'm honored. I'm honored and safe and loved. I remember noticing the sheet and the flowers on it. I remember doing the breathing and the critical part of me saying your taking too long. So I took what I had in the moment I was in the car. reliving the experience in the car. I remember going in and out of the room (my critic) like a near death experience[sic]. I remember hitting the bag with the hose and the long silence in that I wasn't being given an answer. Something to say, I was trapped in this car and no one was telling me what to do. So I began working on solutions. That was the turning point. It seemed like a long time, I knew I was at a helpless place. How am I going to get out of the car if no one rescues me. Then getting into the grief and despair. I don't know how I transitioned into my body being ugly and molested. I remember her bathing suit came down I remember doing a 1,2,3 stop due to a misrepresentation of my mom and the body shame. She was drunk when she wanted to touch it, so I don't remember the transition. I remember feeling okay about doing this work. I needed to do it. The body shame was so deep and profound to the very core of me. I became aware there that we were taking a lot of time. The bathing suit issue I did relive that one, asking her to keep her bathing suit on. Then the things did merge. I was able to talk to the therapist of my mom and I found it empowering to claim my body as my own.

About me being ugly and fat I couldn't answer to that so I moved into I'm a person too. The solution was in making my decisions. I can't stop being ashamed. I remember you doing the smell, and my sweat, I remember I cried a lot".

Discussion:

Mrs. B. was successful in identifying her primary core issues of shame and abandonment. Mrs. B. regressed to a child-like stage in the post-hypnotic narrative therapy and subsequently transitioned into the here and now without intervention. She was successful in tracking the beliefs and feelings to her early childhood issues with her mother**.** Mrs. B. had several sessions prior to this session and was experienced at the post-hypnotic transition. Mrs. B. was able to reprocess her psychogenic beliefs regarding the sexual trauma and she chose to accept herself. Mrs. B. stated she still had work to do but that this was a good session. This insight was further integrated and cognitively expressed in the post-hypnotic interview.

FOLLOW-UP QUESTIONNAIRE

QUESTION:

1. Do you perceive a change in your self concept as a result of your hypnotic psychotherapy experience?
2. Have the feelings of understanding toward yourself changed?
3. Did you feel the (Interview) narrative therapy session assisted you in the integration of the hypnotic psychotherapy insight gained?
4. Do you feel you gained valuable information from the hypnotic psychotherapy that will enable you to better assess your own interpersonal conflicts in the future?
5. Any additional comments you feel you would like to add? Please insert a note here.

RESPONSE

#1. Responses were 9 total: 6 yes, 2 no, and one maybe.
#2. Responses were 9 total: 9 yes.
#3. Responses were 9 total: 8 yes, and 1 no.
#4. Responses were 9 total: 9 yes.
#5. Responses were 8 total: Eight of the nine participants submitted a paragraph regarding their experience and integration of their insight. The paragraphs validated the positive responses to insight integration in the questions. The one individual that did not respond must be considered a negative response which is significant with such a sample size.

ADDENDUM
QUESTION #5

Case #1. Ms. M. "I saw my fear of water as a result of a traumatic incident instead of unknown etiology. I saw myself as a less fearful person."

Case #2. Ms. R. "More valuable than hypnosis has been the analytic regression I am currently experiencing. The old experience with mother has been re-created in the present within the therapeutic alliance between my analyst and myself. The experience is profound. It is both exciting and remindful of death. I am experiencing abandonment depression in this process. I am taking both a benzodiazipine and an anti-depressant to help with the symptoms.

Case #3. Ms. S. Dual session. "I was never able to decrease stimuli. I felt a need to perform. I felt it inhibited communication between my partner and I, there was a lack of processing."
Mr. A. chose not to participate in any follow-up research regarding his participation in the hypnotic psychotherapy.

Case #4. "The whole process really had an amazing influence on my life. I feel much more integrated and the problems with my wife are a thing of the past. She is pregnant again. I am less aggressive though more assertive. I accept myself for the first time and love it. I experience wonderful moments of thankfulness towards our Creator and really do not have time for depression anymore. The hypnosis is very powerfull in establishing insight into sometimes an incidious process of traumas like abandonment which eventually builds up into a huge problem. The healing process is designed so well that it provides the opportunity to understand this chain of trauma and also provide the opportunity to red yourself properly of all negative energy attached to these feelings and situations. I had an apportunity to face all the issues and situations from an early age which eventually compounded into my deep feelings of abandonment with resultant depression. Having faced them now I am tremendously relieved. What is also wonderful is that the negative feelings are extinguished and replaced with wonderful positive feelings of love. I have much more self-confidence now especially having done the ego strengthening during hypnosis. I still use my anchor often and it provides an immediate boost for

my personality and self- confidence. Because the new coping skills and techniques help such a lot I am using the anchor less and less as the skills become better and better. The highlight of the process is still the inner child work. Holding that little abandon boy was amazing, and helping him to release and let go did wonders for me."

Case #5. Ms. N. "I feel that I am more respectful and patient because of my own experience. I understand it better (the process of hypnotic psychotherapy) and can help them (future patients) by giving a little of my own".

Case #6. Mr. D. "Being a therapist who has done much personal exploration over the years, my insights and sense of change can be very subtle, small shifts. New awareness as to the concept of self is infrequent. At least not major ones. The feelings of understanding toward myself have changed, in so far as I gained increased compassion for myself and for family members with whom I have had conflicts with or anger toward. This occurs via a sense of watching myself go through the drama (as if in a play). If I had not in the past stated my needs and not had them heard and affirmed this would be even more cathartic and empowering. Another point-breathing sounds, and movement occuring during the enactment may have much to do with a sense of release. In fact these may have more to do with catharsis than the particular emotion being replayed. I personally found it difficult to feal fully in the emotion being acted out, yet felt less tension and charge around the frustration regarding my parents."

Case #7. Ms. M. No comments made.

Case #8. Ms. Y. No questionnaire returned.

Case #9. Ms. B. "Recognizing the old negative feelings in daily life after hypnotherapy was much easier and these feelings (patterns) have transformed since. I now use hypnotherapy in my practice with much success. I also continue to grow myself by further hypnotherapy for myself."

Case #10. Mrs. B. "I did not know how to tell you this but I was not in a trance. I had already worked on this stuff and just did't know how to tell you.

DISCUSSION

Utilizing an individual, interpersonal mode of therapy is commonly successful in identifying and resolving these early emotional conflicts. Ego strengthening through the use of T.A., Gestalt, and Cognitive/Behavioral therapy can aid the client in resolution of past conflicts and provide the ability to identify and possibly stop or alter present and future patterns of dysfuntional thinking due to the basic core issues.

The previous case illustration verbatum narratives were all detailed recollections by each individual participant, all of which were obtained within 24 hours after the hypnotic psychotherapy session. The technique of utilizing previous hypnotic learnings has been used with resistant or novice (0-2 previous hypnotic psychotherapy sessions) patients effectively (Erickson, 1967). Simply comfortably seating the client (as I did in each post-session) and asking them to give a detailed account of the immediately preceeding hypnotic session can result in a post-hypnotic trance. Each participant demonstrated a total focus on the preceeding session and each displayed affect appropriate to content. Affect ranged from tearing eyes, to a sigh of relief during the narrative therapy post-hypnotic interview. This is common among clients utilizing traditional narrative therapy as they divulge their interpersonal histories**.** In each case the individual had areas of amnesia which is common due to dissociation of feelings. In many cases resolution of the resistances is greatly facilitated and therapy accelerated (Erickson, 1967). I have found these sessions (case illustrations) enabled each client to integrate their new trance state material into their here and now perspective. Reprocessed decisions regarding the content of the session were elaborated on by each participant and were seemingly instilled. A follow-up questionaire was completed by 8 of the 10 participants eight months after the study regarding the reprocessing and retention if any of their insight/s. This reprocessing confirmation may add to the validity of the participant to integrate more thoroughly the subconscious material that was brought into consciousness during the hypnosis session.

This study has identified and outlined some of the more common long-term effects of a variety of types of child maltreatment. Further, identification of a constellation of human core issues that parallel perceived traumatic events, was done. Clinical as well as hypnotic phenomena were discussed and outlined regarding traumatized incidents. Many traumatized clients may fall into diagnostic categories such as PTSD, DID,

Narcissistic/or Borderline Personality Disorders. Diagnosis of each individual case is illustrated and discussed in the addendum following. The exploration of clinical and hypnotic psychotherapeutic phenomena have been bridged in this study. Hypnotic psychotherapy, as done here, emphasized support, consolidation, desensitization, and emotional insight. It has been noted that survivors of painful memory recall accessed solely in an intellectual way usually utilize dissociation (Briere, 1992). I believe that each case illustrated demonstrated dissociation during the post-hypnotic narrative interview, each individual had periods of no recall and stated so. This type of abuse-focused therapy rather sought to foster the clients' healthy (nondissociated) experience of strong feelings associated with the specific traumatic memory. Emotional release facilitated in this supportive contained relationship allowed the client to experience and express painful affect. Abuse survivors normally have difficulty with this process if done in an entirely cognitive intellectual fashion (Briere, 1992). What is identified here is that through age regression the client experiences repeated emotional processing. This allows the client to learn how to experience intense feelings associated with upsetting events and restimulated trauma without resorting to previously conditioned associations between traumatic memory and anxiety by instead pairing the memories with contemporary therapeutic support and relief associated with catharsis in a safe emotional discharge. This new coping strategy often results in a stepwise manner: as one trauma experience is desensitized and integrated, there is sufficient dearousal that the need for dissociation decreases and another memory can be addressed, desensitized, and integrated. Over time this learning can generalize to other settings, possibly leading to greater trust and improved self-efficacy in various social situations.

Any or all of these techniques are useful only to the extent that the therapist actually conveys acceptance, empathy, respect, and validation during the hypnotic psychotherapy process. It is essential that the therapist stay attuned to the client's needs for safety and containment over the optimal level of therapeutic intensity. Hypnotic psychotherapy based on this study apparently offers the client the safety and control they feel comfortable with. This interpersonal approach is rapid, in depth, and often insightful, as the follow-up questionnaire reflects.

REFERENCES

Antrobus, J.S. (1970). *Cognition and Affect*. Little Brown and Company. Boston

Axelrod, J.; Reisine TD. (1984). Stress hormones, their interaction and regulation. *Science*;224:452-9.

Bower, B. (1996). Right brain takes memories personally. *Science News*, July. vol. 150. Pg. 5.

Brazil, J.A. & Blizzard, R.M. *The Influence of the Endocrine Glands Upon Growth and Development*.

Briere, John, M. (1992). *Child Abuse Trauma: Theory and Treatment of the Lasting Effects*. Sage Publications.

Burke, James., & Ornstein, Robert. (1997). *The Axemakers Gift*. First Trade Paperback Edition, NY.NY.

Butler, K. (1996). The Biology of Fear. *Networker*; 39-46.

Budman & Gurman. (1988). *Theory And Practice Of Brief Therapy*. The Guilford Press.

Charney, D.S., Deutch, A.Y., Krystal, J.H., Southwick, S.M., Davis, M. (1993). *Arch Gen Psychiatry*; 50:294-305.

Cheek, D.B and LeCron, L. (1968). *Clinical Hypnotherapy*. Grune & Stratton, Inc.

Chopra, D. (1992). *Escaping the Prison of the Intellect. A Journey from Here to Here*. Quantum Publications Inc.

Chopra, D. (1993). *Ageless Body Timeless Mind*. Random House Inc.

Cohen, S., Tyrrell, D.A.J., & Smith, A.P. (1991). Psychobiological Stress & Susceptibility to the Common Cold. *New England Journal of Medicine*, 325, 606-612.

Davis, L. (1991). Murdered Memory. *In Health*, 5, 79-84

Donovan, D.M., & McIntyre, D. (1990). *Healing the Hurt Child*. W.W. Norton. N.Y. N.Y.

Dowd, E T., & Healy, J. M., (1986). *Case Studies in Hypnotherapy*. New York: Guilford Press,

Edgette, J.H, & Edgette, J.S. (1995). *The Handbook of Hypnotic Phenomena in Psychotherapy*. Brunner/Mazel Publishers. New York.

Erickson, M.H., (1980). *The Nature Of Hypnosis And Suggestion. The Collected Papers of Milton H. Erickson on Hypnosis*. Vol. 1-4.

Erickson, M.H., Hershman, S., & Secter, I.I. (1990). *The Practical Application of Medical and Dental Hypnosis*. New York. Brunner/Mazel.

Erikson, M.H. (1954). Pseudo-Orientation in time as an Hypno-therapeutic Procedure. *Journal of Clinical and Experimental Hypnosis*, 2 261-283.

Estabrooks, G.H. (1957). *Hypnotism*. E.P. Dutton & Co., Inc.

Famularo, R., (1997). What Are the Symptoms, causes, and treatments of ChildHood Post Traumatic Stress Disorder? *The Harvard Mental Health News Letter*. Jan, 8.

Freud, S., (1971). *Dora: An Analysis of a Case of Hysteria*. Crowell-Collier Publishing Co., Inc.

Freud, S. (1919/1954). *Introduction to psychoanalysis and the war neuroses*. Standard ed. 17:207-210. Strachey J, trans/ed. London: Hogarth Press.

Fromm, E., & Nash, M.R. (1992). *Contemporary Hypnosis Research*. Guilford.

Green, E., Green, A., & Walters, E. Voluntary Control of Internal States: Psychological and Physiological. *Journal of Transpersonal Psychology*, 190, 2 1-16.

Hadfield, J.A. (1920). The Influence of Suggestion on Body Temperature. *Lancet*, 268-69.

Hay, Louise, L. (1982). *You can Heal Yourself*. Santa Monica, CA: Hay House.

Haley, J. (1973). *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, MD*. New York: Norton.

Haley, J. *Maps of The Mind*. (1981). Mitchell Beazley Publishing Limited.

Herman, J.L., & Harvey, M.R. (April 1993). The False Memory Debate: Social Science or Social Backlash? *The Harvard Mental Health Letter*. Vol 9 #10, 4-6.

Hilberman, E., & Munson, M. (1972). Sixty battered women. *Victimology*, 460-1.

Holmes, D.S. (June 1994). Is there Evidence for Repression? Doubtful. *The Harvard Mental Health Letter*. Vol. 10 #10, 4-6. Hypnosis. New York: Citadel Press, 1965.

Johnson, S.M. (1994). *Character Styles*. W.W. Norton & Co.

Kepner, J.I. (1992). *Healing Tasks in the Psychotherapy of Adult Survivors of Childhood Abuse*. The Gestalt Institute of Cleveland. Cleveland Press, Cleveland,OH.

Kroger, W.S. (1977). *Clinical and Experimental Hypnosis* (2nd ed.) J.B. Lippincott Co.

Laderman, C. (1993). Taming the Wind of Desire. *Psychology, Medicine, and Aesthetics in Malay Shamanistic Performance*. University of California Press, Berkeley, CA.

Lemonick, M.D. (1995). Glimpses of The Mind. *Time*: 44-52.

Levitsky, A. (1966). The Constructive Realistic Fantasy. *The American Journal of Hypnosis: Clinical, Experimental, Theoretical*, 9: 52-55.

Mohr, F. Psychophysisch Behandlungsmethoden. (1954). Cited by H.F. Dunbar, *Emotions and Bodily Changes* (4th ed.) New York: Columbia University Press.

Morrison, A.P. (1989). *Shame: The Understanding of Narcissism*. The Analytic Press, Hillsdale, NJ.

Moser, D. (Nov. 1996). Heart Attacks: High Hopes vs. High Anxiety. *Science News*. Vol 150 # 18. pg. 277.

Murphy, M. (1992). *The Future of The Body*. G.P. Putnam's Sons, N.Y.

Myss, C. (1996). *Anatomy of the Spirit*. 3 Rivers Press, N.Y.

Ornstein R.E. (1977). *The Psychology of Consciousness* (2nd ed.) W.H. Freeman & Co.

O'Connor, J., & Seymour, J. (1990). *Introducing NLP Neuro-Linguistic Programming*. The Aquarian Press. San Francisco, CA.

Pavlov, I.P. (1926). *Conditioned reflexes: an investigation of the physiological activity of the cerebral cortex*. Anrep, G.V., trans/ed. New York: Dover Publications.

Pawlak, L. (1996). *Appetite: The Brain-Body Connection*. INR / Biomed.

Reed, S.K. (1987). *Cognition Theory and Application* (2nd ed.). Brooks Cole Publishing.

Rhue, J.W., Lynn, S.J., & Kirsch, I. (Eds.). (1993). *Handbook of Clinical Hypnosis*. Washington, DC: A.P.A.

Sagan, C. (1977). *The Dragons of Eden*. Random House Inc.

Schacter, D.L., & Graf, P. (1986). Effects of elaborative processing on implicit and explicit memory for new associations. *Journal of Experimental Psychology: Learning, Memory, & Cognition*, 12, 432-444.

Schacter, D.L., & McGlynn, S.M. (1989). Implicit memory: Effects of elaboration depend on unitization. *American Journal of Psychology*, 102, 151-181.

Shapiro, F. (1995). *Eye Movement Desensitization And Reprocessing: Basic Principles, Protocols, and Procedures*. The Guilford Press, New York.

Schiff, J.L. (1975). *Transactional Analysis Treatment of Psychosis* Cathexis Reader. Harper & Row, Publishers, Inc.

Schneider, A.M.. & Tarshis, B. (1975). *Physiological Psychology*. New York: Random House.

Schrof, J.M. (1997). Questioning Sybil. Being A "Multiple" is chic. But Does The Illness Exist? *U.S. News & World Report*. January, 66-68.

Shalev, A.Y., & Rogel-Fuchs, Y. Psychophysiology of PTSD: from sulfur fumes to behavioral genetics. *J. Ment Nerv Dis* (In Press).

Solomon, Z., Barb, R., Bleich, A., & Grupper, D. (1985). Reactivation of combat-related post-traumatic stress disorder. *Am J Psychiatry* Vol 144:51-5.

Spiegel, D. (Oct. 1984). Hypnosis. *The Harvard Medical School Mental Health Letter* Vol. #14 pgs. 3-5 Literature Review.

Squire, L.R., & Zola-Morgan, S. (1991). The Medial Temporal Lobe Memory System. *Science*, 253, 1380-85.

Swerdlow, J.L. (June 1995). Quiet Miracles of the Brain. *National Geographic*. National Geographic Society.

Taylor, R.L. (1982). *Mind or Body*. R.R. Donnelley & Sons, Inc.

Teyber, E. (1996). *Interpersonal process in psychotherapy.* 3rd edition. Pacific Grove, CA: Brooks/Cole Publishing Co.

Tomkins, S.S. (1963). *Affect Imagery Consciousness*. Vol. II, New York: Springer.

Turner-Charles, H. (1981). *Maps of The Mind*. Mitchell Beasley Publishers Limited.

van der Kolk, B.A., Greenberg, M.S., Boyd, H., & Krystal, J.H. (1985). Inescapable shock, neurotransmitters and addiction to trauma: towards a psychobiology of post traumatic stress. *Biol Psychiatry* Vol: 20:314-25.

van der Kolk, B.A., & van der Hart, O. (1989). Pierre Janet and the breakdown of adaptation in psychological trauma. *Am J Psychiatry,* Vol 146: 1530-40.

van der Kolk, B.A., & van der Hart, O. (1991). The intrusive past: the flexibility of memory and the engraving of trauma. *Am Imago* Vol 48:425-54.

Wickramasekera, I. (1988). *Clinical Behavioral Medicine: Some concepts and Procedures*. Plenum, N.Y.

Zager, E.L., & Black, P.M. (1985). Neuropeptides in human memory and learning processes. *Neurosurgery,* Vol 17: 355-69.

Zimberoff, D. (1989). *Breaking Free From the Victim Trap*. The Wellness Press, Seattle, WA.