A HYPNOTHERAPY (EGO-STATES) MODEL FOR SURVIVORS OF SEXUAL CRIMES: A PSYCHO-EDUCATIONAL PERSPECTIVE

by

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DECLARATION

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I declare that **A HYPNOTHERAPY (EGO-STATES) MODEL FOR SURVIVORS OF SEXUAL CRIMES: A PSYCHO-EDUCATIONAL PERSPECTIVE** is my own work and that all the sources that I have used or quoted, have been indicated and acknowledged by means of complete references.

A M FOURIE

February 2003

Dedicated to my best friend,
knowledgeable colleague
and sister
***Albé Fourie**,*
who was and will always be
the wind beneath my wings…

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Anita Fourie

A HYPNOTHERAPY (EGO-STATES) MODEL FOR SURVIVORS OF SEXUAL CRIMES: A PSYCHO-EDUCATIONAL PERSPECTIVE

SUMMARY

Dissociation is commonly associated with sexual crimes or other forms of trauma where a person experienced a threat to the existence or survival of the self. During dissociation the ego may split in such a way that ego-states (subselves or segments of the greater personality) form to encapsulate feelings of guilt, pain, fear, and anger. If dissociation is severe, sufferers will have no conscious recollection of the sexual trauma as it is deeply repressed in the subconscious. This may result in symptoms/pathology later in life.

Research indicated that hypnosis (due to its dissociative nature) is favourable as treatment modality for pathology/symptomatology associated with trauma and dissociation.

This research study investigates the development of ego-states during experiences of sexual trauma and hypnosis (especially Medical Hypno-analysis and Ego-State Therapy) as effective treatment modality within the field of psycho-education. It proposes a hypnotherapy model where the diagnostic tools as indicated by the Medical Hypno-analysis model, are being used to determine the existence of repressed memories related to sexual trauma. The therapeutic processes as indicated by the Ego-State Therapy model, are being used to resolve and work through the core repressed traumatic experiences through the mobilization of associated and related ego-states.

This study presents four case studies and discusses their clinical diagnostic procedures and therapeutic processes. The case studies illustrate that certain symptomatology/pathology experienced later in life may be the result of repressed memories and the formation of maladapted ego-states earlier in life when sexual trauma was experienced. Highly charged emotional and negative beliefs were set in the ego-states and could only be disarmed from their

destructive content through regressions and hypnotherapy. A detailed discussion of the proposed hypnotherapy model and its application and concerns regarding its application within the field of psycho-education are also presented.

The results of this study indicate that the proposed hypnotherapy model (the combination of Medical Hypno-analysis and Ego-State Therapy) can be used effectively and successfully when working with survivors and symptomatology/pathology associated with sexual crimes.

Key terms:

Hypnosis; Hypnotherapy; Ego-State Therapy; Medical Hypno-analysis; Survivors of sexual crimes; Personality Segmentation; Dissociation; Age Regression; Repressed Memories; Sexual trauma

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“Yesterday, I cried.
I cried because I hurt. I cried because I was hurt.
I cried because hurt has no place to go
except deeper into the pain that caused it in the first place,
and when it gets there, the hurt wakes you up.
I cried because it was too late. I cried because it was time.
I cried because my soul knew that I didn’t know
that my soul knew everything I needed to know.
I cried a soulful cry yesterday, and it felt so good.
It felt so very, very bad.
In the midst of my crying, I felt my freedom coming,
Because
Yesterday, I cried
with an agenda.”

- *Iyanla Vanzant, 1998*
  (from “Yesterday, I cried”)

A HYPNOTHERAPY (EGO-STATES) MODEL FOR SURVIVORS OF SEXUAL CRIMES: A PSYCHO-EDUCATIONAL PERSPECTIVE

CHAPTER 1

INTRODUCTION TO THE RESEARCH STUDY

On the pulse of the Morning
History, despite its wrenching pain,
cannot be unlived, but if faced
with courage, need not be lived again.
Lift up your eyes
upon this day breaking for you,
give birth again.

- **Maya Angelou**

1.1 AWARENESS OF THE PROBLEM AND MOTIVATION FOR THE STUDY

1.1.1 INTRODUCTION

In this chapter the awareness of the problem is described and the motivation for the study explained. This is presented by means of the theoretical background to the study from which the research is approached, in this instance, from a psycho-educational and hypnotherapy perspective. The literature overview of the perspectives will be followed by a short literature survey on sexual crimes. Thereafter, the statement of the problem, hypothesis involved and aim of the

study will follow. The chapter will be concluded with clarification of concepts and a summary of the division of chapters in the research.

1.1.2 AWARENESS OF THE PROBLEM

The term *"crimes"* used in this paragraph does not refer to the term *"crimes"* as used in common criminal law, where it implies an offence committed against someone and the perpetrator being punished for the offence by a court of law. The term *"crimes"* in this context will imply that an offence was committed against a person (where a person's rights and personhood were affected) but the perpetrator was not prosecuted and therefore not punished for his/her acts by a court of law. *"Sexual crimes"* will, therefore, refer to any act (verbal or non-verbal) directed towards a person with a covert or overt sexual intention, and which resulted in the survivor experiencing feelings of being sexually violated as a person, physically or psychologically. *"Sexual crimes"* include the whole spectrum of acts from sexual comments directed towards a person up to the act of sexual penetration.

It is common knowledge that there was a tendency in the past for the survivors of less severe sexual crimes, to keep the knowledge of offences committed against them, to themselves. In fact, a few decades ago it was almost considered offensive to use terminology such as *"sex"*, *"sexual acts"* or even *"sexual abuse"* in respectable social conversation. This possibly resulted in many young people and children keeping sexual crimes committed against them, as secrets to themselves. Only in exceptional cases would they have shared their secrets with a person they regarded to be trustworthy and in a position to bring about change. However, such revelations would often lead to disappointment and regret, as the authoritative persons would not have listened, or would have disbelieved them or failed to act on the information given (Shapiro in Shapiro & Dominiak, 1992:3). Fortunately, things have changed and nowadays more focused attention is given to sex, sexual acts and sexual crimes, and incidents are more readily reported. However, it is the generation which stems from the more conservative times and

who had to function as adolescents, young adults and adults (husbands, wives and parents) with the memories of childhood sexual abuse, which is of concern to the researcher.

The researcher first became aware of the traumatic after-effects on adult survivors of sexual crimes committed against them during their childhood, when she was consulted by a young mother who only experienced the emotional trauma of being molested as a child, when her own daughter reached the same age that she was when she was sexually abused. This phenomenon was particularly interesting as the mother's optimal functioning was inhibited and all her relationships sabotaged just after her daughter's third birthday, without the mother having a conscious reason for this happening. The memories related to her own sexual abuse was repressed and subconscious discomfort was only experienced once her daughter reached the age of three. This age triggered the revival of the traumatic emotional content of the mother's memories associated with the age of three. It was only after a few sessions where hypnotherapy was used, that the mother was able to connect her current emotional state with her childhood sexual trauma. This case urged the researcher to a greater awareness to the problem of repressed memories and the psychological effects thereof, on the identity and self-concept development of adult survivors of childhood sexual crimes.

1.1.3 MOTIVATION FOR THE STUDY

In the researcher's further experiences as counseling psychologist, she came across more and more young adults suffering from some form of aftermath from sexual trauma experienced as children. A pattern was slowly emerging where such patients experienced severe problems in their relationships with themselves as well as with other people, especially those of the same sex as the perpetrator. Patients were not always able to connect their consequent internal and external suffering to the childhood sexual trauma and the effect thereof on their

development and actualization as healthy functioning individuals (although they sometimes did have a memory of the trauma, but without any emotional content).

On many occasions it was only through the use of hypnosis and hypnotherapy, that the connections were made and internal cognitive changes and emotional, spiritual and psychological growth obtained. Those inner connections had a direct impact on survivors' external worlds, positively affecting their relationships on all levels. It became evident to the researcher that hypnosis and hypnotherapy could be a powerful tool in the short-term therapeutic process when working with adult survivors of childhood sexual crimes.

The researcher found the use of specifically the Medical Hypno-analysis model very useful in resolving issues related to low self-esteem, low self-image and underlying feelings of being unloved and unworthy (as often found in depressive patients), as this model traces all symptoms as far back as feelings of rejection experienced in the mother's womb. Such events are often the initial factors in the development of psychopathology/ symptomatology. However, in the researcher's experience, the mentioned model on its own does not appear to be very effective in working with post traumatic stress symptoms as found in adult survivors of childhood sexual crimes.

On the other hand, the Ego-State Model (which is underscored by the Dissociation Theory) proved to be effective in resolving trauma symptoms. The researcher is of opinion that a combination of the two models might be even more effective when working with adult survivors of childhood sexual crimes, as they often suffer from depression and are to a certain degree dissociated from reality. This pathological dissociation is normally the cause for patients not reaching their full potential as found in psycho-educational theories of self-actualization. It is therefore within this field that the researcher wishes to establish an effective short-term therapeutic model when working with adult survivors of childhood sexual crimes.

The current trend of increased openness towards acknowledging sexual molestation- and rape-trauma prompted the establishment of many rape crisis centers throughout the world. It was also only recently that adult survivors of childhood sexual crimes were beginning to make it known and acknowledged in the open, that they did even in adulthood, suffer from the psychological after-effects of those crimes. As a result of this an effective, sufficient and cost effective short-term model for resolving the trauma related to childhood sexual crimes, is currently in serious demand.

1.2 A PSYCHO-EDUCATIONAL PERSPECTIVE

1.2.1 INTRODUCTION

A psycho-educational perspective views the child from the educational essence. Jacobs (in Roets, 1989:95) states that although educational-psychology refers to children, *"the same theory is applicable to adults since personality is not static, but develops constantly."* Therefore, every individual's personality is unique (be it that of a child still gradually developing, or that of an adult). This study will focus on adults, as it is believed that every adult nurtures an inner child and therefore, is still in one way or another developing.

1.2.2 THE SELF AND SELF-ACTUALIZATION: EDUCATIONAL PERSPECTIVE

According to Roets (1989:96) personality can be defined in terms of the *"I", "self", "self-actualization"*, *"self-concept"* and *"identity".* Jacobs (in Roets, 1989:95) describes the *"I"* as the spiritual side of a person; the guiding and supportive power behind all his/her actions and thoughts. The *"self"* is seen as everything a person is and can call his/her own. *"The individual's self is therefore the Gestalt of who and what he is and of what he calls his own. The self includes his system of ideas, attitudes, values and the things to which he commits himself."* (Jacobs

in Roets, 1989:100). The self is constantly in the process of becoming, of self-realization (realization of values and of meaning) and/or of self-actualization, as a person is always in relations with and relating to something, someone, circumstances and/or ideas. These relations confront man in the core of his human existence and being, challenging him to grow and develop by means of choices and decisions, partaking in the process of constant becoming – becoming a personality. As the self is the center of experience, the personality is expressed by way of the self (Jacobs in Roets, 1989:100). Through these processes and experiences, self-actualization can be achieved.

The educational perspective (according to Brennicke and Amick in Roets, 1989:101) describes the self-actualizer as *"…a person in the fullest sense of the word. He is completely involved in life and experiences intense pleasure and profound grief, not only his own, but also that of the people with whom he lives."* He feels internal love, safety and acceptance (from the *"I"* towards the *"self"*) and accepts himself with a realistic sense of his abilities and limitations, not allowing the latter to affect his personal dignity or self-concept. A person's self-concept includes the action, identity and self-esteem of the person (the way the person knows him/herself). According to Verny (in Roets, 2001:6) *"Self-identity is the congruence into an integrated unit of (1) the person's conceptions of himself, (2) the stability and continuity of the attributes by which the person knows himself and (3) the commonality of a person's self-conceptions of himself by people who are important to him."*

It is evident that the nature of the relations and relationships a young developing child is engaged in, may to a great extent, influence the development of the young person's sense of self, self-identity and self-concept, as well as growth towards self-actualization in a positive or negative manner. A negative identity may (i) reflect an unhealthy intrapsychic structure due to earlier childhood needs not being adequately met, and (ii) result in the development of psychological or psychosomatic symptoms or pathology later on in life. The concept of self has thus a direct effect on one's *"…ability to enjoy the experience of being."* (Benson in Roets, 1989:103)

1.2.3 THE SELF AND SELF-ACTUALIZATION: PSYCHOLOGICAL PERSPECTIVE

In contrast to the educational perspective, Modlin (1999:61) refers to the *"I"* as the subconscious mind, which stores all emotions and memories and controls and regulates the body. The *"self"* is seen as the conscious mind, which includes reasoning, understanding, logical thinking and decision-making.

He further highlights the relationship between memories and emotions – that all memories are either stored with pleasant or unpleasant emotional content. Memories stored with unpleasant emotional content creates discomfort in the subconscious mind, leading to the development of defenses in order to protect the conscious mind against the emotional content/intensity of the unpleasant memories (in educational terms, the conscious *"self"* is being protected against the subconscious *"I"* that is experienced as bad). Such a defense may be in the form of psychological, psychosomatic and/or physiological pathology. Goldstein (in Kaplan, Sadock & Grebb, 1994:255) described self-actualization as the creative powers within each individual that leads one to fulfill one's potentialities. The goal is to obtain equilibrium between inner dynamic properties. Sickness and/or traumatic events disrupt self-actualization as it disrupts the organism's integrity. Holocoenosis occurs and psychopathology (in a variety of possible forms) develops.

The following is a short summary of the most well-known theoretical perspectives on the self and self-actualization as stated by Moller (1995:25-242):

TABLE 1.1: Perspectives on self and self-actualization

Perspective	Self/Self-actualization	Theorist
Psychoanalytical	There is harmony between the id, ego and super-ego. Person is relatively free of ego-defenses and has insight in unconscious motives for his/her behaviour.	Freud
Analytical Psychology	Maturity is the integration within the self, thus within the complex network of systems interacting with each other. Individuation is the integration and solving of conflicts between opposing forces within the personality.	Jung
Personal Construct	The availability and permeability of personal constructs (including contrasts and similarities) by which the person is able to predict and interact with his/her environment successfully.	Kelly
Cognitive-Emotive	The absence of irrational thoughts and a clear insight and application of the ABC (Activating event, Belief, Consequences) model of influences of thought on emotions.	Ellis
Self-Theory	The person's ability to use all its attributes and potential to maintain and develop itself and is happy with itself. Increased congruence between the person's self-concepts and experiences.	Rogers
Existential	The integration of somatic, psychic and spiritual aspects of the self and a deep spiritual sense of purpose and meaning in life.	Frankl

(Compiled from Moller, 1995:25-242)

According to Adler (in Kaplan et al., 1994:254) every individual is born with an *"inferiority complex"* (a sense of inadequacy and weakness). Self-actualization is the process through which an individual thrives to overcome the feelings of

inferiority through consistent human relatedness. This human relatedness leads to decreased isolation and increased hope and affiliation with society, as individuals develop a sense of dignity, worth and renewed appreciation for their abilities and strengths. Therefore, any unpleasant event in a person's relatedness might induce rather than reduce feelings of inferiority. The phase in a person's developmental process when the event occurs, as well as the importance of the relatedness, will impact the person's inferiority complex and striving for self-actualization to a greater or lesser extend. Alexander (in Kaplan et al., 1994:254) with his concepts of *"corrective emotional experiences"* and *"modes of relatedness"* (especially between therapist and patient) attempted to provide a possible solution to counteract noxious influences in a patient's development.

The self-actualization theory of Maslow (in Kaplan et al., 1994:257) – the need to understand the totality of a person – described a hierarchical organization of needs present in every individual. Self-actualization (a powerful transcendental state of consciousness) can only be achieved once the more primitive needs (such as hunger, thirst and later affection and self-esteem) of a person have been met. Most psychologically ill persons are stuck on a certain level of this hierarchy, because one or more of their basic needs are not yet being met. If an individual does not feel a sense of affection and love towards the self, then it is impossible for him/her to move on to a higher level towards self-actualization.

1.3 A HYPNOTHERAPY PERSPECTIVE

1.3.1 INTRODUCTION

The aim of the research in this study is the therapeutic application of hypnotherapy, specifically concepts and structures from the two models of Medical Hypno-analysis and Ego-State Therapy, to several adult survivors of early-life or childhood sexual crimes. In this chapter a brief introduction and

summary of both models are presented. A more detailed description of both models will be given in Chapter 3.

1.3.2 THE MEDICAL HYPNO-ANALYSIS MODEL

The Medical Hypno-analysis model is a structured model based on the process of diagnosis and therapy. In diagnosing the root causes of all presenting problems, the symptoms or pathology is investigated and explained through a thorough and detailed case History-taking (observing verbal and non-verbal communication) and a Word Association Test conducted while the patient is in a hypnotic trance. Once the psychodynamic diagnosis is made, therapy is conducted in a relatively short timeframe (between 10 – 18 sessions) when underlying subconscious problems are addressed (Matez, 1992:155).

The *"Triple Allergenic Theory"* (an analogy used by the model to explain past incidents and trauma) refers to the development of a *"psychological allergy"* that is viewed to be the equivalent of the development of a visible medical allergy (Modlin, 1999:59). In both instances, a visible allergy will only develop once there is an Initial Sensitizing Event, a Symptom Producing Event and a Symptom Intensifying Event. The Initial Sensitizing Event refers to (a) past incident(s) or trauma(s) of which the conscious mind has no memory. The Symptom Producing Event refers to a subsequent similar incident, triggering the previous incident with its full emotional consequences. The Symptom Intensifying Event refers to the event(s) that intensified the symptoms that have already occurred previously (Modlin, 1999:60) and this is usually the event that patients suffer from.

Another concept often referred to in the Medical Hypno-analysis model is the *Birth Experience*. Although the birth experience is not the main focus of the researcher's attention in this study, knowledge of the model's viewpoints on the birth experience is essential. The model posits that the birth experience (and/or experiences in the mother's womb - prenatally) is often the Initial Sensitizing Event and the root cause for the symptoms experienced later in life. Perceptions

of the inner self are influenced by experiences in the mother's womb (prenatal), the actual birth experience and the first six years of a person's life (Scott, 1993:5). The person's sense of self and self-concept are thus developed and influenced mainly through experiences from the time of conception up to the age of six years. Should the child experience any sense of threat to his/her survival during these initial developmental years, defense responses will be activated as a means of survival.

Any defense response will have a direct impact on the child's identity-formation, self-concept and growth towards self-realization and self-actualization. A repetition of an event experienced as a threat to the survival of the self, will result in the development of a more severe, or another ego-defense. Although most memories (with their emotional content) of such events are stored in the subconscious mind, the conscious mind is often suffering from the defense(s) chosen by the subconscious mind and the patient's functioning as self-actualized individual, is inhibited. It is often these subconscious defenses that manifest in psychological or physiological symptoms and/or pathology, which bring the patient for therapy.

The Medical Hypno-analysis model further states that only when these repressed memories (the elements of the Triple Allergenic Theory) are accessed and the threatening emotional content *"disarmed",* will the symptoms and/or pathology be corrected. The patient's sense of self and self-concept will be positively influenced through these corrective emotional experiences and consequently growth towards self-actualization can be achieved.

1.3.3 THE EGO-STATE THERAPY MODEL

"Ego-state therapy is a psychodynamic approach in which techniques of group and family therapy are employed to resolve conflicts between various "ego-states" that constitute a "Family of Self" within a single individual. Although covert ego states do not normally become overt except in true multiple

personality, they are hypnotically activated and made accessible for contact and communication with the therapist." (Watkins, 1993:abstract).

John Watkins is the father of the Ego-State Therapy theory, although the concept of personality segmentation has been known since the days of Freud. Watkins (Watkins, 1993:233) underscored two processes in the development of human personality: integration (the process whereby concepts are put together, for example cats and dogs are called animals) and differentiation (the process whereby general concepts are separated into specific meaning). Both processes are normal. However, when differentiation becomes excessive and maladaptive, dissociation occurs (of which Dissociative Identity Disorder is the extreme form).

Ego-State Therapy focuses on the *"general principle of personality formation in which the process of separation has resulted in discrete segments, called ego-states, with boundaries that are more or less permeable."* (Watkins, 1993:233). The concept of discrete segments or multiplicity can also be understood as the experience of a physical or mental process as a part of the self (the *"I"*) or as an object (he/she/it). This is determined by the nature of the energy (ego or object) that activated the experience. Personality is therefore seen as a collection of perceptions, cognitions and effects organized into clusters or patterns, called ego-states. An ego-state is *"executive"* when it is invested with ego energy and is aware of the other ego-states as objects (invested with object energy). An executive ego-state becomes the *"self"* in the here and now (Watkins, 1993:234).

The development of an ego-state springs from normal differentiation, introjection of significant others and reactions to trauma (Watkins, 1993:234):

Normal differentiation*:* The child discriminates and develops patterns of behaviour that are appropriate for dealing with various social situations or interaction (for example the child discriminates between good and bad tasting foods and are able to adapt when dealing with parents and playmates).

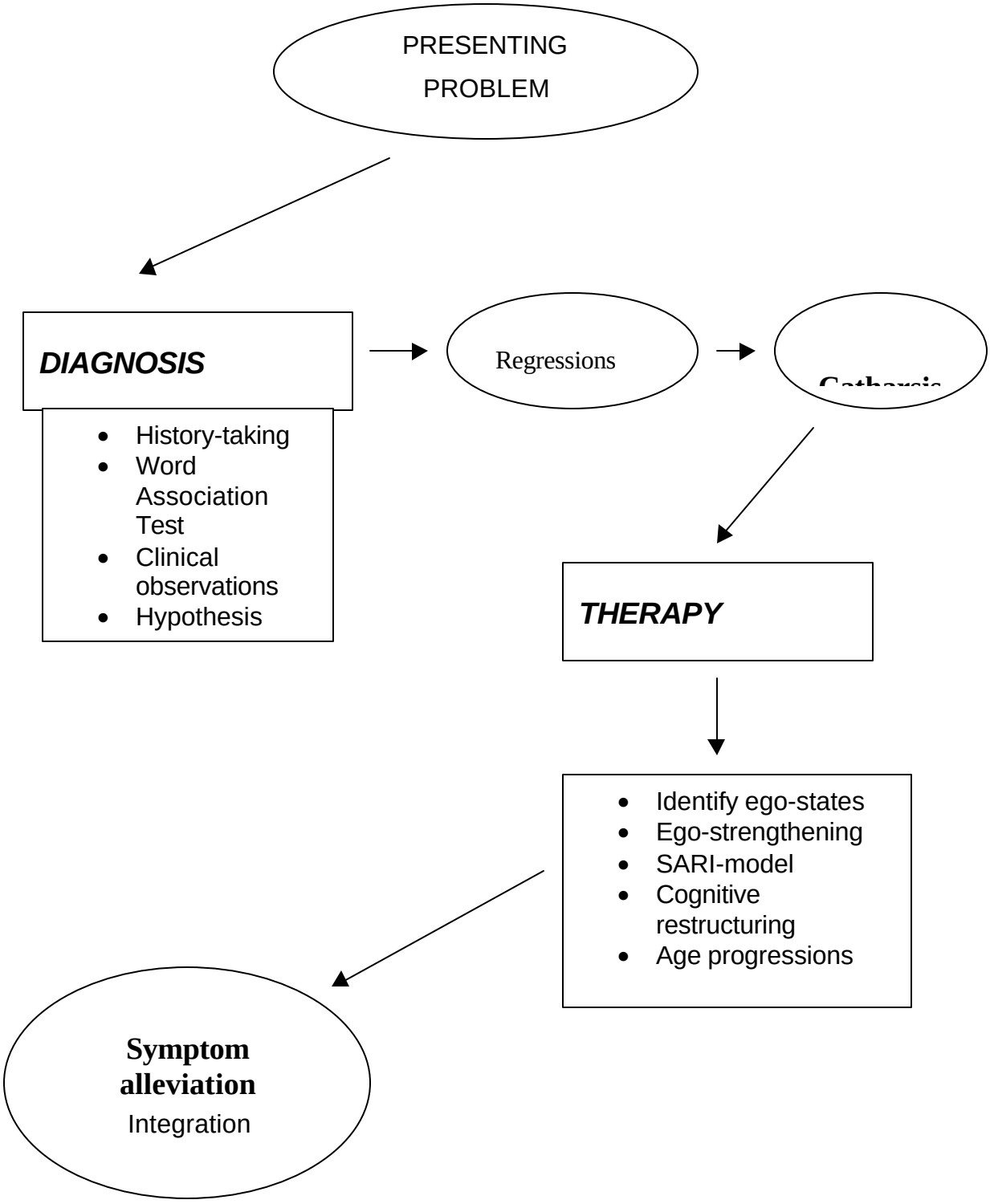
***Introjection of significant others**:* The child erects clusters of behaviour which if accepted by the self, becomes the roles identified as it's own; if not, it becomes an inner object with which he/she must relate and interact. These introjected significant others continue to live inside the child, even into adulthood (a child's perception of a punitive parent becomes an internalized object in the form of an ego-state and the ego-state becomes punitive on the child him/herself, in some form of self-mutilation. This self-mutilation might even continue into adulthood).

***Reactions to trauma**:* The child may dissociate as a survival response when confronted with overwhelming trauma, rejection or abuse (physical and/or emotional). The child may *"remove"* a part of him/herself (an ego-state) and repress it, but later on in life conflict or environmental pressure may reinvest repressed ego-states with energy and cause it to re-emerge. The re-emerging of such a repressed ego-state is more often than not malevolent.

In this study, the researcher will use concepts of the Medical Hypno-analysis model as well as the Ego-State Therapy model to identify the root causes for presenting symptoms/pathology and to intervene so that symptom alleviation can be achieved.

The following diagram can illustrate the treatment model, which is going to be used in this study:

FIGURE 1.1: Treatment model



SARI Model: Safety and Stabilization; Accessing Trauma Material; Resolving Traumatic Experiences; Integration and New Identity

1.4 LITERATURE SURVEY

"Sexual abuse develops out of the pervasive atmosphere of neglect…and may constitute a paradoxical attempt to solve kindness." (Scharff & Scharff, 1994:5)

TABLE 1.2: Literature survey summary

Some authors who wrote about sexual trauma and related topics	
TOPIC / THEME	**AUTHOR**
Behaviour Problems	Paivio & Nieuwenhuis (2001); Edmond, Rubin & Wambach (1999); Barnette (1987); Hall (1999); Scott (1999); Koopman, Gore-Felton & Spiegel (1997); Alexander, Anderson, Brand, Schaeffer, Grelling & Kretz (1998); Duane (1997); Frederick & Phillips (1995); Schwartz & Cohn (1996); Wade & Wade (2001)
Childhood Abuse	Shapiro & Dominiak (1992); Hagoon (2000); Paivio & Nieuwenhuis (2001); Edmond et al. (1999); Schooler (2001); Hall (1999); Heilbron & Guttman (2000); Scott (1999); Brown (1997); Koopman et al. (1997); Gill & Tutty (1997); Alexander et al. (1998); Duane (1997); Melchert & Parker (1997); Rodriguez (1996); Frederick & Phillips (1995); Schwartz & Cohn (1996); Wade & Wade (2001); Herman (1992)
Relationship Problems	Hagoon (2000); Edmond et al. (1999); Hall (1999); Scott (1999); Koopman et al. (1997); Gill & Tutty (1997); Alexander et al. (1998); Frederick & Phillips (1995)
Grief	Paivio & Nieuwenhuis (2001); Hall (1999); Alexander et al. (1998); Wade & Wade (2001)
Post Traumatic Stress	Kaplan, Sadock & Grebb (1994); Paivio & Nieuwenhuis (2001); Edmond et al. (1999); Barnette (1987); Koelling (1984); Hall (1999); Scott (1999); Brown (1997); Koopman et al. (1997); Alexander et al. (1998); Rodriguez (1996); Frederick & Phillips (1995); Schwartz

	& Cohn (1996); Wade & Wade (2001); Herman (1992)
Self-esteem	Kaplan et al. (1994); Shapiro & Dominiak (1992); Hagoon (2000); Koopman et al. (1997); Gill & Tutty (1997); Duane (1997); Rodriguez (1996)
Identity and Gender Identity	Barnette (1987); Koelling (1984); Gill & Tutty (1997)
Aggressive Behaviour	Kaplan et al. (1994); Hall (1999); Duane (1997); Rodriguez (1996); Frederick & Phillips (1995)
Substance Abuse	Kaplan et al. (1994); Scott (1999); Schwartz & Cohn (1996)
Sexual Victimization	Shapiro & Dominiak (1992); Gill & Tutty (1997); Duane (1997)
Self-harming Behaviour	Shapiro & Dominiak (1992); Hagoon (2000); Scott (1999); Alexander et al. (1998); Duane (1997); Wade & Wade (2001)
Spiritual Healing	Koelling (1984); Barnette (1987); Heilbron & Guttman (2000); Ganje-Fling, Veach, Kuang & Houg (2000)
Mental Imagery	Koelling (1984); Brown (1997)
Incest	Alexander et al. (1998); Duane (1997); Melchert & Parker (1997)
Family Dysfunction	Koopman et al. (1997); Gill & Tutty (1997); Alexander et al. (1998); Duane (1997)
Repressed Memories	Shapiro & Dominiak (1992); Edmond et al. (1999); Schooler (2001); Hall (1999); Scott (1999); Melchert & Parker (1997); Frederick & Phillips (1995); Schwartz & Cohn (1996); Wade & Wade (2001)
Anxiety	Abdulrehman & De Luca (2001); Kaplan et al. (1994); Koelling (1984)

Some authors who wrote about Hypnotherapy and related topics	
TOPIC / THEME	**AUTHOR**
Psychosomatic Illness	Barnette (1987); Koelling (1984); Scott (1999); Frederick & Phillips (1995); Schwartz & Cohn (1996)
Eating Disorders	Hagoon (2000); Scott (1999); Duane (1997); Schwartz & Cohn (1996)
Suicide	Kaplan et al (1994); Hall (1999); Duane (1997)
Alcohol and Drug Addictions	Kaplan et al (1994); Koelling (1984); Hall (1999); Scott (1999); Duane (1997)
Intimacy	Hagoon (2000); Koelling (1984); Koopman et al (1997); Gill & Tutty (1997); Alexander et al (1998); Duane (1997)
Recovered Memories	Shapiro & Dominiak (1992); Barnette (1987); Schooler (2001); Hall (1999); Scott (1999); Melchert & Parker (1997); Frederick & Phillips (1995); Schwartz & Cohn (1996); Wade & Wade (2001)
Guilt	Shapiro & Dominiak (1992); Edmond et al (1999); Brown (1997); Duane (1997); Somer & Szwarcberg (2001)
Dissociative Disorders	Kaplan et al (1994); Paivio & Nieuwenhuis (2001); Edmond et al (1999); Schooler (2001); Hall (1999); Scott (1999); Koopman et al (1997); Rodriguez (1996); Frederick & Phillips (1995); Schwartz & Cohn (1996); Wade & Wade (2001)
Emotional Focused Therapy	Paivio & Nieuwenhuis (2001)
Eye Movement Desensitization and Reprocessing	Edmond et al (1999); Wade & Wade (2001)
Prenatal Trauma	Barnette (1987); Koelling (1984)
Birth Trauma	Koelling (1984); Barnette (1984)
Ego-State Therapy	Scott (1999); Frederick & Phillips (1995); Schwartz &

	Cohn (1996); Wade & Wade (2001)
Conscious and Subconscious	Hagoon (2000); Barnette (1987); Koelling (1984); Schooler (2001); Scott (1999); Brown (1997); Alexander et al (1998); Melchert & Parker (1997); Frederick & Phillips (1995); Schwartz & Cohn (1996); Wade & Wade (2001)

1.4.1 SEXUAL TRAUMA, SELF-ACTUALIZATION AND HYPNOSIS

The phenomenon of suffering from symptoms related to post traumatic stress disorder as a result of being a victim of sexual crimes, is a topic that occurs through-out the theoretic history of both psychology and education. As early as the writings of Freud (1907), Milton Erickson (1967) and Carl Rogers (1969) the focus was on the impact of any traumatic event on the development and actualization of the individual self in relation to the self, as well as to the external world in all its facets. From thereon the development of the relation theory, which has as focus point self-actualization (to be the best you that you can be), as well as healthy relations and relationships. This implies that internal growth and development has the objective of establishing healthy relationships with the person him/herself, as well as with other individuals, objects and ideas.

Self-actualization focuses on the establishment of a healthy, balanced ego in which the person has a positive, strong self-concept, self-value, self-identity, self-experience and self-involvement of the internal self projected, and in relation to the external self and the individual's world (Sandler & Sandler, 1978:285). Self-actualization is therefore inhibited as long as the individual is still suffering from any form of unresolved emotional issues, memories or painful events. Neglecting to resolve these events timeously may result in the development of pathology or malfunctioning of the internal self, as the subconscious mind might develop pathological behaviour to protect the conscious mind from unresolved trauma (Erickson, 1967:195).

According to a study done by Cameron (2000:77) caused unresolved childhood sexual trauma (either abuse, molestation or rape) cumulative developmental damage in the development of the self. Adult survivors commonly suffer from unsatisfactory relationships with persons of the same sex as the perpetrators and often have extreme social attitudes towards sex and sexual behaviour (such as being either promiscuous or totally withdrawn). The majority of them also suffered from low self-esteem and self-value, as well as partial or total amnesia of the childhood incidents. Hagoon (2000:81) found in her study that projective techniques such as art and progressive relaxation were successful in accessing repressed memories of traumatic childhood sexual experiences. Hartman (1994:01) also used hypnosis with children successfully in resolving sexual trauma. He stated that sexual trauma inhibited the development of healthy ego-states and that only through hypnosis can these ego-states be accessed, activated and the trauma resolved.

1.4.2 CONCLUSION

Extensive research has been done over many years in the fields of sexual trauma, sexual abuse (specifically childhood sexual abuse) and hypnosis, and even during the time of Freud were hypnosis, hypnotic suggestions and age regressions in adulthood successfully used to access repressed memories of childhood sexual trauma. Research also reflects that concepts from the Medical Hypno-analysis as well as concepts from the Ego-State Therapy models were utilized during therapeutic intervention with survivors of sexual crimes. Erickson (1967:195), Hagoon (2000:26), Kaplan et al. (1994:188), Scharff and Scharff (1994:81), and Hartman (1994:01) all researched the use of Ego-State Therapy with children survivors of sexual abuse. However the combination of the two models as an integrated model within the perspective of psycho-education and with adult survivors of earlier sexual abuse has not yet been documented. It is therefore evident through the literature survey done, that this study is warranted.

1.5 STATEMENT OF THE PROBLEM

In the preceding sections the researcher became aware of the fact that psychopathology and/or posttraumatic stress symptoms in adulthood might not only be the result of childhood sexual crimes, but might date back to the experience of the birth process (as possible Initial Sensitizing Event) as well. Although it has been noted, the researcher's main focus will be on the sexual traumatic events unless otherwise indicated.

The use of hypnotherapy as therapeutic tool proved to be successful in treating unresolved trauma. The research question confronts the use of both modalities within hypnosis; thereby exploring the phenomenon that symptom reduction might be even more successful when linking unresolved birth trauma with unresolved childhood sexual trauma.

The question to be addressed is whether:

A hypnotherapy model can be used successfully for the treatment of survivors of sexual crimes from a psycho-educational perspective?

This study problem implicates the following research aspects:

- Research literature on *the therapeutic tool* - the use of two hypnotherapy models, Medical Hypno-analysis and Ego-state Therapy in the treatment of survivors of sexual crimes,

- Research literature on *the effects of childhood sexual crimes* on the formation and development of psychopathology and growth towards self-actualization in adulthood,

- The effectiveness of this model within a psycho-educational perspective.

1.6 HYPOTHESIS

This study will be qualitative of nature and the main sources of data for analysis will be case studies. The effectiveness of this model will be evaluated in terms of the satisfactory reduction and/or resolution of symptoms associated with sexual trauma as well as the effects thereof on the survivor's psychological development and growth towards self-actualization, after the therapeutic process has been completed. The researcher's hypothesis is as follows:

The first hypothesis the researcher will endeavour to prove is that the use of this hypnotherapy model will be highly effective with adult survivors of sexual crimes (survivors of this study will have a five-year or older memory of the incident(s)).

The second hypothesis is that the use of regression in hypnosis will activate ego-states related to the trauma and therefore allow for therapeutic intervention in the subconscious mind at the core of the formation of the defense mechanism to protect the *"self"* and *"identity"* of an individual. Repressed memories will be recalled and the full dynamic picture of a memory accessed in order to remove wrong perceptions and to change the effect of the emotional content of a traumatic event.

The researcher is also of opinion that this specific hypnotherapy model (the combination of Medical Hypno-analysis and Ego-State Therapy models) could contribute to the field of educational-psychology and will be effective in helping the patient to re-establish healthy relationships and relations not only within him/herself and with him/herself, but also with his/her external world in order to reach his/her full potential in the quest for self-actualization.

The hypothesis will be stated formally in the research design (Chapter 4).

1.7 AIM OF THE STUDY

The aim of the study is as follows:

1.7.1 to do a literature study on the effects of unresolved sexual trauma and the aftermath of earlier sexual crimes committed against a victim,

1.7.2 to empirically investigate and evaluate the use of a combination of two hypnotherapy models (Medical Hypno-analysis and Ego-State Therapy) from a psycho-educational perspective as a therapeutic technique in resolving trauma related to sexual crimes (specifically earlier sexual abuse). The study will focus on the practical feasibility of such a model within current trends in short-term therapy and hypnosis. It will further evaluate the effectiveness of combining different hypnotherapy models in order to develop and enhance healthy internal and external object- and ego-relations for survivors of sexual crimes.

1.7.3 to evaluate the use of such a model within the framework of a psycho-educational perspective on survivor's psychological development and growth towards self-actualization.

1.8 DEMARCATION OF THE STUDY

As the purpose of this study is to answer the research question, it will only focus on the aftermath of sexual crimes on young adult survivors, and not on the perpetrator, or the criminal aspects involved when working with sexual crimes.

The literature survey highlights a wide variety of concepts within the field of sexual crimes, but the researcher decided to use the word *"survivor"* instead of *"victim"* to describe the patients used for this study. The aim being that the word *"victim"* implies that a person is powerless (without the ability to defend him/herself) whilst *"survivor"* implies having been powerless but lived to

overcome the powerlessness and being on the road to healing and internal growth. Thus, *survivors* in this study will be young adults (male or female) between the ages of 18 and 30 years, who have lived through the trauma of sexual crimes and continued to remain active beyond the extent of their abuse.

The term *sexual crimes* will include any sexual abuse, molestation and/or rape that had occurred at least five years prior to the patient's current age and/or during childhood. Survivors might have a vivid memory or no memory of these sexual crimes.

1.9 CLARIFICATION OF CONCEPTS

All the concepts used in this study (which have not yet been clarified) are briefly presented in this chapter and will be further discussed in the following chapters:

- **Sexual crimes**

  Acts that in some way violated another person's basic human rights. A sexual crime is thus any sexual violation of another's human rights; often a violation of another's right to choice, freedom and privacy. In this study *"sexual crimes"* will refer to sexual abuse, rape, molestation or both. It is any form of illegal sexual act against any other person, child or adult. It is any penetration of a survivor's ultimate territorial boundary of his/her skin, leaving the survivor feeling *"not whole",* not able to maintain basic trust in others and questioning his/her ability to control his/her environment.

- *Survivors of sexual crimes* are persons who fell victim to a sexual crime during some stage or developmental phase of their lives.

- *Sexual abuse* refers to any form of physical contact (fondling, touching, kissing, stroking) of a person with another (regardless of their ages), without penetration. The physical contact is more intense than that of

showing *"normal"* affection or nurturing (giving a hug or helping to get dressed).

- *Sexual molestation:* Sexual molestation refers to any act of a person (verbal or non-verbal) that is sexually underpinned, directed at another person, but does not involve physical contact or penetration (for example flashing of genitals, verbal gestures and suggestions, touching of self in front of another and so on) (Scharff & Scharff, 1994:6).

- *Rape:* Rape is the perpetration of an act of sexual intercourse with a male or female, without the person's consent and against his/her will (whether his/her will is overcome by force or drugs or intoxicants or fear resulting from the threat of force; or when because of mental deficiency he/she is incapable of exercising rational judgment, or when he/she is below an arbitrary age of consent)(Kaplan et al., 1994:789).

- *Incest:* Incest is defined as the occurrence of sexual relations or intercourse between close blood relatives or persons who are related to one another by some formal or informal bond of kinship that is culturally regarded as a bar to sexual relations (for example sexual relations between stepparents and stepchildren) (Kaplan et al., 1994:788). In some cultures such sexual acts are seen as initiation acts or traditional rituals symbolizing the transition between puberty and adulthood and therefore in those cultures are not regarded as sexual crimes or incest (Wettlaufer, 2000:113).

➢ **Adult survivors of childhood sexual crimes**

Adult survivors of childhood sexual abuse, molestation or rape occurring five years or more prior to the therapeutic intervention. The rationale behind this is that adult survivors suffer the trauma within their inner child and it is this inner child that will show the signs, symptoms and pathology similar to that of a child that was sexually abused.

- **Hypnosis**

Hypnosis is a normal physiological altered state of consciousness and can also be seen as a dissociative and focusing process, as it increases concentration of the mind, relaxation of the body and susceptibility to suggestion (and therefore change) (Watkins, 1993:233). It allows *"access"* to the subconscious mind, as conscious defense mechanisms are *"side-stepped"*. It is also in this altered state of consciousness that repressed memories can be recalled through regression.

- **Hypnotherapy**

Hypnotherapy is any form of psychotherapy conducted with a patient in an altered state of consciousness or in hypnosis. As the right-hand side of the brain is more dominant during hypnosis, the therapist can communicate to a greater or lesser degree with the patient's subconscious mind (Scott, 1993:57).

- **Hypno-analysis**

According to Scott (1993:49) the term hypno-analysis was used in the past to refer to the implementation of hypnosis as a therapeutic technique whereby direct suggestions were used to aid psychoanalysis and/or to remove psychological and/or physiological symptoms. The aim of hypno-analysis is to diagnose the patient's total personality attributes in order to formulate a treatment plan.

- **Medical Hypno-analysis**

The Medical Hypno-analysis model is a structured model based on the process of diagnosis and therapy. In diagnosing the root causes of all presenting problems, symptoms or pathology are investigated and explained. Once the psychodynamic diagnosis is made, therapy is conducted in a

relatively short timeframe (between 10 – 18 sessions) when underlying subconscious problems are addressed (Matez, 1992:155).

- **Ego-State**

An ego-state is a state of operation and constitutes an organized system of behaviours and experiences whose elements are bound together by some common principle (Watkins, 1993:233). Ego-states may constantly develop and/or be altered. An ego-state is like a *"small personality"* within a greater personality – like a cake divided into different segments. It may therefore be large or small and so its influence on the person's efficient functioning.

- **Ego-State Therapy**

Ego-State Therapy is therapy normally conducted in hypnosis and with two or more ego-states. It has as basis the principles as found in group and family therapy and view the person as a *"self"* constituting of different ego-states, integrated to a lesser or greater degree. Psychological and psychosomatic symptoms, as well as psychopathology are viewed as the malfunctioning of an ego-system within the patient.

- **Differentiation**

Differentiation is the process whereby a person separates general concepts into specific meaning, such as discriminating between *"good mother"* and *"bad mother".* It is a normal process and allows a person to experience a set of behaviours as appropriate in one situation but inappropriate in another.

- **Regression**

Regression refers to a therapeutic technique used when the patient is in hypnosis, enabling the patient to access and recall memories of an earlier age or stage in his/her life. *"Regression"* in the Medical Hypno-analysis model

traces memory back to the period right after conception, even before the birth process commenced.

- **Integration**

"Integration refers to an ongoing process of undoing all aspects of dissociative dividedness that begins long before there is any reduction in the number or distinctness of the personalities, persists through their fusion, and continues as a deeper level after the personalities have been blended into one." (Kluft in McClendon, 1994:Abstract).

1.10 DIVISION OF CHAPTERS IN THIS STUDY

The study comprise of seven chapters of which the brief outlay is as follows:

- *Chapter 2:* Literature review and theoretical background on trauma related to sexual crimes (earlier age sexual abuse, rape and/or molestation), and the aftermath thereof.

- *Chapter 3:* Literature review and theoretical background on hypnotic theories and perspectives with specific reference to the Medical Hypno-analysis and Ego-State Therapy models.

- *Chapter 4:* Description of research design and research methodology that will be used in this study:
    - Medical Hypno-analysis Questionnaire
    - Analysis derived from this questionnaire.

- *Chapter 5:* Data and collective information of patients (case studies) as well as the analysis and discussion of the research results.

- *Chapter 6:* Discussion and application of the proposed hypnotherapy model within the frame of psycho-education.

- *Chapter 7:* A summary of the study as well as conclusions arrived at and recommendations made as a result of the study.

1.11 CONCLUSION

Extensive research has been done on the topic of childhood sexual abuse. Previous researchers have established the fact that childhood sexual trauma has an immense impact not only on children survivors, but also adult survivors. Therapeutic interventions with such survivors proved to be a long-term and tedious process, as the scars had been carried since childhood.

With this study, the researcher will investigate the possibility of a more effective short-term therapeutic intervention, by combining concepts from the Medical Hypno-analysis and Ego-State Therapy modalities. The hypothesis is that the use of hypnosis will bypass conscious defenses that might counteract the therapeutic process, whilst the use of the diagnostic techniques (from the Medical Hypno-analysis model) will help to diagnose and establish the root causes of symptoms, thus enhancing the therapeutic process. The treatment model (Ego-State Therapy) proved to be successful in the treatment of symptoms/pathology associated with dissociation and trauma, and as exposure to sexual crimes during childhood might lead to the development of defenses such as dissociation, the use of this model will also enhance recovery and inner healing.

CHAPTER 2

A LITERATURE STUDY OF SEXUAL CRIMES

"Every one of us is a sum total of past experiences and perceptions. When we cut ourselves off from our pasts, we cut ourselves off from our own identities. We are less than whole. The whole and healthy person embraces both past and future."

- **Maxine Hancock, 1988.**

2.1 INTRODUCTION

A wide variety of psychological, physiological and social problems have been connected with childhood sexual crimes. Although life itself once in a while spontaneously heals by providing corrective emotional experiences for trauma, symptomatology is often left untreated and the same problematic behaviours carried into adulthood (such as anxiety, depression, low self-esteem, sexual problems, revictimization, suicidal tendencies, fear, aggression and guilt) (Abdulrehman & De Luca, 2001:195). Herman (1992:96) stated that the majority of children do not disclose sexual crimes until adulthood for an array of different reasons, such as the conflict between the need to deny unbearable experiences and the need to give testimony. Disclosure is often delayed due to the child's fear of social rejection, mistrust of parents/people, the belief in the importance of obedience to grownups and sometimes even the fear of the criminal justice system.

Somer and Szwarcberg (2001:339) identify variables pertinent to the withholding or disclosure of childhood sexual crimes such as the child's guilt and shame, helplessness, emotional attachment to the perpetrator, idealized self-identity,

mistrust of others, dissociation, the burden of the secret, ego-strengthening experiences, concern for others, loyalty to the family and concern for family integrity, fear of blame and the intensity of the traumatization. Many of these variables undermine a child's evolving assumptions about him/herself and the world. Hagoon (2000:79) finds that when children disclose sexual crimes, parents often ignore these reports, silence the child, threatens the child or minimize the incidents. This often results in the trauma being left untreated and repressed.

The researcher is of opinion that it is of the utmost importance to investigate the symptomatology/pathology experienced by traumatized children in order to understand the complexity of the phenomenon of sexual trauma related to childhood sexual crimes and the effects thereof in adulthood. This chapter will consequently focus on the signs and symptoms of childhood sexual crimes in adult survivors, ego defenses, the effects of childhood sexual crimes on relationships and object relations, and the treatment of adult survivors of childhood sexual crimes. As childhood traumatic material is often repressed, the process of memory storage will also be investigated.

The purpose of this chapter is to establish the theoretical background/framework for the phenomenon under investigation in this study. Through the conceptualization of the theoretical background of the phenomenon, the researcher focuses on answering one aspect of the research question, namely *the effects of childhood sexual crimes* on the development of psychopathology and growth towards self-actualization in adulthood.

2.2 DEFINITION OF CHILDHOOD SEXUAL CRIMES

Childhood sexual crimes can be defined as any physical contact between a child (minor) and a significantly older person that the child perceives (or comes to perceive) to be of a sexual nature and to have resulted in undesirable consequences (Gasker, 1999:82). It refers to any sexual experience whereby the

child felt violated, traumatized or abused in any way by a perpetrator. Shalev, Yahuda and Mcfarlane (2000:168) divided abuse into three groups based on the degree of violence on the body: *penetrative sexual abuse* (vaginal and/or anal intercourse); *non-penetrative sexual abuse* (petting, touching and masturbation) and *abuse involving no physical contact*. Hagoon (2000:84) defines sexual crimes as a neglect of the child's intimate needs through the imposition of an adult's will. It is assaultive to the senses – sight, hearing, touch, smell and taste – and occurs unseen and unheard by outsiders. This leaves the child confused, without any external validation of his/her reality, often feeling not only polluted on the outside, but also on the inside.

"You are not even safe within your own body." (Hagoon, 2000:57)

Incest refers to a paradox that occurs when the logic of a relationship is cancelled, for example when someone is asked to play two or three incompatible roles of which one is a sexual role (Everstine & Everstine, 1989:89). A child who is caught in an incestuous family system is immersed in such a paradox because he/she must be a child, a *"lover"* to the parent and a *"parent"* to the sexually uninvolved parent. Time is therefore suspended for the child, as it is halted and accelerated. The child is thrust into a complex sexual relationship beyond his/her years, which accelerates time, but the relationship is also so overpowering that it arrests some of the significant aspects of personality development (therefore halted).

According to Krystal (in Scharff & Scharff, 1994:23) *childhood trauma* is experienced when stimuli are defined as trauma by active, affective, perceptive and cognitive processes. These processes register the stimuli in terms of the child's personal subjective reality in the situation of helplessness, to which meaning was ascribed in the light of past experiences and attitudes about the self. It is further heralded by intense affect from which the parent failed to protect the child.

2.3 SIGNS AND SYPMTOMS OF CHILDHOOD SEXUAL CRIMES IN ADULT SURVIVORS

Trauma and post-traumatic stress is often associated with childhood sexual crimes, as external events is psychologically perceived and transduced into psychological, physiological and social manifestations (Shalev et al., 2000:168). Elhai, Freuh, Gold, Gold and Hamner (2000:710) found that the clinical presentation of post-traumatic stress on the MMPI-2 presented more similarities than differences for combat veterans seeking outpatient treatment and post-traumatic stress diagnosed adult survivors of childhood sexual crimes. However, childhood sexual crimes differ from other traumatic stressors, as indicated in the table below:

TABLE 2.1: The differences between childhood sexual crimes and other traumatic stressors.

- It is human-induced and often premeditated, - It entraps the victim due to the length of time it continues, - It often occurs in the context of other forms of abuse such as physical mistreatment and/or emotional neglect, - It is misrepresented to the child, who is threatened to keep it a secret, - It is often continuous and intervention is not available, - The impact thereof often derails the child's personal and social development.

(Courtois in Classen, 1995:2)

Landis (in Everstine & Everstine, 1989:13) divided traumatic consequences of childhood sexual crimes into initial and long-term effects, where **initial effects** occur in the first two years after the abuse ceased (such as fear, anxiety, sleep disturbances, somatic complaints, regressive behaviour, poor self-esteem, inability to trust, depression with underlying anger and hostility, poor concentration, inappropriate sexual behaviour, guilt, shame, and self-destructive

behaviours). **Long-term effects** occur during adulthood (such as depression, self-destructive or suicidal behaviour, anxiety, feelings of isolation and alienation; negative self-concept; impaired interpersonal relationships; vulnerability to revictimization, a propensity to choose abusive partners, problems with sexual adjustment and substance abuse).

Courtois (in Classen, 1995:18) categorized the initial and long-term effects of childhood sexual crimes and their associated symptoms into seven categories:

1. Post-traumatic and post-traumatic stress syndrome reactions;

2. Emotional reactions (anxiety, fear, depression, guilt, anger, self-destructive thoughts and behaviours);

3. Self-perceptions that are predominantly negative and indicative of low self-esteem, shame, stigma, and a sense of malignant power;

4. Physical and somatic effects (including physical manifestations of emotional reactions);

5. Sexual effects (dysfunctions, aversions, and obsessions/compulsions);

6. Interpersonal effects characterized by mistrustful relationships and difficulty with intimacy;

7. Social effects ranging from superior functioning to a total inability to function socially or occupationally.

Additionally, he indicated that survivors often have histories marked by depersonalization and periods of dense amnesia, repeated victimizations in adulthood, repeated episodes of self-harm (cutting, burning, risk-taking

behaviour), repeated suicide attempts or chronic suicidal ideation, and sometimes repeated unsuccessful attempts at therapy.

Landis (in Everstine & Everstine, 1989:15) indicated the following variables in after-effects of childhood sexual trauma:

TABLE 2.2: Variables in the after-effects of sexual trauma.

- The age of the child; - The emotional vulnerability of the child; - The child's previous sexual knowledge or experience; - The type of assault, presence of violence and degree of bodily penetration; - Number and frequency of assaults; - The child's relationship to the perpetrator; - The reactions of significant other; - Being supported and believed or not; - The availability of treatment/ therapy.

(Landis in Everstine & Everstine, 1989:15)

Classen (1995:xvi-xix) indicated the following developmental factors regarding the survivor's age, influencing his/her response to sexual crimes:

- ***Infancy:*** Infants will be affected by the physical trauma of the experience and it will jeopardize their basic trust, physical integrity and sense of having control over external events, but they will not have any awareness of the inappropriateness of what is occurring;

- ***Toddlers:*** Begin to show an awareness of social situations, but little awareness of impropriety. They are making significant advances in the development of a sense of self and sensitivity to social interactions, therefore sexual violation at this age might result in

physical and emotional trauma even though the child is still too young to have specific memories.

- ***Preschoolers:*** (age 2-5) They are working to integrate a sense of themselves as active agents in the world with the restrictions imposed on them by the outside world. They are beginning to learn skills for coping with distress and if these skills are inadequate then denial or dissociation may occur.

- ***Elementary school years:*** Children's cognitive capacities increase along with their social competency. They are able to reflect on themselves as objects and considering other's perspectives. They have developed the capacity for guilt, have a moral sense of right and wrong and use defenses such as rationalization and blaming others. Sexual crimes will result in feelings of shame, guilt and confusion leaving them feeling insecure and hindered in their development of interpersonal relationships.

- ***Adolescence:*** They are struggling with issues of identity and sexuality, have developed the ability for abstract thinking, which enables them to reflect on their inner experiences, thoughts and feelings of others. Sexual crimes will lead to confusion, shame, and guilt, having an adverse effect on the development of self-identity and inhibiting exploration of relationships with the opposite sex.

An adult survivor's locus of control has an impact on the severity of the symptoms developed related to childhood sexual crimes (Porter & Long, 1999:12). A survivor with an internal locus of control often suffers lower levels of distress, while someone with an external locus of control suffers from extremely elevated levels of distress. The following paragraphs will investigate the physiological, psychological and spiritual symptoms related to adult survivors of childhood sexual crimes.

2.3.1 PHYSIOLOGICAL SYMPTOMS

The American Medical Association (1995) indicated that the intensity of childhood sexual crimes impairs the adult survivor's neurophysiological mechanisms of adaptation. The person's physiological ability to regulate and tolerate internal and external stimuli can be altered in such a way that his/her ability to organize perceptual stimuli and cognitive information is being compromised. This results in the survivor being more susceptible to a range of somatic disorders and a spectrum of anxiety and depressive disorders. This correlates with the findings of Steiger, Gauvin, Israel, Koerner, Ng Ying Kin, Paris and Young (2001:842) suggesting that childhood sexual trauma often reduces post-synaptic 5-HT activity and cortisol levels (hypothalamic-pituitary-adrenal axis).

Research by Bollerud (in Shapiro & Dominiak, 1992:143-158) noted that chronic hyper-arousal and the alteration of the central nervous system contributed to survivors' heightened vulnerability to addiction. The alterations in the levels of several neurotransmitters (including nor-epinephrine and serotonin), as well as deregulation of the endogenous opioid system, can also lead to ineffective coping and self-soothing strategies (Putnam in Alpert, 1995:45).

Other physical complaints related to adult survivors of childhood sexual crimes include autoimmune illnesses, chronic pain and/or fatigue, chronic pelvic pain, gynecological problems, chronic urinary tract conditions, dizziness, migraines, headaches, respiratory disorders (asthma), epileptic seizures, gastrointestinal difficulties, eating disorders, sexual dysfunctions and increased lifetime risk of surgery (Hyman, 2000:200; Monahan & Forgash, 2000:31).

2.3.2 PSYCHOLOGICAL SYMPTOMS

"A profound sadness coloured my growing-up years. I remembered feeling a special affinity for stories of child heroes who sacrificed themselves for their country, their religion or (especially) for their family." (Aluna, in Cameron, 2000:129).

There is considerable evidence that many children who are sexually abused will grow up to experience psychological difficulties as adults. *"Sexual victimization of children creates in them a sense of powerlessness, worthlessness and an inability to produce change or gain control over their surrounding environment even into adulthood."* (Shapiro & Dominiak, 1992:01). These difficulties are rather a spectrum of psycho-physiological conditions than a single disorder (Lucenko, Gold & Cott, 2000:169; Monahan & Forgash, 2000:28). It is also possible that a survivor's first consummated sexual encounter in adolescence or adulthood may parallel childhood sexual abusive incidents and trigger a series of promiscuous, dangerous and self-destructive behaviours (Alexander, Anderson, Brand, Schaeffer, Grelling & Kretz, 1998:49; Freud in Kaplan et al., 1994:237).

An adult survivor's childhood and even early adolescence history is also often marked by psychosomatic and/or psychological symptoms. The researcher is of opinion that the effects of sexual crimes on children should also be understood before adult symptomatology can be investigated. Hagoon (2000:79-85) elaborates on the following symptoms in sexually traumatized children:

- ***Fear and guilt*****:** Traumatized children are fearful not only of the consequences of the sexual activity, but also of the possibility of subsequent incidents of abuse if they are not in an environment completely safe from the perpetrator. Fear, anxiety and guilt often affect other parts of their lives such as: making friends, concentrating on schoolwork, nail-biting, shyness, sleep disturbances, bedwetting and nightmares;

- ***Depression*****:** Traumatized children may exhibit depression *overtly* (they appear sad and subdued) or *covertly* (masked with fatigue or physical illness). Self-mutilation or suicide attempts may be acted out;

- ***Anger*****:** Traumatized children usually turn their anger inwards resulting in depression, but they may also have frequent temper-tantrums, poor impulse control, and become abusive (emotionally, physically and

sometimes sexually) towards their siblings, other children or adults. Defiance and disobedience are common;

- ***Low self-esteem and poor socialization skills*:** Low self-esteem is reflecting in acting out behaviour. Traumatized children typically seek to confirm the negative view of themselves by acting out and provoking others to reject, abandon or abuse them, thus validating that they are indeed worthless;

- ***Poor boundaries*:** Traumatized children are usually starved for affection or have learned to get it by sexualized behaviour. They may have little or no concept of appropriate boundaries;

- ***Sexually abusing other children*:** They may act out sexually with other children;

- ***Personal safety and self-protection*:** Traumatized children learn several different self-protective behaviours, such as seduction.

Classen (1995:xxi) stated that psychological conditions in adult survivors of childhood sexual crimes can be divided into four categories: **emotional problems** (anxiety, sadness, shame and guilt for having received some gratification out of the experience, depression, rage and confusion due to conflicting feelings of pleasure and pain); **low self-esteem and identity problems** (survivors believe that there's something inherently wrong with them, therefore they deserved the abuse and are bad or worthless); **relationship problems** (having been betrayed and traumatized, survivors may have difficulty forming close and trusting relationships); and **sexual problems** (survivors may engage in compulsive sexual acting out or have difficulty in becoming aroused and/or an inability to orgasm).

Research found that most psychological symptoms correlated closely with post-trauma stress disorder symptoms due to the traumatizing nature of childhood sexual crimes. Following is a table of the most common symptoms:

TABLE 2.3: Psychological symptoms in adult survivors of childhood sexual crimes.

Negative body image	Roussillon (1999); Cameron (2000)
Low self-esteem	Kenny & McEarchern (2000); Abdulrehman & De Luca (2001);Roussillon (1999); Monahan & Forgash (2000); Rice (1987)
Substance abuse	Kenny & McEarchern (2000); Abdulrehman & De Luca (2001); Teuch (2001); Clay, Olsheski & Clay (2000); Roussillon (1999); Bollerud in Shapiro & Dominiak (1992)
Eating disorders	Roussillon (1999); Everstine & Everstine (1989)
Difficulty with intimacy	Roussillon (1999); Monahan & Forgash (2000)
Disturbances in sexuality	Abdulrehman & De Luca (2001);Roussillon (1999); Erickson & Rossi (1989); Everstine & Everstine (1989)
Depression	Kenny & McEarchern (2000); Abdulrehman & De Luca (2001); Whiffen, Thompson & Aube (2000); Roussillon (1999); Monahan & Forgash (2000); Rice (1987); Lucento et al. (2000); Cameron (2000); Everstine & Everstine (1989); Erickson & Rossi (1989); Bollerud in Shapiro & Dominiak (1992)
Intrusive thoughts/flashbacks	Erickson & Rossi (1989); Bollerud in Shapiro & Dominiak (1992)
Interrupted sleep	Monahan & Forgash (2000); Erickson & Rossi (1989); Everstine & Everstine (1989); Bollerud in Shapiro & Dominiak (1992)
Agitated behaviour/irritability	Monahan & Forgash (2000)
Anger dyscontrol	Abdulrehman & De Luca (2001); Monahan & Forgash (2000); Everstine & Everstine (1989); Cameron (2000); Bollerud in Shapiro & Dominiak (1992); Kenny & McEachern (2000)

Concentration problems	Monahan & Forgash (2000)
Feeling alienated from others	Abdulrehman & De Luca (2001); Rice (1987); Elhai, Gold, Mateus & Astaphan (2001); Monahan & Forgash (2000)
Phobic or avoidance behaviour	Monahan & Forgash (2000); Everstine & Everstine (1989); Cameron (2000)
Feelings of hopelessness	Monahan & Forgash (2000)
Feelings of helplessness	Monahan & Forgash (2000)
Mood swings	Monahan & Forgash (2000)
Flat affect	Monahan & Forgash (2000); Erickson & Rossi (1989); Kernberg in Shapiro & Dominiak (1992)
Inability to trust	Rice (1987); Everstine & Everstine (1989); Freud in Shapiro & Dominiak (1992)
Poor social skills	Abdulrehman & De Luca (2001); Rice (1987)
Poor self-concept	Rice (1987)
Hostility and suicidal tendencies	Abdulrehman & De Luca (2001); Rice (1987); Erickson & Rossi (1989); Everstine & Everstine (1989); Cameron (2000); Lucento et al. (2000); Freud in Shapiro & Dominiak (1992)
Fear and anxiety	Kenny & McEarchern (2000); Abdulrehman & De Luca (2001); Everstine & Everstine (1989); Cameron (2000); Lucento et al. (2000); Bollerud in Shapiro & Dominiak (1992)
Guilt and shame	Everstine & Everstine (1989); Kenny & McEachern (2000)
Self-destructive/ mutilative behaviour	Kenny & McEarchern (2000); Abdulrehman & De Luca (2001); Everstine & Everstine (1989); Cameron (2000); Kolb in Scharff & Scharff (1994); Elhai et al. (2001)
Dissociative symptoms	Lucento et al. (2000); Elhai et al. (2001)
Chemical dependency	Freud in Shapiro & Dominiak (1992)
Cognitive deficits	Elhai et al. (2001); Kernberg in Shapiro & Dominiak (1992)
Promiscuity	Kernberg in Shapiro & Dominiak (1992)
Self-hatred	Abdulrehman & De Luca (2001);

Substance abuse is often a form of self-medication (in order to maintain the dissociation of traumatic memories and to facilitate interpersonal functioning) for adult survivors of childhood sexual crimes. The substance abuse symbolically repeats the traumatization as it allows the survivor (substance abuser) to re-experience the affects associated with earlier trauma (the despair, denial, shame, helplessness) as part of the substance abuse. In therapy and through transference the patient can gain mastery over these affects and subsequently achieve a stable recovery from both illnesses (Teusch, 2001:1531).

The commonly repressed nature of early traumatic events may appear unrelated to the symptom profile at the time of treatment, thus often leading to misdiagnosis of psycho- and physiopathologies. Female patients with a history of childhood sexual crimes are often diagnosed with borderline personality disorder; bipolar disorders (such as depression); dissociative disorders; or dissociative identity disorder (Freud in Shapiro & Dominiak, 1992:37). Women with histories of self-mutilation and unresolved emotions of shame and guilt often struggle with intolerable psychic tension due to inherent feelings of bodily disgust and self-hatred. This leads to dissociative states as the act of cutting serves to dispel the dissociative state and provide temporary relief from the intensity of the psychic and emotional pain.

The above-mentioned symptomatology and pathology are in fact ego defenses activated to ward off or mitigate any intrapsychic, external and interpersonal conflict. An ego defense is a subconscious defense mechanism to resolve intrapsychic conflict between the id (the person's primitive drive for pleasure) and the super ego (the person's sense of right and wrong). It assists the ego in maintaining intrapsychic harmony and inner peace (Kernberg in Shapiro & Dominiak, 1992:46). An ego defense can be mature or immature. A mature ego defense is a healthy way of coping with emotional distress, while an immature ego defense is an unhealthy way of coping, which is detrimental to the whole system.

TABLE 2.4: Ego defenses.

Mature	*Immature*
Altruism	Acting out
Humor	Compulsion to repeat
Suppression	Denial
Sublimation	Minimizing
	Projection
	Conversion
	Dissociation
	Splitting
	Repression

(Compiled from Freud in Shapiro & Dominiak, 1992:51)

Mature ego defenses will manifest themselves in an adult survivor of childhood sexual crimes as follows:

Mature ego defenses:

Altruism: Involves performing vicariously constructive services to others that also are gratifying to the self. Anna Freud (in Shapiro & Dominiak, 1992:51) describes *"…altruism as maintaining dual purposes…the first purpose…as providing an interest in gratification of other people's instincts as opposed to one's own…the second purpose…as serving to liberate inhibited activity and aggression as it relates to the self."*

Humor: Playfulness and humor allows expression of emotions while reducing or eliminating stress and anxiety.

Sublimation: The subconscious process of re-channeling aggressive or sexual impulses into culturally acceptable vehicles for expression, for example the desire to marry might be transformed into writing a novel.

Suppression: A conscious decision to refrain from focusing on unpleasant thought, and/or memories. A person therefore delays (not avoids) dealing with unpleasant memories, situations or feelings.

Immature ego defenses:

Immature ego defenses will manifest themselves in an adult survivor of childhood sexual crimes as follows:

Compulsion to repeat*:* A survivor's instinctual attempts to recreate, overcome or master previously unresolved conflicts related to the trauma might lead to re-enactment of traumatic events. Traumatized adults continue to expose themselves to events that are reminiscent of the original trauma (re-victimization).

Conversion: The act whereby repressed trauma-related memories, impulses, and affects are transformed into bodily symptoms.

Denial: The screening out of external reality in order to avoid painful and anxiety-provoking thoughts, wishes or experiences. It acts as a shield against the intolerable and painful realities of the past. Continued use of denial can lead to doubt about the occurrence of prior trauma.

Splitting: Protects the ego through the compartmentalization of contradictory experiences of the self and significant others, called distortion. The self, the world and those within it are split into either *"all good"* or *"all bad".*

Minimizing: An image-distorting defense that leads to a distancing and detachment from thoughts and affects associated with the sexual trauma. It dilutes the experience of shame and guilt related to the trauma, thus rendering their emotional impact less profound. It's a stylistic way of coping with anxiety.

Projection: An act whereby thoughts or impulses that are unacceptable to the self, are attributed to others (such as paranoid thinking).

Repression: Is the process through which the ego rejects and avoids unwanted material from the conscious mind. This defense assigns the painful and intolerable data to the realm of the subconscious mind and it often underlies the basis of all ego defenses.

Dissociation: (the most common neurotic defense) a temporary alteration of the general integrative function of the consciousness. Dissociative states range from momentary lapses of consciousness to severe episodes of fragmentation that include splitting, sleepwalking, psychogenic amnesia, de-realization, depersonalization and dissociative identity disorder. De-realization and depersonalization are dissociative experiences that render the self, feeling estranged and unreal. It intensifies the risk of self-harm as it leads to a constant flight from internal reality. Other less severe forms of dissociation include substance abuse, psychic numbing, perceptual disturbances, nightmares and flashbacks (Zlotnick, Mattia & Zimmerman, 2001:359; Gold, Hill, Swingle & Elfant, 1999:160; Elhai, Gold, Mateus & Astaphan, 2001:49). If the less severe forms of dissociation are left untreated, psychological defenses such as denial and repression will be reinforced. Survivors will act out in symptoms such as going numb, emotionally shutting down or going blank in situations where they experience intense anger, anxiety, confusion or pain.

Interpreting the nature of these defenses is made clearer and more tolerable when understood in the context of their possible development and protective functions. Children are neither psychologically or developmentally able to mitigate cruel and repeated forms of traumatic sexual crimes. Initially the defenses serve to protect children from intolerable situations and experiences. In adulthood, the same defensive structure designed for protection can become pathological.

Although Kernberg (in Shapiro & Dominiak, 1992:46) stated that childhood sexual trauma often play a role in the history of borderline personality disorders, therapists need to differentiate patients suffering from unresolved childhood

sexual crimes from true borderline, masochistic or manipulative patients. They may superficially share many characteristics, but the emotional dynamics of the self-destructive or acting-out behaviour of patients with borderline personality disorder, are different from those subjected to childhood sexual trauma. The latter may be trying to express the unspeakable through their behaviour.

2.3.3 SPIRITUAL SYMPTOMS

The affects of childhood sexual crimes on adult survivors' spiritual functioning is often neglected. Human beings are body, mind and soul, where soul refers not only to a person's emotional well-being but also to his/her sense of spirituality and divinity. Ganje-Fling, Veach, Kuang and Houg (2000:88) indicate that survivors often experience obstacles to their spirituality, especially feelings of unworthiness, existential questions, anger towards and distance from God and the view that God is disapproving and rigid. Spiritual distress pervading their whole life-being and their being-in-the-world, often arouse feelings of hopelessness in survivors (Fater & Mullaney, 2000:281). Therefore addressing these obstacles is crucial to the survivor's healing process.

2.4 MEMORY

2.4.1 ASPECTS OF MEMORY

The word *memory* refers to a number of processes in which the mind/brain is able to perceive a stimulus, encode elements of it, and store it for later retrieval (Solomon in Alpert, 1995:43). According to Siegel (in Mark & Incorvaia, 1997:229-230), the following six basic principles should be kept in mind when working with memory:

- Memory is a cognitive process (it is believed to be the product of the interactions of complex networks of nerve cells in the brain);

- Memory is reconstructive, not reproductive (both the processes of encoding and retrieving an event, are products of neural processing. These various stages of processing are influenced by active mental models or schemas that link together perceptual biases, associated memories, emotions and prior learning);

- Memory and consciousness are not the same (some forms of remembering involve conscious awareness, others not);

- Memory involves monitoring processes that assess the origin and accuracy of a memory;

- The development of memory is profoundly influenced by interpersonal experiences;

- Trauma may uniquely affect memory processing at the levels of encoding, storage, retrieval and recounting.

Due to the overwhelming affect of trauma, individuals often dissociate or distance themselves from the experience, leading to a nonintegrated, incoherent memory and/or even dissociative amnesia (Edwards, Fivush, Anda, Felitti & Nordenberg, 2001:249; Hammond in Alpert, 1995:107). Charcot (in Alpert, 1995:52) sums it up: *"Memories are a coherent group of associated ideas which install themselves in the mind in the fashion of a parasite, remain isolated from all the rest, and may be explained outwardly by corresponding motor phenomena."* According to Courtois (in Classen, 1995:03) dissociation involves an alteration in a person's consciousness concerning personal identity, memory and ongoing awareness. Amnesia and disturbances of memory are normal responses to sexual traumatization, and it may thus be for this reason that traumatic memories are different from ordinary memories (Roth & Friedman Ed., 1998:86). *"The loss of specific memory and the presentation of a blank history of childhood can mainly result from the devastation of mental functioning in the wake of sexual abuse."*

(Scharff & Scharff, 1994:09). A child subject to sexual trauma attempts to keep the traumatic situation frozen in order to control it (Fairbairn in Scharff & Scharff, 1994:8). Casement (in Scharff & Scharff, 1994:55) addresses the original freezing of the sexual traumatic situation and the organization of the personality after the trauma in order to keep things frozen so as to preserve an unencumbered area of self functioning.

The ways in which a survivor has adapted to the trauma, both during the event(s) and afterwards, determine how the mind encodes the experience into the memory. In children, adolescents and adults, the self emerges from the way the mind has encoded experiences (Siegel in Mark & Incorvaia, 1997:226). Traumatic memories seem to be encoded differently from non-traumatic events as it may be better retained and is less susceptible to forgetting. The purpose of memory recall therefore is more reconstruction than reproduction in order to achieve memory integration.

Kafka (in Alpert, 1995:139; Ferenczi in Scharff & Scharff, 1994:46) identified two types of memory formation namely sensori-affective-motor memories (memories played out through somatisation) and learning from experience (where pleasant or painful memories influence perception and promote future expectation). Kafka defined three basic functions of memory and their disruption in survivors of childhood sexual crimes:

- Memories help organize the self and maintain inner cohesion through influencing perception, facilitating new learning, motivating behaviour and affecting self-esteem;

- Memories sooth and protect the self from harsh and unwanted realities (people recall pleasant memories twice as often as unpleasant ones);

- Subconscious memories keep the self, honest as it does not matter in whatever ways memories get stored (be it through the interweaving of interpersonal experiences with body/mind states, through the protective,

defensive mental mechanisms that create splits in the personality, or through repressive familial, cultural and political forces). It represents aspects of the self that are most consonant with a person's temperament and nature.

The concept of memory is also associated with the assumption that it is accurate from a historical perspective. The accuracy individuals count on in memory helps them to feel grounded in reality and gives them a connection to others in their social sphere. It helps them to feel that reality is understandable and that the same reality is shared with others (Gasker, 1999:85). The sharing of memories related to childhood sexual crimes are the first steps towards healing, which is the process of integrating traumatic memory into a functional life narrative.

2.4.2 MEMORY STORAGE

Siegel (in Mark & Incorvaia, 1997:223) stated that from the beginning of an infant's life, mind/brain is recognizing, summarizing and organizing experiences and stimuli, attempting to make sense of them. These cognitive processes are thought to reside in the complex parallel processing of the neural networks that compose the architecture of the brain. With development and experience, these networks acquire increasingly sophisticated capabilities to represent individual stimuli as well as to categorize objects and events. Perceptual categories and conceptual categories thus form the basis for neurologically making sense of the world (Edelman in Mark & Incornaia, 1997:223).

Generalization of repeated events can be encoded into a schema or mental model for a given type of experience. The purpose of these schemas is believed to bias present perceptions and to influence future decisions (Alba and Hasher in Mark & Incornaia, 1997:223). The following factors may influence the formation of a mental model as each factor may lead to a disruption in the normal processing of perceptual input towards long-term memory:

- Overwhelming emotions (a sense of fear, helplessness, shock and horror);

- Perceptual details that flood the capacity to sort through and selectively attend to input that has never been sensed before;

- Extreme stress and physical pain;

- Social context and the meaning of the event (sense of loss, betrayal, abandonment);

- Cognitive adaptations during and immediately after the event which may influence encoding (perceptual avoidance, divided attention, fantasy of escape and somatic numbing);

- Deviations from previously established schemas or mental models for expectable occurrences.

A memory can either be implicit or explicit (Solomon in Alpert, 1995:43; Roth & Friedman, 1998:92; Siegel in Mark & Incorvaia, 1997:223). Implicit memory (or nondeclarative memory system) refers to the behavioural (emotional, somato-sensory and sensory) memory processes that develop first and which are likely to reside in the brain structures that mediate their initial encoding. This information is not consciously available. Explicit memory (declarative memory system) is a term referring to what people generally think of as *"memory"*. It is information consciously available about past experiences (Stocks, 1998:423). Explicit memory requires conscious attention for processing. Retrieval of memory may influence behaviour directly (implicit memory) or may lead to the subjective conscious experience of recalling a fact or event (explicit memory).

TABLE 2.5: Memory

Explicit memory	Implicit memory
Facts and events	Skills and habits (automatic behaviour) Strong emotional associations Conditioned sensori-motor responses

(adapted from Solomon in Alpert, 1995:42)

Psychosocial trauma (such as childhood sexual crimes) that results in dissociative amnesia typically leave the explicit memory untouched while obscuring all or part of the implicit memory (Erickson & Rossi, 1989:76). Pillener and White (in Scharff & Scharff, 1994:37) proposed a theory of first and second memory systems. The first memory system stores information from birth ironically in response to people, feelings and places. These memories are accessed through images and experiences that recall earlier time. *"The second memory system develops after language acquisition and stores experiences in narrative forms, and so they can be reached by words."* Overwhelming trauma is believed to be stored in the first memory system regardless of the existence of the second system, therefore the conscious *"repression"* of such memories.

Levine (in Scharff & Scharff, 1994:35-36) indicated four levels of memory namely **registration** (attentiveness to events and facts registered in the short-term memory); **active working memory** (remembering while reading or computing); **consolidation** (long-term recall and general memory organization) and **retrieval**. Registration and encoding is the creation process of the memory (Roth & Friedman, 1998:91). Consolidation is an intermediate step whereby the memory is structured in order to be stored over time, while during retrieval, the memory is removed from storage and made available to consciousness.

2.4.3 FALSE MEMORIES

False memories are memories that do not really exist, but are *"created"* by patients and believed to be true. The formation of a false memory is dependant on factors such as the patient's longing for a memory as a desperate attempt to make sense of his/her symptoms and history and to explain the damage to their selves and/or the need to blame someone else (such as parents) for present life difficulties (Scharff in Scharff & Scharff, 1994:79). From there the term *"False Memory Syndrome".*

De Rivera (2000:379) indicates that the creation of false memories can be restricted when therapists are being nondirective and non suggestive, focusing on the direct impact of childhood sexual crimes on the body and the bodily self. The validity of a memory is also not indicative of the success of the therapeutic process and symptom reduction.

2.4.4 MEMORY RECOVERING

"I never anticipated the profound disruption of remembering the past, nor the rewards of knowing and understanding it." (Annette in Scharff & Scharff, 1994:210).

Roth and Friedman (1998:83) indicated that memories are forgotten due to failure to encode the memory at the time of the event, dissociation, simple fading of a memory over time, repression, conditioned extinction (active inhibition of previously learned behaviour), state dependent learning and long-term depression. In most of the cases memories can be retrieved, one way or the other, by focusing on the meaning of the symptomatology the survivor suffers from.

Many patients come to therapy with psychosomatic complaints, not knowing or suspecting the repression of memories related to childhood sexual crimes. Freud

(in Shalev et al., 2000:164) stated that the ego is a body ego derived from bodily sensation. Therefore the body is the center of existence. Everything a person thinks and feels must register in his/her body (Hudsinson in Shalev et al., 2000:171). A psychosomatic symptom is the memory repressed in a bodily experience.

Sometimes entering and exiting life stages or developmental phases can also trigger the surfacing of repressed memories. Adult survivors often suffer from undefined anxiety when they become parents or when their children approach the same age that they were when they were sexually traumatized. Roussillon (1999:336) found in his study that pregnancy and the giving of birth experiences are developmental events that often trigger memories of previous sexual crimes. Women who have no recollection of sexual trauma may begin to experience feelings, dreams, memories and behavioural patterns that do not make sense to them until the memories are recovered and dealt with in therapy. Often the bodily feeling of *"being out of control"* and dependent on others during the birth giving process, brings back a mixture of feelings related to childhood sexual crimes.

"… memories (somatic or symbolic) related to the trauma are elicited by heightened arousal." (Solomon in Alpert, 1995:43).

Information acquired in an aroused or otherwise altered state of mind is retrieved more readily when the objects are brought back to that particular state of mind. State-dependent memory retrieval may also be involved in dissociative phenomena in which traumatized persons may be fully or partially amnesic for memories or behaviours enacted while in an altered state of mind.

"The full power of unconscious memories is revealed when they engulf the consciousness of incest survivors, submerging awareness of present reality. Flashbacks of brutal events match in their ferocity the force of all the person's efforts at dissociation, denial, and depersonalization." (Kafka in Alpert, 1995:147)

Subconscious memories are open Gestalt that creates intrapsychic tension and demand closure. It insists on the truths being heard (therefore the symptomatology as a *"reminder"* of hidden aspects of past experiences and the self, that need to be confronted and addressed). Retrieval of repressed memories reinstates and integrates these memories, including its concomitant emotional responses from the time of the event, in the personality. This process is called abreaction (Siegel in Mark & Incorvaia, 1997:265).

A patient may recall some of the details of an event, including its time, place and context, but may lack recall of what it was like to be there. Clinically it has been noted that symptoms of an unresolved trauma – startle response, avoidance behaviour, psychic numbing, amnesic periods, nightmares, flashbacks, intrusive images, and somatic sensations of traumatic content – are prone to reoccur if intervention has not involved some form of therapeutic abreaction. The retrieval of a memory by itself is not therapeutic, nor does it necessarily alter the form in which the memory is stored. A flashback or abreaction that does not involve therapeutic processing only exposes the patient to a repeated experience of being overwhelmed, helpless and in pain. A therapeutic abreaction emphasizes processing, both cognitive and emotional, of dissociated elements of a previously inaccessible or partially accessible memory. Thus it allows implicit memories to be processed in an explicit manner.

Siegel (in Mark & Incorvaia, 1997:248) listed a few reactions to the initial breach of amnesia:

- Initial memories tend to be more factual than emotional;
- Regression to the age of the memory formation;
- Relief and understanding;
- Troubling emotions (often disillusionment, grief and horror);

- Choosing not to remember;
- Denial;
- Sometimes choosing to confront the abusers.

2.5 RELATIONAL PROBLEMS AND OBJECT RELATIONS

Research agree that intimate relationship difficulties in adulthood are often the result of childhood sexual crimes, as the dissociative nature of ego defenses, emotionally disconnect and isolate survivors from others (Shaffer, Brown & McWhirter, 1998:74; DiLillo & Long, 1999:61; Rumstein-McKean & Hunsley, 2001:472; Humphrey & White, 2000:421). This if often enhanced by a lack of trust in others, poor communication skills and social adjustment difficulties. Melchert (2000:65) found in his study that the emotional aspects of parent-child relationships such as parental acceptance and responsiveness to a child's needs might influence the intensity of relational distress in adulthood. It was also found that survivors of childhood sexual crimes might choose abusive (emotionally, sexually or physically) partners or lovers and expose themselves to a pattern of revictimization (DiLillo, 2001:575; Abdulrehman & De Luca, 2001:202). Other common relational problems in intimate relationships include marital adjustment and commitment problems, sexual dysfunctioning and difficulty in parenting their own children (Oz, 2001:297; Einhorn, 2000:12).

In order to fully understand the dynamics of these relational problems, the researcher will in short elaborate on the Shame Theory of Kaufman, the Attachment Theory of Bowlby, Fairnbairns Object Relation's Theory, and the Bond of Secrecy.

2.5.1 SHAME THEORY OF KAUFMAN

Humans have a fundamental need for relationships. Many theorists have previously emphasized the importance of the need to feel loved and wanted by a significant other (VanDerHeide and Alexander in Mark & Incorvaia, 1997:345). In addition to being loved, a person must be allowed to give love in return and to experience the uncritical acceptance of that love, as valued and desired. Over time the young child develops trust in the existence of this two-way relationship.

Kaufman and Wohl, (1992:130) describes the emotional bond that develops with others through communication, caring and trust as an interpersonal bridge. A major source of damage to this bridge is the awareness that one's most basic expectations of the other are wrong. An important caregiver who refuses to relate to the child or who actively withdraws love violates the child's expectations that this significant person values him/her. When this interpersonal bridge is damaged, shame is created and internalized. The internalization of shame plays a major part in the formation of identity. The sequence of events involved in the process of shame internalization consists of an inappropriate response to a child's need or expression of affect, the conversion of the need or affect into a bad feeling, and the consequent decision that it is the self that is bad. Once shame is internalized and magnified into a bad sense of the self (self-blame), a child may loose his/her ability to be connected to other feelings and other individuals. Adult survivors often resist facing past traumas due to a fear that the full recall and clarity will overwhelm them and lead to self-annihilation due to shame (Alexander et al., 1998:53).

2.5.2 ATTACHMENT THEORY OF BOWLBY

Bowlby (1969:65-74) proposed that people possess an *"attachment behavioural system"* that functions to elicit comfort from and maintain proximity to the caregiver, leading to a consistent sense of security. It also serves to reflect mental representations of the self in relation to others (referred to as internal

working models of attachment). It forms the basis for interpretation of later experiences as well as allowing an individual to predict experiences in future relationships. Each individual has an attachment style linked to behaviour, cognition and affect in childhood, adolescence and adulthood. The quality of interaction with the primary caregiver as well as the security of the child's attachment will influence the development of a secure or insecure attachment style. The attachment style has a great impact on the child's emotional and psychological development and ability to cope with traumatic events in his/her life.

2.5.3 FAIRNBAIRN'S OBJECT RELATIONS THEORY

Object relations are defined as the internalized images of self and others in interaction. It forms the basis for an individual's capacity to engage in and sustain relationships (Morrell, Mendel & Fischer, 2001:866). In the object relations' theory, adult psychopathology is seen as stemming from pathological relationships with primary caregivers. Trauma and childhood sexual crimes affect the developing of object relations of the child, often resulting in interpersonal and intrapsychic difficulties in adulthood (Fairnbairn in Scharff & Scharff, 1994:50). Fairnbairn (in Scharff & Scharff, 1994:51) also stated that a child's psychic structure forms from the internalization of the child's good-enough experiences (good object internalization) and the splitting and repression of its frustrating aspects (bad object internalization) in the caregiver-child relationship. Bad object internalizations along with their corresponding parts of the child's ego and the associated affects are often repressed in the subconscious and split off from the main personality, resulting in interpersonal and intrapsychic pathology.

2.5.4 BOND OF SECRECY

"I felt special. His soothing voice, saying it was our secret, made me dependent on him for comfort and for love." (Addie in Cameron, 2000:66)

Secrecy is the essential ingredient in most childhood sexual crimes. As stated in 2.5.1 children have a tremendous need for love, attention and affection. A child therefore easily bonds with a perpetrator who makes him/herself the child's major resource. Although secrecy is imposed on the child, he/she feels compelled to keep the secret either due to fear of or threats by the perpetrator, or due to a sense of being an accomplice to what was happening (guilt feelings) (Cameron, 2000:124). The closer the child bonds with the perpetrator, the more he/she alienates him/herself from others, and the more he/she becomes dependent on him/her in an ever-tightening circle of betrayal.

2.6 THE TREATMENT OF ADULT SURVIVORS OF CHILDHOOD SEXUAL CRIMES

"The survivor needs to be in control of this choice and have her choice respected. Her self-control was severely limited during the abuse, and an underlying goal of treatment is for her to regain control and overcome helplessness." (Courtois in Shapiro & Dominiak, 1992:25)

As stated throughout this chapter, adult survivors often have diminished the intensity of sexual traumatic events by some form of dissociative process. These defenses might have been their only solace and to reflect on that may leave them feeling stripped of the anesthesia against the pain of the assault. Thus, throughout the treatment process, there should be a careful balance between direct inquiry and a sensitive request for repressed material, while giving the patient a sense of safety and control. Ego defenses should only be confronted after laying considerable groundwork. The moment therapy becomes *"too dangerous"* the patient will either flee from therapy or develop a pathological transference to the therapist.

2.6.1 THE THERAPEUTIC PROCESS

Various therapeutic models have identified a number of experiences which assist the patient in his/her therapeutic process, such as clarification, confrontation, interpretation and analysis of the transference, experiencing as well as understanding, thought balancing action, increased contact with reality and corrective feedback (Scharff & Scharff, 1994:68). Therapy forms the psychological space for self-discovery in the context of a generative relationship. It fosters the patient's capacity *"for being in uncertainties, mysteries and doubts without irritable reaching after fact and reason."* (Scharff & Scharff, 1994:68) A *"paradox"* of knowing and not knowing - the process of inner healing and integration.

Research done by Herman (1992:133), Bollerud (in Shapiro & Dominiak, 1992:147-150), Everstine and Everstine (1989:170) and Harvey and Harvey (in Classen, 1995:xxvi; 1995:57-93) indicated different stages or phases of psychotherapy in working with adult survivors of childhood sexual crimes. These stages are summarized in Table 2.6.

TABLE 2.6: Phases / Stages of treatment.

Herman (1992)	**Bollerud (in Shapiro & Dominiak, 1992)**	**Everstine & Everstine (1989)**	**Harvey & Harvey (in Classen, 1995)**
Establishing a sense of safety	Stabilization	Shock	Authority over the remembering process
Remembering and mourning the trauma	Memory & affect integration	Denial of what happened	Integration of memory and affect
Reconnection with the self and others	Self and self-esteem development	Depression	Affect tolerance

		Mood swings	Symptom mastery
		Anger	Self-esteem and self-cohesion
		Philosophical reflection	Safe attachment
		Laying to rest	Establishing new meaning

The initial stages in treatment involve securing safety, achieving stability, and fostering self-care. When safety and self-care have been reliably established, then a survivor may embark upon the second stage, a process of reviewing, exploration and integration of the traumatic events into the personality. In the third stage, exploration and integration give way to the pursuit of intimate connectedness and the negotiation and renegotiation of important relationships.

2.6.2 THERAPEUTIC MODELS

Different theoretic models have been used in the past to address specific psychological conditions such as depression, anxiety, anger, guilt and low self-esteem as part of the aftermath of childhood sexual crimes. These models include:

Emotion Focused Therapy – where trauma feelings and memories are accessed in order to be available for modification through the admission of new information (Paivio & Nieuwenhuis, 2001:131). (The belief is that chronic over control of affective experiences (through defenses) leaves the person cut off from the orienting information believed to be associated with specific emotions),

Rational Emotive Therapy – where trauma may shatter existing functional core beliefs or schemas about safety, trust, power/control, esteem and intimacy, or confirm existing dysfunctional core beliefs or develop dysfunctional core beliefs of a survivor, leading to maladaptive behaviour (Rieckert & Moller, 2000:101), and

Eye Movement Desensitization and Reprocessing – where eye movements are used to rapidly metabolize the dysfunctional residue from the traumatic events and transform it into something useful. This is an interactive, intrapsychic, behavioural, cognitive, body-oriented therapy (Edmond, Rubin & Wambach, 1999:114).

Nemoriff, Schindler and Schreiber (2000:679) indicated that interpersonal psychoanalysis, (a two-person psychology with its focus on transference and counter transference) created a mutative experience for the survivors. Price, Hilsenroth, Petretic-Jackson and Bonge (2001:1119) stated that this mutative experience involved enactments in the analytical relationship whereby dissociated material and processes can be brought to life and therefore integrated into the personality and the survivor's life history. The cognitive behavioural therapy and hypnosis approaches seem to be more favorable when working with survivors of sexual crimes, and will be discussed in more detail.

2.6.2.1 Cognitive Behavioural Therapy

"All forms of psychotherapy and behaviour therapy, …share fundamental commonalities, to the extent that they all are attempts to help human beings who have problems." (Hagoon, 2000:42).

Cognitive behavioural therapy has been increasingly demonstrated to be highly effective in the treatment of anxiety, depression, anger management and many other psychological disorders common to survivors of sexual crimes (Hagoon, 2000:23; Clarke & Pearson, 2000:176; Wolfsdorf & Zlotnick, 2001:175). The basic approach of this model is to address irrational thoughts (which are automatic and cause feelings of depression, anxiety or anger), and to enable patients to value themselves and gain a sense of empowerment, as it is often easier to gain control over thoughts than feelings (Sharff & Scharff, 1994:279; Maker & Buttenheim, 2000:168; Manning, 1996:42).

This therapy focuses on balancing the patient's interaction with reality as he/she transforms him/herself to external reality, on augmenting feedback (the relationship between action and reaction thus taking responsibility for everything in his/her life), on fostering exploration, experimentation and activity, especially in interpersonal relationships, and on balancing verbal with nonverbal communication (Nayak, Resnick & Holmes 1999:108; Price et al., 2001:1096). Rieckert and Moller (2000:96) found that cognitive behavioural interventions, which included gradual exposure, modeling, education, coping and prevention skill training, usually resulted in marked improvements on measured post-traumatic stress disorder, depression and anxiety.

2.6.2.2 Hypnotherapy

"Therapists should be ever mindful that the power which is inherent in the therapeutic transference may be terrifying to adults who were sexually assaulted as children, because they do not possess the foundation of a healthy parent-child trust relationship." (Peters in Everstine & Everstine, 1989:156)

The invasion of personal privacy, the violation of the body, and the lack of control, which are inherent in episodes of sexual crimes, can have devastating effects on anyone, especially a child (Maldonado and Spiegel in Classen, 1995:163). Therefore, therapists may use hypnotic techniques as a way of assisting patients in accessing repressed and dissociated memories, while allowing them to maintain a sense of being in control through management of symptoms such as nightmares, sleep disturbances, intrusive thoughts, psychosomatic complaints and flashbacks (Manning, 1996:44). Ratican (1996:33) mentioned that during the accessing of repressed memories it is important to identify the survivor's age at the time of the sexual crime, as the developmental stage of the patient influenced his/her thoughts and feelings and the often-faulty cognitive messages locked in the psyche.

Freud (in Scharff & Scharff, 1994:41) stated that psychical trauma was the basis for most hysterical and neurotic symptoms. These symptoms were bodily expressions, which occurred when feelings of distress had become disconnected from accompanying thoughts during any sexually traumatic moment. Freud's therapeutic success was based on the belief that integration can only be achieved through the de-repressing of subconscious material locked in physical symptomatology, by using hypnosis and forced association (an action whereby he would put a hand on the patient's eyebrow suggesting that the pressure would force a flow of thoughts to conscious speech). Imagery and associative techniques used in hypnosis may empower survivors and foster the healing of internal shame and self-blame (Elliott, 1999:252; Hartman, 1994:1225).

2.7 SUMMARY

This chapter dealt with childhood sexual crimes and its aftermath in terms of the development of symptomatology and psychopathology. The traumatic affect of sexual crimes can also have an influence on memory storage and the formation of interpersonal relationships. As a degree of dissociation seems to be evident in all survivors of childhood sexual crimes, hypnotherapy tends to be the logical choice as a therapeutic model for the resolution of the inter- and intrapsychic affects of childhood sexual crimes.

Chapter 3 will investigate the specific use of the Word Association Test (derived from the Medical Hypnoanalysis model) and Ego State Therapy (a sophisticated form of hypnoanalysis) in hypnosis, as treatment modality for adult survivors of childhood sexual crimes.

"It is not the letting go that hurts, it's the holding on."

- **Maxine, 2002.**

CHAPTER 3

A LITERATURE REVIEW OF MEDICAL HYPNO-ANALYSIS

AND EGO-STATE THERAPY

"All forms of psychotherapy and behaviour therapy…share fundamental commonalities, to the extend that they all are attempts to help human beings who have problems."

- Hagoon, 2000:42

3.1 INTRODUCTION

This chapter will investigate Ego-State Therapy as therapeutic treatment modality and elements from the Medical Hypno-analysis modality as indicative of possible problematic developmental stages (where ego states developed, split off, or dissociated from the personality) and the possibility of repressed memories related to childhood sexual trauma. As patients suffering from trauma almost always experience some dissociative symptoms (to alter their perception of the traumatic reality) and both modalities are mostly conducted within trance, hypnosis as therapeutic tool will also be described. With both, hypnosis and trauma, the mind enters an altered state of consciousness not accessible in the normal state. Since hypnosis and dissociation use the same mental processes, hypnosis can be a powerful tool to help patients explore and change their altered perceptions of reality.

3.1.1 HYPNOSIS

Watkins and Watkins (in Zeig & Munion, 1990:404) described hypnosis as *"…an intensive interpersonal relationship experience that affords access to covert (unconscious) levels of personality functioning. Within a hypnotic state patients often are able to recall significant (and forgotten) life events, release bound or dissociated affects, and act upon constructive suggestions."*

Hypnosis can also be defined as a psycho-physiological state of aroused, attentive, and receptive focal concentration with a corresponding relative suspension of peripheral awareness (Tinnin in Shapiro & Dominiak, 1992:76). It is a state where the body is deeply relaxed and the mind highly attentively focused and open to suggestion. It is the enhancement of an everyday trancelike phenomenon (such as daydreaming) for therapeutic purposes. In trance, perceptions rooted in the subconscious can be accessed and altered through suggestions.

As hypnosis is in itself a controlled form of dissociation, it facilitates the likelihood of retrieving strong emotional reactions and previously dissociated material such as conscious unavailable traumatic memories, through a process called age regression. Lavoie (in Fass & Brown Ed., 1990:77) described age regression as *"…the capacity of the patient to relive in an extremely convincing subjective manner "forgotten" events or childhood episodes and to behave in a way compatible with the child the patient believes him/herself to have been (simultaneously feeling like a child and like an adult observer)."*

According to Mark and Anderson (in Mark & Incorvaia, 1997:195) most patients experience hypnosis as empowering, since they are taught how to control the depth of the trance, physical body sensations, the pace of remembering and the intensity of the emotional reactions.

3.1.2 THE CONSCIOUS AND SUBCONSCIOUS MIND

According to the Medical Hypno-analysis model the brain is divided into two parts, the conscious mind and the subconscious (or unconscious) mind (Modlin, 1999:6; Scott, 1993:xiii). The conscious mind is the thinking, reasoning, logical, decision-making part of the mind, whilst the subconscious mind is the *"memory bank"* which records everything that happens to a person from birth till the present. It *"…monitors and controls virtually everything that goes on in your mind, your body, and in your life. It is the imagination and creative part of your mind. It is the source of all of your emotions and your emotional responses to everything that you experience in the living of your life."* (Matez, 1992:5).

Matez (1992:5) used the diagram on the next page to explain the working of the conscious and subconscious minds. The diagram can be explained as follows:

Information gathered through the senses (vision, hearing, smell, taste and touch) (3) enters the conscious mind where it is processed, analyzed, understood and filtered. All this information is then stored in the subconscious mind (the memory bank) (4) where most of it is available to the person (5). It forms the learned psycho-neurophysiological habit patterns that human beings develop in their lives (6). As it is learned habit patterns, it can also be de-learned (Scott, 1993:9). According to Modlin (1999:47) these habit patterns can either be positive (acceptable behaviour and pleasant feelings) or destructive (the problematic symptomatology the patient suffers from).

According to Matez (1992:6) 80% of all information may bypass the conscious mind and go directly into the subconscious mind (7), without the conscious mind even being aware of it. As the subconscious mind is always awake, real or imagined information is recorded, regardless of the conscious mind's state of awareness. Thus all information (even before birth, when the conscious mind has not yet been developed) can enter the subconscious. The information that enters the subconscious can be neutral or have positive or negative suggestions.

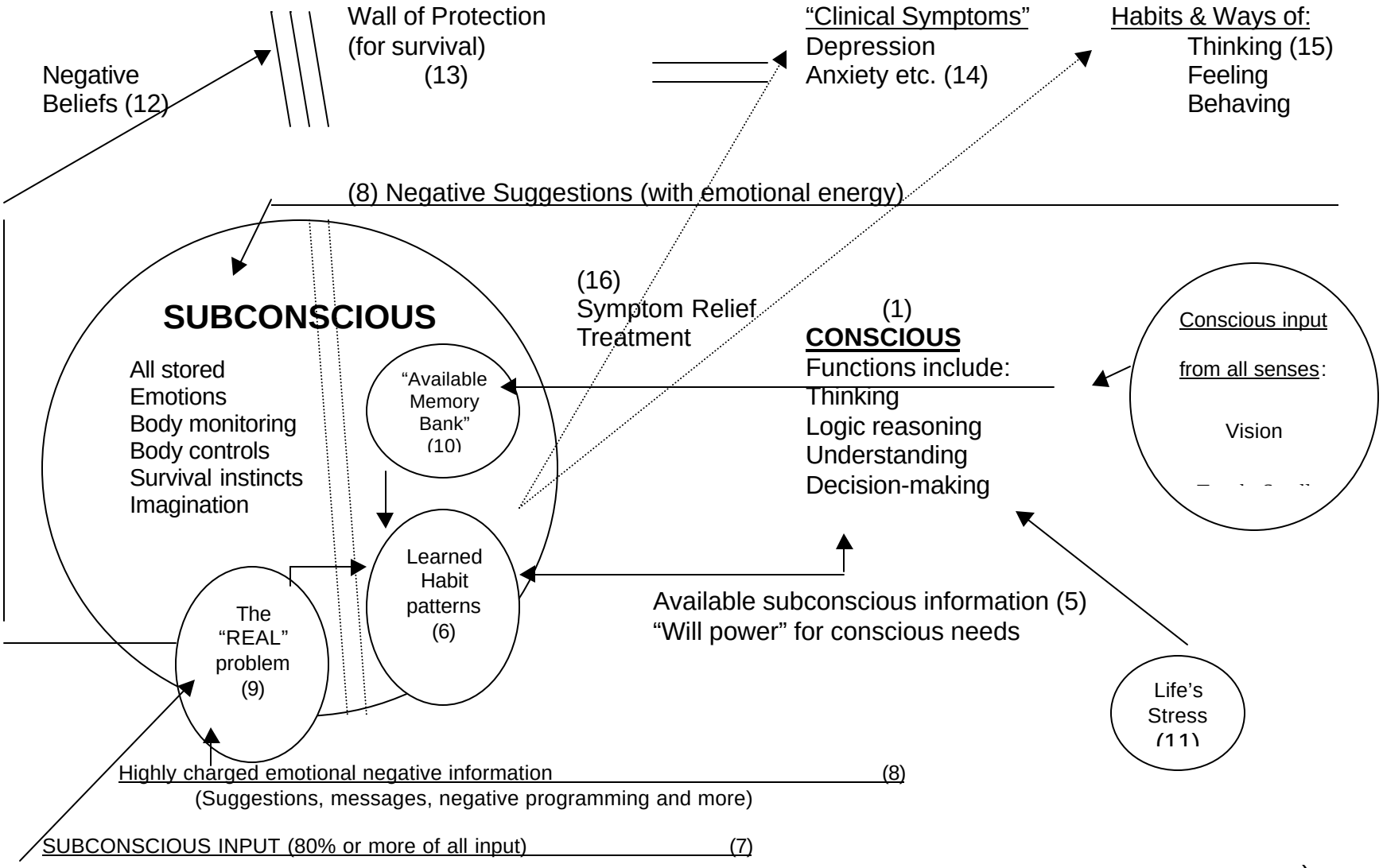
The subconscious accept all information, whereas the conscious screen and reject unwanted information.

Some of the negative information that enter the subconscious are *"…highly charged emotionally negative information* (8) *…and all of it together becomes the "underlying problem" or the "REAL PROBLEM"."* (9) (Matez, 1992:7). The real problem is the origin of the manifesting symptomatology.

There is a *"brain barrier"* (10) between the two parts of the brain, preventing the conscious mind from accessing information stored in the subconscious mind, leaving it unaware of the underlying origin of the problematic symptomatology. The lack of knowledge in the conscious mind about the information stored in the subconscious causes an inability to change wrong perceptions formed in the subconscious. Matez (1992:7) stated, *"…the subconscious does not have the ability to erase thought, and that's why we have problems."*

The function of the subconscious mind is to protect and therefore it tries to deal with everyday life stressors (11) with all the information, knowledge and experience available from the mind (5). If something happens that causes more stress than what a person can handle (11), the subconscious provides information to protect or help. This information can be positive, neutral or negative. Negative information cannot be used as it activates the *"real problem"*, loaded with negative emotional energy (12). To further protect the person the mind puts up a *"wall of protection"* (13) as barrier and this then becomes the symptomatology (14) the patient suffers from (Matez, 1992:8).

FIGURE 3.1: Schematic diagram of input of information and the formation of subconscious problems.



Adapted from Matez (1992:5)

Symptoms experienced are thus not the real problem, but merely the symptoms of the underlying problem. As humans are in the habit of producing symptoms in their own way of thinking, feeling and behaving (15), they would rather deal with the symptoms than the real underlying problem. Often medication is taken for symptom relief (16), but the real problem is not addressed. For complete recovery, the problem hiding in the subconscious mind needs to be resolved (Modlin, 1999:51; Scott, 1993:30).

3.2 MEDICAL HYPNO-ANALYSIS MODEL

According to Scott (1993:xiv) Medical Hypno-analysis is a specific structured *"…psychotherapeutic procedure"* similar to a physician's procedures (from there the term *"Medical"*). A patient expresses the symptoms and the therapist forms a tentative diagnosis of the problem, using the patient's full history and a projective test (The Bryan Hypnotic Word Association Test). After diagnosing the subconscious problem, treatment can commence.

The approach focuses on underlying (subconscious) causes rather than symptoms and the resolution of these causes as a means of symptom alleviation. It deals only with those events that contributed directly to the patient's presenting symptomatology. As the subconscious mind (repressed memories, cognitive interpretations and misinterpretations) is the object of study, most sessions are conducted with the patient in hypnotic trance (Modlin, 1999:49; Matez, 1992:11).

Although the researcher does not intend to use the Medical Hypno-analysis model as treatment modality but as diagnostic tool in this study, it is still important to understand the theory behind the model.

3.2.1 THE TRIPLE ALLERGENIC THEORY

As stated in Chapter 1, the Triple Allergenic Theory identifies the pathology of emotional problems, for example the development of an emotional problem is like the development of a physical allergy (Modlin, 1999:51; Scott, 1993:68-69). The first time a person is exposed to a foreign substance (called an antigen) like the poison of a bee sting, the production of antibodies is stimulated. These antibodies continue to float in the bloodstream to protect the body against that particular antigen the next time it enters the body. During the second exposure to that antigen, the antibodies are activated to neutralize the effect of the antigen, and it is this activation that causes the allergic reaction. Within the Medical Hypno-analysis model, all symptomatology is emotional allergic reactions caused by anxiety, fear or guilt (Modlin, 1999:51).

Modlin (1991:71) described the Triple Allergenic Theory as *"…a cascade of perceived life-threatening events which have a highly charged emotional impact and which INITIATE the learned negative emotional response, PRODUCED the symptom with the second event, and INTENSIFY the response with subsequent events."* There are three important events in the formation of an emotional allergy:

- The **Initial Sensitising Event (ISE)**;
- The **Symptom Producing Event (SPE)**; and
- The **Symptom Intensifying Event (SIE)** (Scott, 1993:69; Matez, 1992:5).

The Initial Sensitising Event is the very first event that the patient perceived as being a threat to his/her survival and which created significant anxiety in the patient's mind. Although it is not recallable by the conscious mind or does not produce any outward symptoms or pathology, it initiates a learned emotional response and is the underlying real problem.

The Symptom Producing Event is the second event that the patient perceives as being exposed to the same kind of threat as in the Initial Sensitising Event. It is often consciously remembered as *"traumatic"* and patients may have a direct association between the event and the occurrence of the symptomatology/pathology. According to Modlin (1999:63) the symptom serves as *"proof of life"* to the patient affirming his/her survival of the traumatic event.

The Symptom Intensifying Event is the next event(s) that has the same emotional threat to the patient's survival as the previously mentioned Initial Sensitising Event and Symptom Producing Events. It intensifies the symptoms the patient suffers from as it reproduces the symptoms every time the patient is in contact with the learned emotional response. It can also be linked to other symptoms, is consciously recallable and is often the reason why treatment is sought (Matez, 1992:6; Scott, 1993:69).

It is evident that the subconscious mind chooses the symptoms or pathology as a defense against a threat from which it suffers. There are many factors involved in its choice and it will always choose the lesser *"…of the evils as the outward expression of the inner threat or conflict, which originates at a more basic priority level of life."* (Matez, 1993:73).

3.2.2 HISTORY-TAKING AND THE WORD ASSOCIATION TEST

The purpose of the History-taking and the Bryan Word Association Test is to determine the three basic traumatic events (the Initial Sensitising Event, the Symptom Producing Event and the Symptom Intensifying Event) in the formation of symptomatology and/or pathology. The History-taking is a lengthy questionnaire that focuses on every aspect of a patient's cognitive, emotional, physiological, sexual and social development. It incorporates the patient's non-verbal behaviour as a way of subconscious communication for possible clues as to where the subconscious problematic areas may be.

The Word Association Test (WAT) is a projective technique originally designed to reveal more of the patient's subconscious thinking. It is administered while the patient is in a trance and consists of words and incomplete sentences to stimulate free association (Scott, 1993:137:). Freud (in Scott, 1993:141) believed that free association stimulates a respondent's projections to reveal his/her characteristic thought processes, needs, anxieties and conflicts. Its purpose is to confirm the therapist's tentative diagnosis derived from the History-taking. More about the procedures and application of both the History-taking and the Word Association Test in Chapter 4.

3.3 EGO-STATE THERAPY

3.3.1 INTRODUCTION

Helen Watkins (Watkins, 1993:233) underscored two processes in the development of human personality: **integration** (a putting together) and **differentiation** (a separation or taking apart). Through the putting together of the concepts such as cats, dogs, rabbits and other animals, the child learns to create a more complex concept of *"animals"* and through differentiation, he/she learns to separate general concepts into more specific meaning such as to discriminate between rabbit and cat, or between what is good to eat and what is bad. Both processes are normal, as it is through this integration and differentiation that the child develops into an increasingly complex personality (Watkins & Watkins, 1990:5). Differentiation is up to a certain point adaptive. Beyond that point, it becomes defensive and excessive. Maladaptive dissociation then occurs, of which Dissociative Identity Disorder is its extreme form.

3.3.2 DEFINING EGO-STATES

"Personality functions in different dimensions: perceptual, cognitive and affective (emotional). It can be manifested in different areas – overt (conscious), or covert

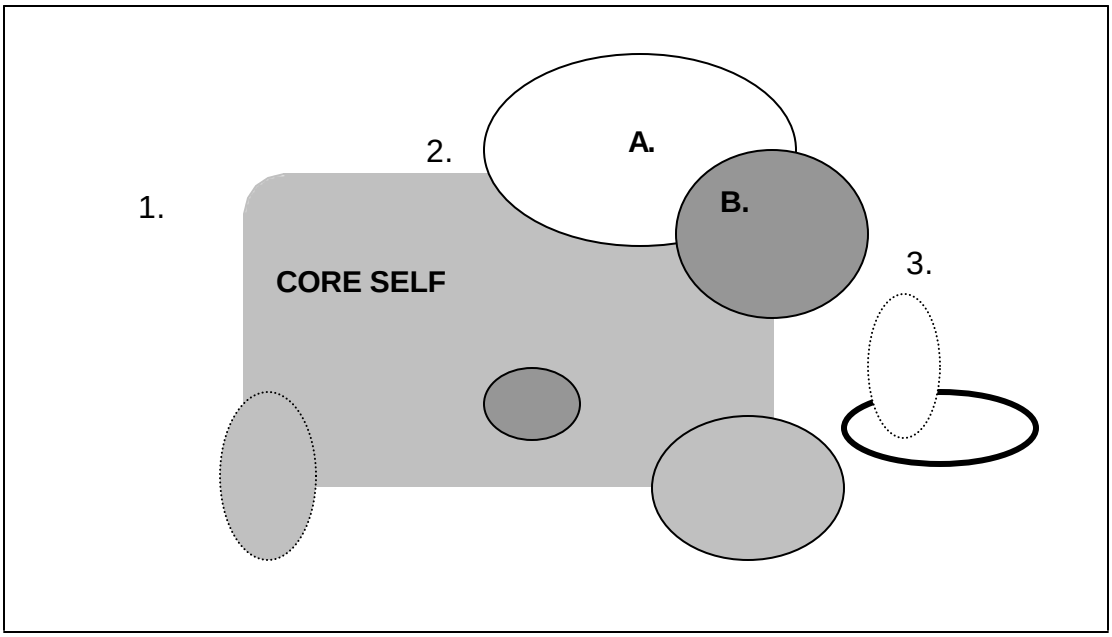
(unconscious), or in some relative degree of each" (Watkins & Watkins, 1993:277).

Although Watkins is generally known as the father of ego-state therapy, the concept of personality segmentation was originally Freud's idea. Paul Federn contributed to Freud's theory by stating that human personality is not necessarily a unity (a collection of perceptions, cognitions and affects), but is divided into segments, which he termed *"ego-states"* (Watkins in Zeig & Munion, 1990:403; Watkins, 1993:233). Federn believed that each ego-state has its own unique combination of history, feelings, thoughts, affects, perceptions, sensations and behaviours (Phillips, 2000:86).

Watkins and Watkins (in Zeig & Munion, 1990:404) defined an ego-state *"…as a body of behaviours and experiences bound together by some common principle and separated from other such entities by boundaries that are more or less permeable."*

Ego-states may be conceptualized as being organized in different dimensions as illustrated in Figure 3.2 (Watkins & Watkins, 1997:26). They may be large and include all behaviours, feelings and experiences (for example as activated in a person's occupation) or they may be small and include only selective behaviours and feelings (for example as activated attending a soccer game). The ego-states may represent current modes of behaviour and experiences or only those apparent at an earlier age (as in the case of hypnotic regression, such as memories, feelings and postures) (Frederick & Phillips, 1995:88).

FIGURE 3.2 EGO-STATES



(Adapted from Watkins & Watkins, 1997:27)

The center may be considered as the *"core self",* containing a number of behavioural and experiential items that are more or less constant in a normal person and which present to the person and to the world a relatively consistent determination of the way the person and others perceive his/her *"self".* The boundaries of this core self can expand or contract (to include more or less psychological material) and are therefore not rigid. When a person is active, the core ego expands, extending the ego cathexis over more mental structures and processes such as he/she feels and appears to be vigorous. When a person is inactive (sleeping or depressed), the core ego contracts its boundaries and withdraws ego cathexis, leaving behavioural and experiential material external to it, unenergized and dormant.

The other ego-states (2 and 3) have more specifically defined ego boundaries (still relatively permeable), and *"…may be considered as segments of the self that were differentiated for adaptive purposes in the course of normal development"* (Watkins & Watkins, 1997:26). These ego-states may overlap in content (B) or be relatively isolated from other ego-states. For example ego-state 2 was formed at age six and ego-state 3 represents behaviours and experiences

dealing with authoritative figures such as the father. Area B therefore includes those psychological structures and processes that were active when at age six and the person was interacting with his/her father. The nature of ego-states can be summarized as in Table 3.1 (Emmerson, 1999:16).

TABLE 3.1 Nature of ego-states

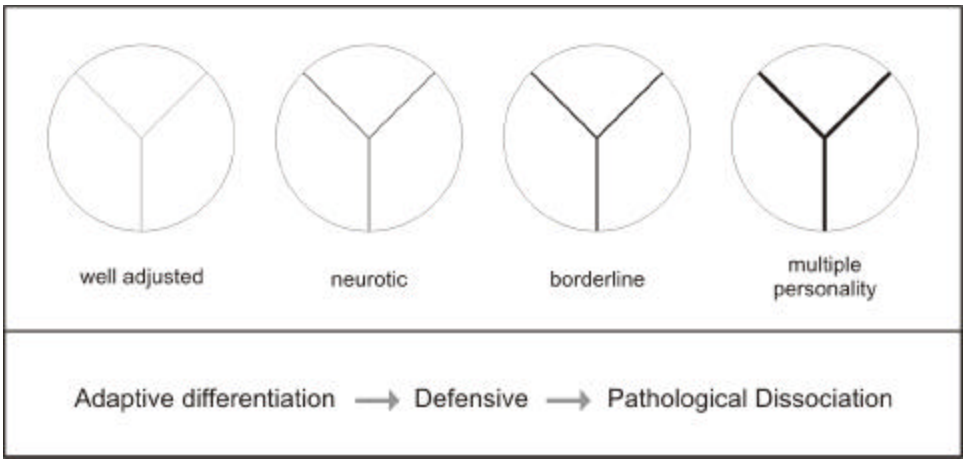
- Can be changed but not eliminated;
- Are able to know how old they feel;
- Can change names but cannot be removed;
- Have its own identity;
- Have feelings and do not like derogatory comments made of them;
- Dissociation between ego-states varies among individuals.

(Adapted from Emmerson, 1999:16)

3.3.3 DIFFERENTIATION – DISSOCIATION

Boundaries separating ego-states lie on a continuum of permeability. At the one end of the continuum are different attitudes and roles (like going to a party on Friday night versus working at the office on Monday) and these situations represent normal adaptive differentiation (integration). If ego boundaries become more rigid and impermeable on the other end, maladaptive dissociation occurs (Watkins and Watkins in Fass & Brown, 1990:257). It is at this end that we find, in its extreme form, dissociative identity disorder where the ego-states alternate in being cathected with ego energy and emerging overtly (see Figure 3.3).

FIGURE 3.3 Differentiation – Dissociation continuum



(Adapted from Watkins & Watkins, 1997:33)

According to Scharff and Scharff (1994:105) in the case of dissociative identity disorder, ego-states (parts of the *"self"*) remain secret from the others and are isolated from the executive ego-state and central integration. These conflicting parts can either be repressed (an active process *"in which the ego gains mastery over conflictual material"*) or be dissociated or split off from the personality as *"the last ditch effort of an overwhelmed ego to salvage some semblance of adequate mental functioning"* (Kafka in Alpert, 1995:139).

3.3.4 EGO-ENERGY

Federn in Phillips (2000:86) also believes that each ego-state contains personality energy that interacts with the energies of other ego-states, somewhat like the members of a family. This personality or psychic energy is defined as cathexis, which means energizing of harnessing energy. It can be cathected to either the ego (ego cathexis) or to the object (object cathexis) (Watkins, 1993:194). Ego cathexis is anything that is experienced by the individual as belonging to him/herself; it *"…has one basic quality, the feeling of selfness"*.

When an object (the other) is experienced as outside of the self, it is invested with object cathexis. Both cathexisses (ego and object) are held together in a

dynamic interplay *"…to accommodate the formation of the defenses and the experience of the self and the other"* (Frederick & McNeal, 1999:76).

The distribution of energy among ego-states can be understood with the concept of the executive ego-state. The executive ego-state is the ego-state which at any given moment contains the most energy in the internal system and which is aware of the other ego-states as objects (invested with object energy) (Frederick & McNeal, 1999:77). The executive ego-state is then experienced as the *"I"* (as it becomes the *"self"* in the here and now) and the other ego-states as *"its"* or *"things".* Thus, when something conscious is ego cathected, I ***experience*** it, but when it is object cathected, I ***perceive*** it.

3.3.5 DEVELOPMENT OF PERSONALITY AND EGO-STATES

Watkins and Watkins (in Zeig and Munion, 1990:404; Watkins, 1993:234) conceptualized personality structure as a multiplicity organized into various patterns of ego-states formed in early childhood. The ego-states are formed under three different conditions of personality development such as **normal differentiation, introjection of significant others** and **reaction to overwhelming trauma** (Watkins & Watkins, 1997:30; Phillips, 2000:86; Frederick & McNeal, 1999:77).

- **Normal differentiation:** The child learns to discriminate between simple things like between foods that taste good and those that to do not. From these discriminations the child develops entire patterns of behaviour that are appropriate for dealing with and adapting to different situations or interactions, such as dealing with parents, teachers and adjusting to school, church and so on. These circumstantial changes are quite normal although they represent syndromes of behaviour and experiences that are clustered and organized under some common principle. As such, they are considered as ego-states with flexible and permeable boundaries.

- **Introjection of significant others:** the child erects clusters of behaviour that if ego cathected (thus accepted by the self), become roles that he/she experience as the *"self"* (as its own), and if object cathected, become inner objects with whom he/she must relate and interact. An introjected parent or significant other becomes a role model of how to act and how to be and continues to live inside the child, even into adulthood (a child's perception of a nurturing parent becomes an internalised object in the form of an ego-state and the ego-state becomes nurturing on the child him/herself in the form of self-care – a form of positive introjection of a significant other).

- **Reaction to overwhelming trauma:** when the child is confronted with severe trauma, rejection or abuse, the child may dissociate as a survival response. The child then forms a creative expression of *"self"* (an ego-state) to contain or deals with the trauma in order to protect the greater personality from having to think about or feel the trauma. It removes the ego cathexis from that part of him/herself, re-energizes it with object cathexis and represses it. The function of that ego-state is either to protect the self, or to punish the self, or to alleviate the perceived guilt of the self. However, later on in life conflict or environmental pressure may cause that part to be reinvested with ego energy and to re-emerge. The re-emergence of such a repressed ego-state is more often than not malevolent, self-punishing or symptomatic.

3.3.6 THERAPEUTIC PROCEDURES OF EGO-STATE THERAPY

Symptomatology and/or pathology are viewed as being the result of an inability to resolve inner intrapersonal conflicts between different ego-states (Phillips, 2000:86). The goals of Ego-State Therapy therefore are not to fuse ego-states, but to integrate all the different ego-states into the central personality (a process of increased permeability of ego-state boundaries and improved internal harmony resulting in better cooperation and congruence among various ego-states)

(Gainer & Torem, 1993:259). Frederick and McNeal (1999:79) defined ego-integration as *"…a condition in which ego states are in full communication with one another, share mental content, and exist in harmonious and cooperative relationships with one another."* During integration ego-states function and relate to one another as if members of a healthy and functional family.

3.3.6.1 Relationships and Ego-State Therapy

Since Ego-State Therapy works with different internal ego-states and views them as a *"family of the self",* it incorporates elements from family therapy and group therapy perspectives. Its main focus is symptom resolution through internal communication, relationships and relationship building. Consequently, according to Phillips (2000:93), there are four levels of relationships in Ego-State Therapy, which must be attended to at all times:

- ***The therapist's relationship with the whole of the personality****:* This relationship is the most important one in Ego-State Therapy, as positive transference can only be established through a strong therapist-patient relationship;

- ***The therapist's relationship with the patient's individual ego-states****:* The key ego-states are those directly involved in or which contribute in some way to the symptomatology and/or pathology, as well as those ego-states that can help to resolve them;

- ***The patient's relationship with inner ego-states****:* The patient must become aware of these parts of him/herself in order to form healthier and more cooperative relationships. Dysfunctional relationships should be confronted and changed;

- ***The relationship of ego-states with each other****:* This is the final step towards conflict resolution, as conflicts and dysfunctional patterns

amongst ego-states must be identified, renegotiated and resolved in order to facilitate harmonious interaction and integration between ego-states. Ego synthesis (inner healing) can only be achieved once the positive parts of the self (ego-states) are utilized to bring the *"self"* together in a cooperative effort to seek physical, emotional and spiritual wholeness.

3.3.6.2 The activation of ego-states

Ego-states are activated when they are filled with ego energy (usually due to an external trigger, stimulus, stressor or life event) and become executive. An ego-state can also be activated in therapy in order to communicate with it and to help it learn to meet its needs (which might be in conflict with those of other ego-states, or those of the whole personality) in more constructive ways (Phillips, 1993:242). Corrective healing and nurturing experiences can be provided during the therapeutic process. According to Frederick and McNeal (1999:79) all ego-states are aware of the happenings in therapy. They might not be executive, but they are all listening in. Therefore they may all be considered possible candidates for the therapeutic alliance.

Before activating an ego-state, it is important to remember that ego-states came into existence in order to help or protect the *"self"* (Phillips & Frederick, 1995:39; Watkins & Watkins, 1997:77), and that all ego-states have their own individual needs, which might be incompatible with those of the greater personality (Phillips, 1995:111). Not all ego-states may be willing to be activated and *"show"* themselves, as they might fear the therapist and see him/her as someone who wants to eliminate certain personality parts or ignore their needs. It is therefore necessary to establish a sound therapeutic relationship before considering the activation of an ego-state, as the therapist often needs to renegotiate ego-states' needs in more constructive ways.

Ego-states can be activated through the use of hypnotic or non-hypnotic techniques (Torem, 1987:98). Non-hypnotic ways include *the empty chair* technique (developed by Helen Watkins in 1978), the *talking through method* and *the personal diary technique*. It is however, the hypnotic techniques that will be discussed in detail (Frederick & McNeal, 1999:81; Watkins & Watkins, 1997:111):

Non-hypnotic techniques:

- ***The talking through method*** is done in non-hypnotic therapy, where the therapist addresses directly or indirectly, the particular ego-state through the greater personality. Through a heightened sense of awareness to certain aspects of the self, the ego-state can acquire enough ego energy to become executive or to share the executive position with the greater personality. The patient then becomes aware of certain thoughts, feelings bodily sensations and/or images that are manifestations of that ego-state. The therapist can use this method to establish a therapeutic relationship with an ego-state, to clarify misapprehensions or resolve possible fears the ego-state might have.

Hypnotic techniques:

- ***Calling out of ego-states****:* According to Watkins and Watkins (1997:109) the calling out of ego-states is the most traditional form of ego-state activation. Through this method the therapist uses trance to establish ideomotor signals through which the ego-state can initially communicate. Thereafter the therapist invites the ego-state to communicate with him/her while the patient is in hypnosis.

- ***Activation through imagery****:* This method is a gentle, non-intrusive way of activating an ego-state and it serves as a means to gain perspective on what is really going on inside the patient. The patient is asked to imagine a safe place and to invite all the parts of the patient's personality to sit around a table. The therapist then interprets the initial appearance of ego-

states patterns as indicative of the patient's current experience of *"being-in-the-world"* (Frederick & McNeal, 1999:83).

- ***Ideomotor activation**:* Ego-states can also be activated through the use of ideomotor signals. This method is especially relevant when working with silent nonverbal or preverbal ego-states as it is the only means to ego activation.

- ***Drawings**:* The therapist asks the patient to make a drawing at home of how the patient sees and/or experiences his/her current situation. In the next session while the patient is in trance, the therapist then uses this drawing metaphorically by asking the patient to imagine it being a very old picture covered with layers of dust, and underneath it all there lays a picture that has something to do with the patient's problem. A symbol of the drawing can then be used to access an ego-state.

- ***A Collage**:* This method is very useful with patients that find it difficult to imagine in vivid detail. The patient is asked to make a collage or poster of his/her life and bring it to the next session. In hypnosis the patient is then asked to point to the picture in his/her collage that is most relevant to his/her presenting problem. The patient then dissociates that picture from all the other pictures and is asked to go into the picture and to become the picture in a fusion. The picture is then personalized as an ego-state is elicited.

- ***Dreams**:* This is a form of free association. The patient can either be asked to dream a dream while in trance or else to bring a dream to the next session and the same method as with a collage is used to elicit an ego-state most relevant to the patient's current problem.

- ***Somatic bridge**:* Any bodily sensation or movement is utilized to access an ego-state through the use of a somatic bridge. The therapist asks the patient to enhance any bodily sensation and allow it to intensify. The

patient is then regressed to the incident, which the somatic sign has represented, or the patient can dissociate that part of his/her body from the rest of the body and personalize it as an ego-state.

Watkins and Watkins (1997:198) reported that ego-states might also present themselves in *"mysterious"* ways, often overlooked by the therapist. They may present themselves in abstract images, or through somato-sensory sensations or through ideomotor signaling. These ego-states are more often than not very shy, fearful and immature. They might resist because they *"…experience a need for power, are frightened of extinction, or have various unresolved, narcissistic wishes and preoccupations"* (Frederick & McNeal, 1999:85).

The last category of ego-states that a therapist might come across is the malevolent or hostile ego-states (Watkins & Watkins, 1997:200). They are the personality parts that manifest in any destructive manner such as self-mutilation, homicide and/or suicide attempts, physical symptoms and even antisocial behaviour (Frederick & McNeal, 1999:85). They need validation of their protective function and should be respected. It is also important that the therapist re-assure the patient (and other ego-states) of the value and adaptive natures of such malevolent ego-states.

3.3.6.3 Ego-states as hidden observers

Hilgard (in Watkins & Watkins, 1997:36) found that when hypnotic deafness has been suggested in a patient, he/she could still hear at some level. He interpreted this as presenting a covert, cognitive structural system, which he called the *hidden observer*. Watkins and Watkins (1990:6; 1997:36; 1997:88) found that the nature of such hidden observers usually represents organized ego-states, and therefore they view these *"hidden observers"* as ego-states. Frederick and McNeal (1999:154) stated that the *"hidden observer"* is that part of the person that has been there since the day the person was born. It is the silent witness to everything the patient has ever experienced and therefore has all the

answers/resources needed to facilitate inner healing and the creation of a harmonious internal family (Watkins, 1993:235).

Phillips and Frederick (1995:87) elaborated on the concept of the *"hidden observer"* and called it *"inner strength"*, as that part of the personality that assisted the patient and helped the patient to survive every life event up to the present. They utilized the concept of the *"hidden observer"* and/or *"inner strength"* (the positive internal energies) as a resource for ego-strengthening, empowering the patient through the knowledge and re-assurance that the patient does have the internal resources, strength and the *"answers"* for internal healing (Frederick & McNeal, 1999:141; Phillips, 2001:249).

3.3.6.4 Ego-states as internal resources

The activation of inner resources has a twofold function: firstly to build ego-strength (an empowering endeavour, whereby weaker positive ego-states can acquire strength and become stronger in order to be able to assert themselves against stronger malevolent ego-states) and secondly to empower the executive ego-state (the main personality) to be able to deal with possible repressed or dissociated traumatic material incorporated in other ego-states necessary for ego-integration without re-traumatization (Frederick & McNeal, 1999:88). Phillips (1995:111) cited the importance of accessing somatic, emotional and cognitive resources that can also contribute to ego-strengthening and personality reintegration.

When the ego is strengthened, its field of perception is widened and its organization enlarged. This enhances the ego's ability to work through subconscious early life conflicts and to direct the individual towards survival and mastery (Phillips, 2001:248). The *"internal system of self"* is utilized to *"…increase the interaction between more, functional aspects of personality and extend their influence over more childlike and dysfunctional states"* (Phillips, 2001:248). Dependant ego-states often need nurturing and the patient is

encouraged to provide internal nurturance to those states, through other more nurturing ego-states (Watkins, 1993:237). Different ego-states can be activated as inner resources as illustrated in Table 3.2:

TABLE 3.2 Ego-states as internal resources

- The activation of helpful ego-states.
- Conflict-free ego-states as internal resources.
- Conflict-laden ego-states as inner resources.
- Joint effort of ego-states as source of ego-strengthening.

(Compiled from Frederick & McNeal, 1999:92)

As ego-states approach one another, communicate with each other, share information and enter into more cooperative ventures, it is as though their resident internal resources both grow and become accessible. An adaptive togetherness along the path of ego-integration is encouraged (Watkins, 1993:236).

3.3.6.5 The Abreaction

The American Psychiatric Association (in Phillips & Frederick, 1995:121) defined an abreaction as *"…an emotional release or discharge after recalling a painful experience that has been repressed because it was consciously intolerable. A therapeutic effect sometimes occurs through partial discharge or desensitization of the painful emotions and increased insight"*. Watkins and Watkins (1997:117) stated the importance of an abreaction in working with ego-states and in Ego-State Therapy, as *"the release of bound emotions through their overt expression, verbally and/or behaviourally"*.

The abreaction is a technique used to bring the entire patient (or a single ego-state – although less sufficient) to the full awareness of a current emotional experience. It can be done either through an *affect bridge* (enhancing and

reinforcing an emotion for regression), or a *somatic bridge* (enhancing and reinforcing a bodily sensation or awareness for regression) or through visualization (called the *silent abreaction*). The re-association and release of affective, somatic, cognitive, visual and sensory aspects of a past experience may manifest in a variety of ways including crying, hyperventilation, trembling of the body (or specific parts of the body), hysterical convulsions, premature disengagement from trance and even autistic-like rocking motions (Phillips & Frederick, 1995:121). The purpose if this awareness is to integrate all the components (visceral, cognitive and motor (expressive)) of the traumatic memory or recalled event.

Watkins and Watkins (1997:118) established a few principles that should be kept in consideration when working with abreactions in hypnotherapy:

- Abreactions are best accomplished through the reliving of a traumatic event that the patient could not face at the time that it occurred;

- It should only be done once there is a strong working alliance between the therapist, the patient and the ego-states involved. It is only through the ego-strengthening of this relationship that the patient is enabled to confront the original traumatic situation, re-experience it, release the bound affect and achieve cognitive meaning;

- Emerging memories should never be allowed to overwhelm the patient and the patient should be taught how to leave a situation that is becoming overwhelming prior to reliving the traumatic event;

- In the case of child abuse/molestation, the introjected representation of the abuser should be confronted and mastered and the self-power lost at that time in the original situation should be recovered;

- The trauma should be relived over and over again until the emotion is completely exhausted and the bound affect completely released.

Thereafter (and only then) should the experience be interpreted and cognitively reframed, hence the patient might not yet be ready to accept the reframing;

- Abreactions involve the principle of counter-conditioning or systematic desensitisation and should be repeated until the patient no longer shows the symptoms that resulted from the original situation.

Watkins and Watkins (1997:123) state that it is not the realization of what had really happened that is most important, but rather the way the patient perceives and interprets the experience. Cognitive restructuring and reframing thus forms a crucial part of the abreaction process (Frederick & McNeal, 1999:316).

3.3.6.6 The SARI-Model

Once the therapist and patient have established a strong therapeutic relationship within clear boundaries, the hypnotherapeutic process may commence. Phillips and Frederick (1995:36) discussed the use of the SARI-model (as four stages of treatment) within hypnosis, when working with dissociative symptoms/pathology (see Figure 3.4). The stages are: *(I) – Safety and stabilization*; *(II) – Accessing the trauma and related resources*; *(III) – Resolving traumatic experiences and restabilization*; and *(IV) – Personality integration and the creation of a new identity* (Frederick & McNeal, 1999:318). Each stage will be discussed in detail.

I. **Safety and stabilization:**

According to Herman (1992:155) this stage is the most important stage and takes precedence over all the other stages. During this stage it is attempted to establish a reasonable degree of safety and stabilization within the therapeutic situation, as well as in the patient's everyday functioning. This means that the patient's support systems are being re-evaluated and established and all manageable symptoms and/or issues addressed (including the patient's

somatic and health issues, emotional and interpersonal difficulties, workplace related issues and any post traumatic symptoms). Substance abuse and addiction problems are also being managed and other self-destructive behaviours (including self-mutilation, eating disorders, impulsive risk-taking and involvement in exploitive or dangerous relationships) addressed. If needed, the patient is referred for medication (Phillips & Frederick, 1995:38).

The creation of safety and stabilization is done through the negotiation of contracts, limit-setting, structured and concrete homework assignments, guided visualizations (such as age progressions) and symptom substitution. *"The use of hypnosis during the first stage is focussed on ego-strengthening, mastery, and empowerment, rather than on exploring the origins of post-traumatic symptoms or dissociative responses"* (Phillips & Frederick, 1995:38). The main aim of this stage is to empower the patient by encouraging the patient to take responsibility for his/her own body and self-care and to create a general attitude of self protection and creation of a safe environment, before addressing traumatic memories and repressed material. It is stated that this will provide the patient with ego-strength needed for the following stages.

II. **Accessing the trauma and related resources:**

Once safety and stabilization have been reasonably achieved, the therapeutic process move towards age regressions to uncover the trauma and related resources that are dissociated from the full experience and connected to the presenting problem (Phillips & Frederick, 1995:42). Abreactions feature in this stage as the patient is connecting to all the different aspects of the traumatic experience.

The reconstructing or uncovering of traumatic material is most successful when initiated by the patient, expressing the need to find out what a particular current symptom or flashback means. Phillips and Frederick (1995:42) indicated that it is the therapist's role to help the patient reconstruct enough of

the traumatic experience in this stage, so that it can be re-associated and renegotiated within the whole personality. This is being done in such a way as not to overwhelm the patient with the information, and bearing in mind that the patient may easily destabilize during this process (Frederick & McNeal, 1999:290). In such event, stage one should be repeated.

III. Resolving traumatic experiences and restabilization:

Frederick and McNeal (1999:297) posed that the mere accessing of traumatic material is not enough for symptom resolution. There must be a reprocessing of the traumatic material so that the patient is desensitized and all the components (visual, sensory, behavioural, motoric, cognitive and affective) reconnected with the mainstream of conscious thought.

> *"…the primary focus of uncovering traumatic material should be on integration and regulating affects to enhance self-control rather than on emotional release and expression"* (Phillips & Frederick, 1995:43). The therapist should therefore be careful not to allow an unmanaged abreaction as this may only re-victimize the patient and leave him/her feeling even more helpless. There should be an alternation between stage one and three so that the patient is empowered to become increasingly capable of maintaining control over the recollections and achieving ego-integration.

IV. Personality integration and the creation of a new identity:

In this last stage, the main focus is on the integration of previously dissociated and reworked traumatic material (Frederick & McNeal, 1999:298). Ego-states are integrated with one another and other personality structures integrated as well. The second focus of this stage is on helping the patient to develop a new identity beyond that of surviving a traumatic experience (Phillips & Frederick,

1995:44). The patient is assisted in creating a hopeful future instead of lurking in the past, through the use of indirect suggestions towards the possibilities of re-education and new learning, as well as age progression.

The SARI-model is a dynamic model. Every time a patient destabilizes or feels unsafe, there is a return to stage one work and should more memories be uncovered, a proceeding to stage two.

FIGURE 3.4 The SARI-Model

			Hypnosis for **Integration and New Identity** Ericksonian approaches to future identity Development of New Identity: internal maturation Ego-state integration Integration of dissociated material
		Hypnosis for **Re-association** Renegotiation Working-through & processing Connecting sensory, visual, behavioural, motoric, affective & cognitive aspects of trauma to mainstream of awareness	Renegotiation of any emerging traumatic events Ongoing processing & working through of traumatic material
	Hypnosis for **Accessing and Mastery of Emerging Traumatic Material** Reconstruction of trauma material in empowering ways Self remembering approaches with and without hypnosis	Ongoing reconstruction of trauma for empowerment Continued safe remembering	Continued focus on reconstructured history for empowerment & perspective Focus on integrating what has been safely remembered & re-associated
Hypnosis for **Ego-Strengthening** Work & family: interpersonal issues Emotional self-regulation Somatic & health: post-traumatic symptoms Therapeutic relationship alliance Substance abuse & addiction problems Suicidal, homicidal & self-destructive issues	Alternate uncovering sessions with ego-strengthening If patient destabilizes, return to Stage 1	Restabilization through ego-strengthening If patient destabilizes, return to Stage 1	Restabilization of entire inner system: ego-strengthening for whole personality Destabilization likely only from external challenges; refocus on stage 1 tasks at deeper levels
STAGE 1 **Safety and Stabilization**	*STAGE 2* **Accessing Trauma Material**	*STAGE 3* **Resolving Traumatic Experiences**	*STAGE 4* **Integration and New Identity**

(Adapted from Phillips & Frederick, 1995:37)

3.3.6.7 Stages of personality integration

Phillips and Frederick (1995:167) conceptualized personality integration as a process with different stages. Although stages are mostly sequential, it may happen at times that a patient *"leapfrog"* over certain stages. The stages are therefore just a guide for integration purposes.

- **The stage of recognition:** This stage involves the overt recognition that other ego-states do exist, and that they are all equal in importance. Ego-states are encouraged to make themselves known, so that they can be acknowledged.

- **The stage of communication development:** Ego-states are encouraged to communicate not only with the therapist but also with each other, as they are part of an internal family. Failure to cooperate with each other might be detrimental to the greater personality.

- **The stage of development of empathy** for other ego-states fosters the integration process as parts are exposed to the pain of other parts and their affective range is enlarged (a sign of maturity).

- **The stage of cooperative ventures towards commonly held experiences and goals:** Ego-states are asked to cooperate in *"group"* activities and assigned tasks. This enhances group cohesiveness and moves the ego-states closer to one another, fostering the maturational process of all ego-states involved.

- **The stage of sharing interiority:** This stage involves the sharing of feelings, thoughts, fantasies, experiences and goals with other ego-states, as they are *"becoming close friends".*

- **The stage of co-consciousness:** Ego-states are now sharing consciousness, perceptions, intentionality and goals with each other and

the greater personality. This can only be achieved once the uncovering/re-association and maturational work has been completed (Wade & Wade, 2001:233).

- **The stage of continuing co-consciousness:** Some ego-states may spontaneously merge with other ego-states, while others may display separate identities. There is a deeper sense of intimacy between ego-states and their boundaries are relatively permeable.

3.3.6.8 Signs of personality integration

Watkins (in Wade & Wade, 2001:241) proposed, *"…the nurturance that heals come from inside of the client as internal needs are satisfied and conflicts resolved. When the internal family is happy, the whole person is well adjusted."*

Further signs of personality integration include:

- The fluctuation of feelings and behaviours as integration is sometimes heralded by unexplained feelings of grief (mourning the old identity);

- A shift of the patient's attention from the *"inside"* to the *"outside"* world (to projects and relationships) and the patient's behaviours are more realistic and grounded in reality;

- Psycho-physiological reactions such as vomiting and/or diarrhea, as the psyche is expelling *"toxic waste";*

- A shift in dream content, displaying integration; and

- A change in the trance material (an ego-state that was normally activated by the trance state is no longer there, and the trance material is less traumatic).

3.3.6.9 Ego-state therapy and sexual trauma

Watkins and Watkins (in Fass & Brown, 1990:257) explained sexual trauma from an ego-state point of view as follows: An abused child who internalizes his or her perceptions of a brutal parent may invest it with object energy. The child then suffers depression as the introjected object continues internally to abuse his/her *"self".* If the child invests this entity with ego cathexis, it becomes a segment of his/herself. He/she now identifies with the parent and no longer suffers depression, but instead abuses his/her own children. Through hypnosis subject experiences can be changed to object perceptions and vice versa. Accordingly, hypnosis is a modality for changing subject and object by manipulating ego and object cathexes in various areas of the soma and psyche.

As traumatized ego-states can be frozen in time, thus blocked from new information by inner walls of dissociation that separate them from the mainstream of conscious experience, reconnection of these split-off personality parts and providing them with corrective learning is essential to ego-state therapeutic work (Phillips, 2000:89). This is done through the SARI-model. Phillips and Frederick (1995:78) highlighted the importance of spending time with the patient as well as the internal family, processing reconstructed or abreacted material, reconnecting it with other recalled information, current feelings and symptoms, and allowing the patient and the ego-states to master it by investing it with perspective and meaning.

3.4 CONCLUSION

Years after the trauma, victims attempt to hold the memories and images associated with the traumatic event away from their conscious awareness by using a mechanism similar to the one they invoked at the time of the trauma itself, namely dissociation. This behaviour suggests that trauma survivors may have heightened hypnotic responsivity, as there is a striking resemblance between some of the symptoms suffered by victims of sexual trauma and the

characteristics of hypnotic phenomena. However, hypnosis by itself is not therapy. It merely facilitates the patient's recovery of affect and memories, his/her ability to dissociate memories from cognition, and the speed with which he/she achieves this.

It is clear that when working with adult survivors of childhood sexual crimes, a therapeutic approach that incorporates memory recovery, abreaction and the re-constructing of cognitive, affective and somatic content, should be utilized. As Ego-State Therapy specializes in the field of dissociation (with its concepts of ego-states and ego-strengthening) it is chosen for the purpose of this study. The researcher is further of opinion that the initial assessment procedures of the Medical Hypno-analysis theory can indicate the possibility of repressed memories related to sexual trauma and can also facilitate the establishment of a therapeutic treatment *"plan".*

The next chapter will deal with the research design and method of data collection.

"Wisdom is born in the heart of experience."

- **Pat Tie**

CHAPTER 4

RESEARCH DESIGN

"In order to generalize our intuitive insights and make them valid insights that are worth transmitting to others, however, we need to test our hypotheses on statistically significant samples of patients. Clinical intuition and scientific exploration must walk, and now do walk, hand in hand."

- Erika Fromm, 1987

4.1 INTRODUCTION

Chapter 1 dealt with the introduction to the study, the awareness of the problem and the motivation for the research. In Chapter 2 an overview of sexual crimes and a literature study on the psychological, physiological and developmental symptoms/pathology due to the aftermath of these traumatic events on the survivor were discussed. Chapter 3 presented a literature study on Medical Hypno-analysis as diagnostic tool in determining the root causes of the symptoms and the precise developmental age of the child at the time of the sexual abuse/molestation. Ego-State Therapy as therapeutic tool and treatment modality for the alleviation of these symptoms was also discussed.

This chapter covers the research design and methods that will be applied during the course of the study. It will describe the qualitative research methods to be used in order to gain and describe information with regard to the multiple case studies in this research. It will also focus on the History-taking Questionnaire and Bryan's Word Association Test as specific tools in the gathering of information and selection of case studies.

4.2 AIM OF THE STUDY

The primary aim of this empirical study is to explain, explore and describe the effects of unresolved childhood sexual trauma and the aftermath of earlier sexual crimes on adult survivors' sexual, psychological, relational and physiological functioning (as discussed in Chapter 2). McLeod (1999:8) explains this as *"…born out of personal experience and a need to know".* Thus, this study will investigate and determine what experiences (from conception to early childhood) or incidents related to the development of malevolent ego-states, had an impact on the development of symptoms/pathology associated with childhood sexual crimes. Through recognizing the symptoms and understanding the pathology associated with repressed memories related to sexual crimes, the psychologist might be better equipped to deal with presenting symptomatology.

The study will also focus on the use of tools from the Medical Hypno-analysis modality (such as the History-taking and the Bryan Word Association Test) in the allocation of the events and possible repressed incidents associated with the development of presenting symptoms/pathology. It will investigate the development and purpose of specific ego-states (as explained in Chapter 3 - the Ego-State Therapy modality) associated with these sexual traumatic events and the therapeutic process in the resolution of inner conflicts.

The following objectives will be considered:

- To define the Initial Sensitizing Event, the Symptom Producing Event and the Symptom Intensifying Event of a multiple case study group;

- To discuss and explore the development of ego-states of patients used in this study;

- To link the experiences of childhood sexual crimes committed against the survivor and the development of ego-states during

those experiences, with symptoms/pathology experienced in early adulthood;

- To discuss the application of the proposed hypnotherapy model from a psycho-educational perspective when working with survivors of sexual crimes.

4.3 RESEARCH DESIGN

Hall and Hall (1996:18) identified the following four stages in research: **the preparation** (the research question, literature review and development of a research design); **the fieldwork** (data collection); **the analysis** (analysis of data and drawing of conclusions) and the **reporting phase** (including recommendation). The research design will steer data collection.

"The design of a study begins with the selection of a topic and a paradigm" (Creswell, 1994:1). Paradigms provide the theoretical and methodological framework for the understanding of a phenomenon to be investigated. The process of understanding is based on the concept of inquiring; therefore the research design is mostly determined by the research question (LeCompte & Preissle, 1993:30; Denzin & Lincoln, 1994:210). The research questions relevant to this study are stated in Chapter 1.

Miles and Huberman (1994:6) explained the aim of a research design as a means to achieve a complete understanding of the context being studied. This research design will be qualitative of nature, attempting to capture both the complexity of the therapeutic process and the covert nature of much of what happens on a moment-to-moment basis (McLeod, 1999:32). The main sources of data for analysis will be multiple case studies. These case studies will be used to gain an overview of the causes of the occurrence of symptoms/pathology in adult survivors of childhood sexual crimes, as well as the effect of Ego-State

Therapy on the alleviation of symptoms/pathology and subconscious inner conflicts.

This study will further seek to gather information that can be integrated to formulate specific findings, thus establishing a correlation between theory and literature. *"Researchers…are therefore engaged in the process of* ***constructing*** *knowledge"* (McLeod, 1999:122). Merriam (1991:59) suggested the use of qualitative case studies to establish the compilation of theory. A case study is an investigation of and inquiry into a specific phenomenon (Merriam, 1991:19). In this case the phenomenon is the symptoms/pathology, which adult survivors of childhood sexual crimes suffer from, inhibiting their optimal functioning and growth towards self-actualization. The investigation will focus on the psychodynamics involved in the development of these symptoms as part of the personality (ego-states).

Although qualitative research can never be as objective as quantitative research, attempts can be made to ensure the analysis of human behaviour to be as unbiased as possible, through deep, profound and general interpretations of the phenomena in question (Vockell & Asher, 1995:192). Denzin and Lincoln (1994:212), Schurink (in De Vos, 1998:242) and Neuman (1997:11; 1997:329) cited the following characteristics of qualitative research design:

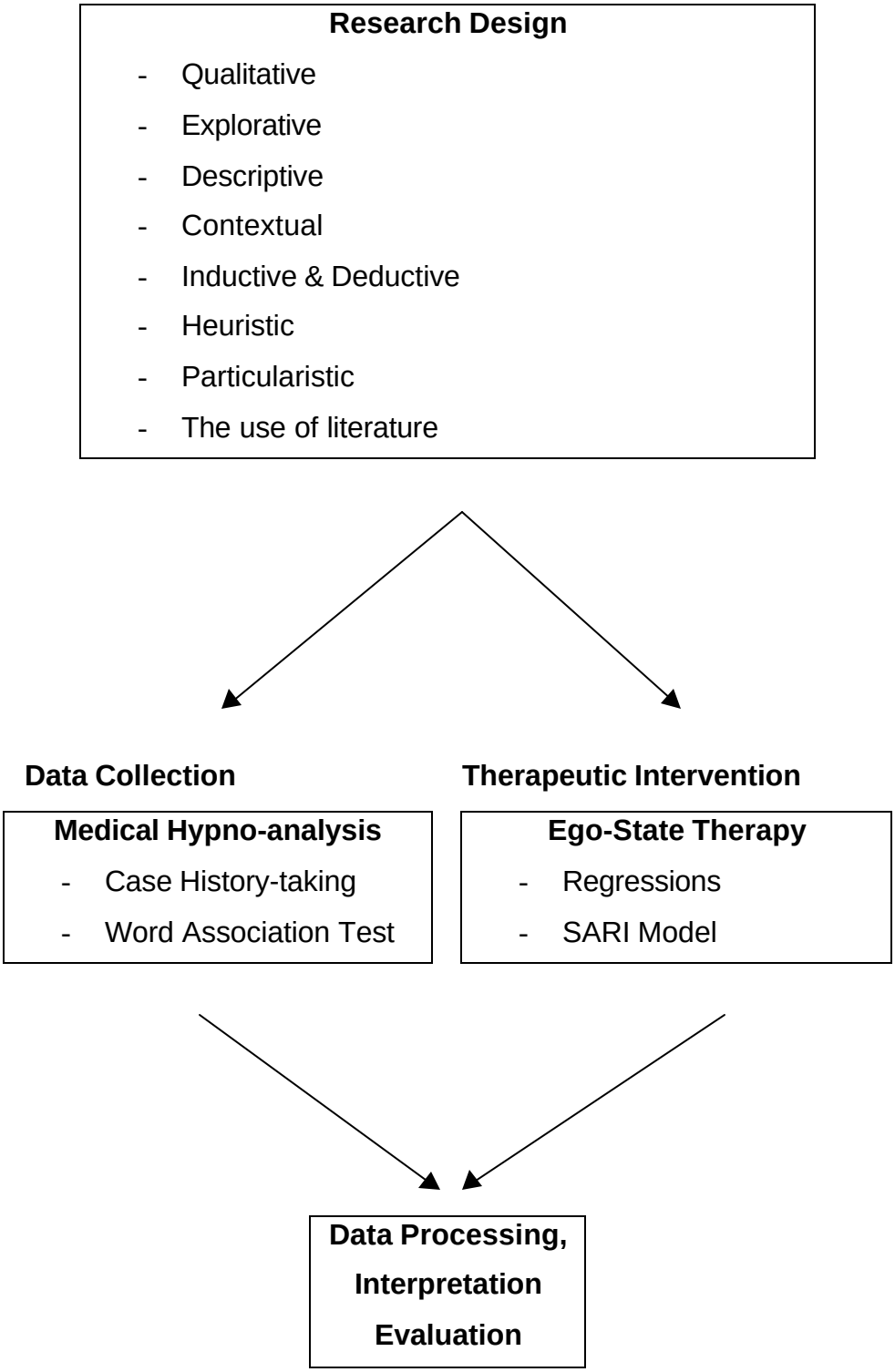
TABLE 4.1 Characteristics of qualitative research design

- It is holistic – focusing on the whole and full picture;
- It refers to the personal;
- It focuses on relationships within a system;
- It constructs social reality and cultural meaning;
- It is a thematic analysis of few cases/subjects;
- It focuses on interactive processes and events;
- It demands time in analysis equal to time in the field;
- Its research procedures are particular and replication is rare;
- It focuses on the understanding of a given phenomenon;
- It demands that the researcher develops a model of what occurred in the setting investigated;
- It demands that the researcher becomes the research instrument and must have the ability to observe human behaviour objectively;
- It requires an ongoing analysis of data gathered;
- Its data are in the form of words from documents, observations and transcripts; and
- It incorporates room for description of the role of the researcher as well as the researcher's own biases and ideological preference.

(Adapted from Denzin & Lincoln, 1994:212; Schurink in De Vos, 1998:242; Neuman, 1997:11; 1997:329)

Figure 4.1 provides a diagram of the research design for this study:

FIGURE 4.1 Research Design



Modified from Neuman (1997:11)

4.3.1 QUALITATIVE RESEARCH

"The aim of qualitative research is not to explain human behaviour in terms of universally valid laws or generalization, but rather to understand and interpret the meanings and intentions that underlie everyday human action" (Mouton in De Vos (Ed.), 1998:240). According to Stake (1995:37; 1995:43) it presses for understanding complex interrelationships among all that exist, through thorough description of experiences from a holistic point of view.

It makes use of multiple methodologies, or a closely-knit set of practices (*"bricolage")*, rather then strictly formalized procedures, to provide explanations to a problem in an existing situation. Therefore the range of such a study is more likely to be undefined. The researcher (*"bricoleur"*) on the other hand, is seen as a Jack-of-all-trades, using a variety of tools to ensure such an in-depth understanding of the phenomenon in question (Levi-Strauss, 1966:17; Denzin & Lincoln, 1994:2).

In this study the researcher will strive to understand the underlying dynamics of childhood sexual crimes and the influence thereof on adult survivors, using the History-taking and the Bryan Word Association Test (as provided by the Medical Hypno-analysis model) and Ego-State Therapy in hypnosis.

"Qualitative researchers examine patterns of similarities and differences across cases and try to come to terms with their diversity" (Neuman, 1997:419). It is a systematic, subjective approach used to describe life experiences through attaching meaning to them, using observations, interviews, content analysis and other data collection methods to report these experiences and behaviours. Its focus is on the relationships among variables (Vockell & Asher, 1995:452-453) and in this study the History-taking, Word Association Test and concepts from the Ego-State Therapy Theory will be used to find the variables and the relationships among them.

According to Denzin and Lincoln (1994:13) is *"…all research…interpretative, guided by a set of beliefs and feelings about the world and how it should be understood and studied"*. Thus, apart from finding relationships amongst variables, qualitative research also focuses on the process, meaning, understanding and interpretation of events and experiences in their natural setting (Denzin & Lincoln, 1994:10). Its preference is to insight, exposure and interpretation, rather than the testing of a hypothesis, therefore the researcher's choice of this method (Merriam, 1991:11).

4.3.2 EXPLORATIVE RESEARCH

According to Creswell (1994:20-21) the aim of exploratory research is to explain a specific phenomenon in terms of specific causes. It studies new ideas and possibilities and excludes predetermined ideas and hypotheses in an attempt to indicate the causality between variables (Mouton & Marais, 1989:45). It *"explores"* through the gaining of information relevant to the phenomenon in the spotlight, by asking specific questions in systematic inquiry form. From this information ideas are generated and tentative theories and conjectures are developed (Neuman, 1997:20).

In this study the explorative method will be used to explore the root causes of adults survivors of childhood sexual crimes' symptoms/pathology and the underlying relationships between these symptoms and personality formation (specifically the development of ego-states and their impact on behaviour). As the focus is on individual case studies, the subconscious dynamics present in the development of these symptoms will also be explored. Consequently, memories (as their development was explained in Chapter 2) and their impact on a patient's behaviour will also be explored.

4.3.3 DESCRIPTIVE RESEARCH

Merriam (1991:27) cited that the purpose of descriptive research is to give a *"detailed account of the phenomenon"* under investigation. The main objective is to understand the meaning of an experience and how the variables relate to and interact with each other (Neuman, 1997:20). It is holistic in nature and includes results gathered through the exploration phase, the in-depth interview and other findings based on conversations and observations (Merriam, 1991:11).

LeCompte and Preissle (1993:39) underscored the importance of the exact and in-depth description of a respondent's experience, in order to describe a process, mechanism or relationship. In this study the exact responses to the Word Association Test as well as the patient's exact experience of the childhood traumatic event, and the exact origin of the establishment of an ego-state(s) will be given.

Denzin and Lincoln (1994:108) stated that a descriptive research study is also interpretative, leading to understanding. This study will also give a detailed description and therefore interpretation of the development of the symptoms/pathology the adult survivor suffered from and the function and relation of an ego-state(s) associated with symptom production.

4.3.4 CONTEXTUAL RESEARCH

Contextual research describes the uniqueness and differences of a study and distinguishes characteristics within a certain context (Mouton & Marais, 1989:52), therefore allowing for the comparison of results with other research findings, but excluding generalization to the greater population (Creswell, 1994:20-21). It uses *"internal validity"* to generate accurate and realistic verdicts concerning the specific phenomenon which was studied. In this research, each individual case History-taking and unique Word Association Test results, will provide accurate and reliable data for analysis. The accurateness of the data gathered, will

however be tested during the therapeutic intervention and process (Ego-State Therapy) when repressed or partly repressed memories are *"remembered"* and accessed during trance.

4.3.5 INDUCTIVE AND DEDUCTIVE RESEARCH

According to Creswell (1994:20-21) observations of specific instances are used in order to formulate more general ideas about their nature in the inductive research method. LeCompte and Preissle (1993:43) posed that inductive researchers hope to find a theory, which will compliment and explain their data and findings. This leads to the development of a new theory from the data collected. In this research, the researcher will endeavour to produce a successful brief hypnotherapy model (incorporating elements from the Medical Hypno-analysis model as means of locating repressed or partly repressed memories associated with childhood sexual crimes, as well as dynamics of personality formation and ego-state development as stated by the Ego-States Therapy model) for the treatment of adult survivors of such incidents.

Hall and Hall (1996:33) stated that deduction on the other hand, starts with theory and uses it to explain observed actions. This study is also deductive, as it incorporates Medical Hypno-analysis and Ego-State Therapy theories (which form the starting point) but excludes other theoretic and therapeutic modalities (as stated in Chapter 3).

4.3.6 HEURISTIC RESEARCH

"Heuristic inquiry is a process that begins with a question or problem which the researcher seeks to illuminate or answer. The question is one that has been a personal challenge and puzzlement in the search to understand one's self and the world in which one lives. The heuristic process is autobiographical, yet with

virtually every question that matters there is also a social – and perhaps universal – significance" (Moustakas in McLeod, 1999:16).

Denzin and Lincoln (1994:212) highlighted that a heuristic research model incorporates a holistic case study, acknowledges the relationships within a system, brings about greater understanding of the phenomenon in question (and not necessarily predictions about it), and is of personal nature, incorporating subjective, personal experiences. In this study a holistic overview of each case study will be formulated by means of the History-taking; the relationships between childhood experiences, repressed memories and symptom development will be investigated, and a greater understanding of ego-states and their function and functioning during traumatic events and instances of dissociation will be underscored through the use of personal individual case study analysis.

4.3.7 PARTICULARISTIC RESEARCH

The particularistic research method *"takes a holistic view and are problem centered and small scale endeavors"* (Merriam, 1991:11). In this study (where case studies are being used) the cases are particular, as it focuses on a specific phenomenon. The importance of the cases lies in what they reveal about the symptoms/pathology associated with childhood sexual trauma, their origin and the development of ego-states.

4.3.8 THE USE OF LITERATURE

Literature, according to Creswell (1994:21-23), provides a background *"frame"* for the research problem. It assists the researcher in the finding, defining and refining of the phenomenon in question and provides the most recent information on research done in that particular field of study (McLeod, 1999:67; Neuman, 1997:89). The goals of the literature review (as elucidated by Neuman, 1997:89) includes (i) to demonstrate a familiarity with a body of knowledge and to establish

credibility; (ii) to show the path of prior research and how a current phenomenon is linked to it; (iii) to integrate and summarize what is known in an area; and (iv) to learn from others and to stimulate new ideas.

In this study, Chapter 2 stated the problem of the aftermath of childhood sexual crimes on adult survivors, and Chapter 3 provided possible therapeutic models and interventions for the gaining of information needed to answer the research questions.

4.4 RESEARCH STRATEGY

The research question and the phenomenon being investigated determine the research strategy. Denzin and Lincoln (1994:223) stated that the research format is the approach followed to answer the research question. In this study, the research is based on a multiple case study strategy, as the research is a qualitative inquiry. Using the concepts from the Medical Hypno-analysis model for data collection, the data analysis, processing and interpretation will be based on the Ego-State Therapy Theory.

4.4.1 MULTIPLE CASE STUDY

"Case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (Stake, 1995:xi). Strauss and Glaser (in Hall & Hall, 1996:197) cited that a case study is *"…based on analytic abstractions and constructions for purposes of description, or verification and/or generation of theory".* Multiple cases lead to a more powerful explanation of a phenomenon as they serve as *"comparison groups".* In this study a number of young adult patients are selected that suffered from a variety of symptoms related to the possibility of childhood sexual trauma. A semi-structured procedure will be followed in the collection and analysis of data, thus strengthening the validity of the research (Miles & Huberman, 1994:29).

4.4.2 SAMPLE STUDY

Miles and Huberman (1994:27) stated that qualitative research usually focuses on a small sample of people, as the size of the sample is not as important as the diffusion of the data and the availability of sufficient vital information. In investigating the formation of ego-states related to childhood sexual crimes in a small number of cases, the researcher will be able to focus in-depth on each individual case.

4.5 METHODS OF DATA COLLECTION

According to Merriam (1991:67) qualitative data consist of *"…detailed descriptions of situations, events, people, interactions and observed behaviour".* Concept formation is an integral part of data analysis and begins during the data collection phase, as conceptualization assists the researcher in organizing and making sense of data (Neuman, 1997:421).

Thorough data collection and the accumulation of information are essential in order to gain answers to the research questions (LeCompte & Preissle, 1993:158). McLeod (1999:96) cited the importance of face-to-face interviewing, as it allows the participants to feel relatively in control of the conversation and it assists the researcher in dealing effectively with complex and sensitive issues.

In this study, data will be collected by means of in-depth structured interviewing (the History-taking and Word Association Test), observations and field-notes (nonverbal behaviour of patients and process notes of hypnotic sessions and regressions) as well as the information given by the patient (when inquiring about ego-states during regressions) (Schurink in De Vos, 1998:300). All subjective meanings that retrieved experiences or memories held for patients, will also be accepted as data collected for analysis (Omery, 1983:50).

4.5.1 THE USE OF THEORETICAL FRAMEWORK IN DATA COLLECTION

Ego-State Therapy (as described in Chapter 3) will be the theoretical framework for this study. A theoretical framework allows for conceptualizing of the research problem, the data collection, analysis and interpretation thereof, within a specific context (Merriam, 1991:53). It influences the researcher's perspective and point of view. The current researcher has undergone specific training in Medical Hypno-analysis as well as Ego-State Therapy with the South African Society for Clinical Hypnosis.

As Medical Hypno-analysis strives to emphasize the root causes of symptoms instead of the symptoms itself, the researcher will apply this model in determining the development of ego-states responsible for the symptoms/pathology adult survivors of childhood sexual crimes suffer from. Through regressing to those specific incidents (the root causes for the development of the malevolent ego-states), symptoms will be removed by addressing and resolving the underlying root causes, and through the negotiation, maturation and integration of ego-states (Scott, 1993:xiii; Watkins & Watkins, 1993:233).

4.5.2 THE CASE HISTORY AS DATA COLLECTION

According to Zelling (1994:4) presenting symptoms in a patient can be examined through a case history, where verbal and non-verbal communication can be observed and conscious and subconscious clues to the causes of the symptoms concluded. This assists the researcher in establishing the psychodynamic diagnosis of a presenting problem.

In this study, the researcher will make use of the specifically designed History-taking Questionnaire and Bryan Word Association Test from the Medical Hypno-analysis Model. This allows the researcher to investigate the patient's subconscious, seeking clues and possibly repressed memories regarding

childhood sexual trauma and the establishment of ego-states related to the presenting symptoms/pathology.

The History-taking Questionnaire is a lengthy in-depth questionnaire, gathering as much information as possible from the patient's present illness, past history, family history, sexual history, psychological history, habits, religion and marital history. Scott (1993:108) cited that the effective treatment of a patient depends on the information gathered and the initial contact session, *"…to get to the heart of the problem quickly and to move towards the desired goal, it is necessary for the therapist to take charge of the interview as soon as possible"*. Bryan (in Ayers, 1994:57) stated *"…the patient will tell you the real problem in the first three sentences of the history."* For effective therapeutic intervention, the therapist needs to record everything (almost word by word) of what the patient is presenting, verbally and non-verbally.

The History-taking Questionnaire consists of the following subsections:

4.5.2.1 Section I: Present Illness

After the biographical information in the questionnaire, the therapist asks the question *"Tell me what the problem is?"* Every exact word, gesture, pause, sigh or other non-verbal behaviour of the patient is then recorded. The first three sentences (according to Bryan in Ayers, 1994:57) of the patient's reply is important as it will reveal the subconscious train of thought and the underlying real problem.

Thereafter, the questionnaire further explores the problem as stated by the patient in asking questions such as *"When did the problem start?"* (helps identify the Symptom Producing Event); *"What is the duration of the problem?"* (might also reflect on the Symptom Producing Event); *"What conditions make the symptoms worse and what conditions make it better?"* (this might reflect on the cause and cure of the problem) and *"What would you do if you are cured from the*

symptom that you cannot do now?" (this question determines whether there is a possible secondary gain from having the symptom) (Scott, 1993:112).

4.5.2.2 Section II: Past History

This section reflects the medical history of the patient and reveals important information about the negative experiences concerning the prevailing symptom. *"…it is in childhood that trauma and/or fright become Initial Sensitizing Events(s) which set the child up for future problems. It is not so much the fact of the event as the impression or interpretation of that event to the mind of the child which makes it traumatic enough to have after-effects severe enough to contribute to the present symptom"* (Scott, 1993:113). Scott (1993:113) also cited that the medical history forms the integration of the patient's body, mind and soul.

4.5.2.3 Section III: Family History

This section explores any critical illnesses of family members and the influence it had on the patient. Following this are questions about the patient's childhood, where it was spent and whether it was unhappy or happy. Information about the patient's parents is also gathered when the therapist focuses on the parents' ages, names, health, status, occupation, personality, how the patient experienced the parent's relationship with each other and lastly the nature of the patient's relationships with each individual parent (Scott, 1993:116).

The next few questions explore the patient's siblings and the patient's place in rank order with regards to other siblings. Hoopes and Harper (1987:6) stressed the *"evaluation of birth order roles and sibling patterns"*.

4.5.2.4 Section IV: Sexual History

This section is very important for the purpose of this research study. Every aspect of the patient's sexual history (the age puberty was reached and the source of initial sexual information), as well as sexual experiences are

investigated here. Any trauma and/or confusion with regard to the patient's sexual history are significant, as repressed sexual trauma will impact consequent sexual experiences. According to Scott (1993:118) the adolescence developmental phase is the most important phase (after the birth experience) in an individual's life.

4.5.2.5 Section V: Psychological History

Questions about a patient's childhood history such as sleepwalking, re-occurring nightmares or repeated dreams assist the therapist to gain information about the first five years of the patient's life. This provides clues for determining the possible Symptom Producing Event and Symptom Intensifying Events. The age the patient went to school, his/her teachers, friends, successes, failures, as well as happy and unhappy experiences are also investigated (Scott, 1993:120).

4.5.2.6 Section VI: Habits

This section focuses on any possible indication of a patient's addictive behaviours by asking questions with regard to the patient's consumption of alcohol, the use of drugs and the amount of cigarettes smoked. Nervous behaviours such as nail biting, stuttering, thumb sucking, hives and nervous tics are also being investigated (Scott, 1993:121).

4.5.2.7 Section VII: Social History

The interpersonal relationship of the patient with the environment and other people is the subject of this section. Questions asked *are "What do you think people say behind your back that you do not like?" "If you could change anything about yourself, what would it be?"* and *"What is your attitude towards the opposite sex?"* It further includes questions related to suicide ideation and attempts and will give the therapist an indication of the patient's ego-strength and consideration regarding suicide during the process of therapy (Scott, 1993:124).

4.5.2.8 Section VIII: Religion

As both modalities (Medical Hypno-analysis and well as Ego-State Therapy – Scott, 1993:125) have a holistic view of human beings (body, mind and soul), it is not surprising that this questionnaire includes questions regarding the patient's religious beliefs and religious history. This is important as the belief in a *"Higher Power"* forms the foundation for ego-strengthening. Forgiveness is often part of the therapeutic process especially when working with trauma and guilt, and the patient's perceptions and beliefs provide the framework for any therapeutic intervention that might touch on the concept of an entity more powerful and greater than the patient him/herself.

4.5.2.9 Section IX: Marital History

Scott (1993:126-129) explains the purpose of the specific questions that should be asked in this section. In this study, information about the patient's sexual habits and behaviour (where applicable) will assist the researcher in making a complete diagnosis.

4.5.3 THE BRYAN WORD ASSOCIATION TEST

The Word Association Test is a projective technique developed by Dr. William Bryan in 1955 (Scott, 1993:137). It consists of 202 words or partially incomplete phrases, designed to reveal subconscious emotions and thought patterns (Scott, 1993:162). Although it is difficult to establish exactly what is being measured (as there are no scores involved), access is gained to the patient's subconscious awareness on a number of sensitive issues. The patient is unaware of the psychological interpretation of the answers, whilst important aspects of the patient's personality and history are revealed.

The Test is administered while the patient is in hypnotic trance and the emphasis is on the patient's freedom to respond with whatever word or phrase first comes

to mind on hearing the words (the therapist reads the words one by one), as there are no *"right"* or *"wrong"* answers (Scott, 1993:164). The therapist then inquires where necessary, to further explore answers given, in order to formulate a diagnosis. When interpreting the patient's responses, the concept of a=b, b=c, thus a=c is kept in mind. This will be illustrated in the following chapters when the case studies analyses are discussed.

Scott (1993:157) posited that the Word Association Test gives the therapist *"…an indication of the overall, general personality type of the subject. General impressions of the degree of depression, anxiety, sexual orientation, confidence or lack of it, maturity level, attitudes towards significant others in one's life and expectations of the future will be indicated on this test."* In this study it will also be used to determine the age and developmental phase the patient was at when ego-states related to symptoms caused by childhood sexual crimes, were formed.

4.6 DEMARCATION

In this study a number of case studies will be used to study the development of ego-states during experiences of childhood sexual trauma and their impact/influences on the presenting symptoms/pathology adult survivors of these events suffer from. The patients will be young adults (between 18 – 28) regardless of their sex, culture, language or profession. The History-taking and Word Association Test of the Medical Hypno-analysis model will be used to determine the Initial Sensitizing Event, the Symptom Producing Event and the Symptom Intensifying Event. Ego-State Therapy will be used to determine the presence of ego-states and to work towards symptoms alleviation.

4.7 PROCEDURES AND TECHNIQUES

The therapist will use the case history and the Word Association Test to determine the Initial Sensitizing Event, the Symptom Producing Event and the Symptom Intensifying Event. This will give the therapist an indication of the possibility of repressed memories related to childhood sexual crimes or trauma. Therapy will then commence starting with regressions in order to identify ego-states associated with the underlying symptoms/pathology, which the patient suffers from, and then working towards ego-integration (that will consequently lead to symptom alleviation).

4.7.1 CLINICAL PROCEDURES OF THE THERAPY

The clinical procedures of therapy will be as follows:

- First session: Relationship building and case History-taking Questionnaire.

- Second session: Completion of the History-taking and explanation of hypnosis (including teaching the patient self-hypnosis, the provision of protective suggestions and the introduction to the process of hypnosis).

- Third session: Completion of the Word Association Test (before the following session the therapist analyzes the test and draws up hypothesis, identifies the three events of the triple allergenic theory and plans the following therapeutic session dependant on the ego-strength of the patient).

- Fourth and succeeding sessions: Age regressions under hypnosis to significant sexual events (and others where applicable), which contributed to the symptoms/pathology developed. Ego-State Therapy will then be used to determine the presence of malevolent ego-states causing the symptoms. Therapy with the ego-states will then commence, focusing on

reframing false or unhealthy core subconscious beliefs and integrating them into the greater personality. This will be done alternating between ego-strengthening sessions and regressions.

- The last few sessions will focus on other significant events that relate to the symptoms (ego-states will identify the existence of such events), as well as the cognitive interpretation and evaluation of the whole therapeutic process.

4.7.2 PROCEDURES OF REPORTING OF CASES

The following report will be given on each of the cases:

i. The presenting problem as stated by the patient in the History-taking;

ii. A condensed version of the patient's history;

iii. A summary of the Word Association Test responses that relate to the presenting problem and childhood sexual trauma as well as hypothesis drawn from the responses;

iv. Regressions to the significant events and the identifying of the different ego-states involved in the production of the symptoms and their function(s);

v. A brief explanation and interpretation of the presenting symptoms/pathology;

vi. Brief feedback on the therapeutic process (the process of ego-integration) followed after the diagnosis.

4.8 GOALS OF THERAPY

The goals of therapy are to identify and *"reframe"* the perceptions of ego-states responsible for causing the symptoms the patient suffers from. The use of regression in hypnosis will activate ego-states related to the trauma and therefore allow for therapeutic intervention in the subconscious mind at the core of the formation of the defense mechanism to protect the *"self"* and *"identity"* of an individual. Repressed memories will be recalled and the full dynamic picture of a memory accessed in order to remove *"faulty"* perceptions and change the effect of the emotional content of a traumatic event. Through this process root causes of prevailing symptoms are worked through and ego-integration achieved. The patient will be assisted and encouraged to find inner resources in order to *"heal"* him/herself and to grow towards self-actualization (a sign of ego-integration).

4.9 DATA ANALYSIS

Tesch (in Creswell, 1994:155) stated that data analysis is conducted to reduce and organize data in order to produce findings that can be interpreted by the researcher. The data in this study will be continuously analyzed as the case proceeds to determine the subconscious needs and strengths of the patient (Denzin & Lincoln, 1994:432).

The researcher will make use of the Miles and Huberman's (1994:10) methods of data analysis in this research. With this method, data analysis is divided into three components of activities: a) data reduction, b) data display and c) conclusion drawing. According to Yin (1989:53) each case is a study on its own and cases form replicas of each other. The subject's problem is determined by using the preferential ranking order, and then dealt with in accordance with the Medical Hypno-analysis diagnostic principles (the Triple Allergenic Theory – the Initial Sensitizing Event, the Symptom Producing Event and the Symptom Intensifying Event) and the Ego-State Therapy's theory on the development of personality (see Chapter 3).

4.9.1 DATA REDUCTION

Miles and Huberman (1994:10) posited that data reduction is *"…the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up field-notes or transcriptions."* Data reduction includes a conceptual framework, research questions, cases and instruments as chosen by the researcher (Poggenpoel in De Vos, 1998:340). In this study data collected from the History-taking, Word Association Test and regressions will be reduced in the form of summaries, coding and clustering.

4.9.2 DATA DISPLAY

A data display originates from extensive information that allows the researcher to draw conclusions and intervene accordingly (Miles & Huberman, 1994:10). Data collected from the multiple case studies will lead to further analysis and interpretation. Miles and Huberman (1994:82-87) indicated the following four analytic transformations that the researcher will keep in mind during this study:

i. Individual Case Synopsis: The synopsis aim to *"disclose what was essential to each person's experience, while reducing the original transcript to one third"* (Miles & Huberman, 1994:86);

ii. Illustrative Narrative: Themes, sequences and keywords reflecting the most characteristic accounts are searched in an attempt to connect all the data and to tie up loose ends of individual segments of data;

iii. General Condensation: A compact description of the characteristics common to the transcripts is given. According to Miles and Huberman (1994:87) a general summary of the data is stated;

iv. General Psychological Structure: The analysis is connected to theory as stated in a literature study, but also to knowledge lying outside of the data set.

4.9.3 DRAWING CONCLUSIONS

Miles and Huberman (1994:11) cited that the purpose of drawing conclusions is to determine what data mean. Conclusions are being drawn from the patterns, explanations, casual flow and configurations of data in a study. All the case studies in this research will follow the same analyzing process (Yin, 1989:57).

4.10 CREDIBILITY, RELIABILITY, VALIDITY OF THE RESEARCH

Validity is *"…the extent to which a test, questionnaire or other operationalisation is really measuring what the researcher intends to measure..."* and reliability is *"…the extent to which a test would give consistent results if applied by different researchers more than once to the same people under standard conditions…"* (Hall & Hall, 1996: 43-44).

Thus, the credibility, reliability and validity of a research study reflects on the trustworthiness of the study in terms of the accuracy of research findings, reality based verdicts and its ability to convince the reader of the worthiness of the research findings (Lincoln & Guba, 1985:290; De Vos and Fouche, in De Vos, 1998:83-86). It is a form of quality control as there is no statistical evidence of findings as found in quantitative research (McLeod, 1999:133).

Merriam (1991:166) proposed that the trustworthiness of a study lies in the researcher's *"…careful design of contexts of production, phenomena and the processes of measurement, inference and interpretation".* The consistency with which the researcher collects data (the use of the same methods), reproduces the actual experiences of each patient and the use of research techniques (as

well as the environment of the research), will heighten the reliability and credibility of the study (Krefting, 1991:216). As this study is qualitative of nature and directed by a literature study, the research environment consistent and the research methods the same for every case, its credibility and reliability would not be in question.

Guba (Poggenpoel in De Vos, 1998:348-351) underscored four aspects of trustworthiness, which are relevant to qualitative research and will apply in this research study: truth-value; applicability; consistency and neutrality. Each one of the aspects will be briefly discussed.

- **Truth-value**

  According to Lincoln and Guba (1985:296) the research needs to be performed in such a way that it enhances the probability of the findings to be found as credible, by having them approved by literature and the phenomenon being investigated. Krefting (1991:215) focused on the validity of the research design of the investigation, and stated that a trustworthy and well thought-through design will enhance the truth-value of the research findings. Careful documentation of the conceptual development of the study will also enhance the truth-value, as all the data pertinent to the research will be available and open for auditing.

  In this study, the multiple case study approach as well as the use of the combination of two therapeutic modalities (Ego-State Therapy and Medical Hypno-analysis) allows for the crosschecking of explanations, adding to the credibility and truth-value of the research findings (Miles & Huberman, 1994:29; Denzin & Lincoln, 1994:216; Stake, 1995:108).

- **Applicability**

  Krefting (1991:216) stated that the applicability of research findings refers to the degree to which these findings can be transferred and generalized to other populations and settings. External validity of a case study investigation is established through the description of the research

phenomenon, the analysis and interpretation of research findings and the comparison thereof with other studies (LeCompte & Preissle, 1993:349).

The findings of this study will be evaluated in terms of the satisfactory alleviation of symptoms/pathology reported by the patient at the beginning of the therapeutic process. These findings will then be transformed into recommendations for clinicians/psychologists working with adult survivors of childhood sexual crimes.

- **Consistency**

  Consistency of data is needed to ensure the trustworthiness of the research. Krefting (1991:216) highlighted that consistency implied that the replication of the study under similar conditions should produce more or less the same outcome as the initial research findings. The results and conclusions derived from the study should furthermore make sense and be dependable when viewed by an objective reader (Merriam, 1991:172).

  In this research, the research design is based on the research questions asked, the problem statement and the literature study (connecting theory to the research) provide a clearly defined framework for the study. The researcher is confident that should this study be repeated under similar conditions and within the same research design framework, results consistent to the ones in this study will be arrived at.

- **Neutrality**

  According to Krefting (1991:316) neutrality should reflect from the research study's unbiased and objective collection, analysis, interpretation of and conclusions arrived at, from the information gathered in the study. It should not be clouded by the researcher's (or patient's) own motivations and/or perspectives.

  In this study, the History-taking Questionnaire and the Word Association Test to be used are structured in such a way that it would be difficult to

influence the patient's responses. The researcher will, however, record all information in an objective neutral way to ensure the validity of the data collected.

During the clinical procedures of therapy, the researcher will stay within the theoretical frame of Ego-State Therapy as stated in Chapter 3. As any hypnotherapy clinician should be very careful not to suggest anything that might be interpreted by the patient as a possibility of existing repressed memories related to childhood sexual crimes (for obvious reasons such as the false memory syndrome and legal aspects), the researcher will not suggest or interpret any hypotheses derived at from the analysis of the History-taking or the Word Association Test with patients.

The researcher is of the opinion that the implementation of all the criteria as stated in this chapter, will ensure the credibility, validity and reliability of this research study. LeCompte and Preissle (1993:322) proposed that accurate, justifiable, warrantable and believable research is trustworthy.

4.11 CONCLUSION

This chapter discussed the research design and research framework. The focus was on the research strategy to be used, the methods of data collection and the demarcation of the study. The History-taking Questionnaire and the Word Association Test were introduced and specific clinical procedures of therapy and the reporting of cases were explained. Concerns regarding the validity, reliability and credibility of the study were highlighted in order to ensure the trustworthiness of the study.

The following chapter will give a detailed discussion of the case studies and the research results.

CHAPTER 5

DESCRIPTION OF CASE STUDIES

"Problems cannot be solved with words, but only through experience, not merely corrective experience, but through a reliving of early fear, sadness and anger."

- Alice Miller

5.1 INTRODUCTION

Everstine and Everstine (1989:23) stated that *"…victims are in search for an understanding ear which will understand the limitlessness of the secret living in their heads.*" This chapter describes the cases of four survivors who got the chance to reveal their secrets to an understanding ear, as well as the therapeutic process involved in dealing with their unresolved childhood sexual crimes. It reports on each case's history, the History-taking Questionnaire, the Word Association Test, hypothesis derived at from the Word Association Test, regressions, the identification of ego-states and the therapeutic process according to the Ego-State Therapy model, as described in Chapter 3.

The following abbreviations will be used in this chapter:

ISE – Initial Sensitizing Event
SPE - Symptom Producing Event
SIE - Symptom Intensifying Event
WAT - Word Association Test

The patients used in this study will be referred to as Case A, Case B, Case C and Case D to keep their identities anonymous. It is further important in the analysis of the Word Association Test's responses, to keep in mind that the Medical Hypno-analysis model uses the formula that if a=b and b=c, then a=c. This equation will be used in the establishing of hypothesis with regard to repressed or semi-repressed childhood sexual trauma and the possibility of the existence of ego-states.

5.2 CASE DISCUSSIONS

5.2.1 HISTORY: CASE A

The patient was a twenty-six year-old married woman with a one-year-old daughter, who came to therapy with complaints of suffering from severe stomach pains after sexual intercourse. These pains would usually last for a day or two. She had difficulty enjoying sex and reaching an orgasm. This resulted in her avoiding sex, rather than experiencing these symptoms. Her husband became very upset and threatened her with a divorce as their sexual relationship deteriorated. She stated that she was experiencing an inability to bond with her daughter, a child whom she did not want, as she became pregnant solely to please her husband.

She was the youngest of seven children and the only child to have obtained Matric. Her father died when she was six years old and she remembered him as a kind person. Her mother was mentally handicapped and she remembered her as evasive, distant and not affectionate as she had always been an alcoholic and not trustworthy. She grew up in very poor conditions as the whole family lived on her grandmother's pension.

During the first two interviews the patient was quite aloof and complained of symptoms related to mild depression such as low appetite, low energy drive and a general tiredness with regard to life in general, as well as her family life.

5.2.1.1 Assessment

Table 5.1 shows the answers from the History-taking that are relevant to this study and indicate childhood sexual crimes committed against the patient. The patient had a faint conscious memory of childhood sexual trauma.

TABLE 5.1: History-taking – Case A

Questions	Answers	Remarks
1. What is the problem?	The biggest problem is sex. In the beginning of our marriage it was good, but now I can't stand it. I get terrible stomach pain after intercourse and it will last for a day. I'm lately also very aggressive and irritated and will throw things in the house or shout at my husband and my daughter. I'm also thinking of my dad a lot more than usual	Relationship problems Sexual problems Depression Unresolved grief
2. Duration of illness?	Since 1983, but worse the last 6 months	SIE; the year her father died
3. Conditions causing variations in illness?	Every time we have sex with penetration, it's not as difficult when there's no penetration	SIE
4. What was unhappy about your childhood?	Everything, mom had a boyfriend, she didn't care about us (children) after dad's death and anything	SIE Unresolved grief Mother-child relational

	could happen to us. I hated a school camp in 1990	problems
5. What was happy about your childhood?	When my dad was still alive, he used to give me lots of love and attention	Unresolved grief
6. Early sexual incidents?	First real sexual experience was in St.8, my boyfriend wanted sex and I was scared he might hit me if I denied him. The neighbour's son and my cousin used to touch me since I was small and it continued until St.3	SIE SPE
7. First sexual intercourse?	Just before our wedding after I met my husband	SIE
8. How do you feel about your body?	I hate my breasts - they're too big. I used to be a tomboy; I always wanted to be a boy. I hated it when boys wanted to touch or kiss me	Sexual identity problems, denying femininity, due to possible sexual trauma
9. Traumatic incidents?	Only the ones I've told you about, the fondling and my dad's death. I have a lot of guilt, it's better, but it still comes back	SIE SPE
10. Nightmares or repetitive dreams?	A dream of my dad, mom and dad getting back together. I'll see dad walking in the street, run to him just to find that he doesn't recognize me.	Anxiety Post Traumatic Stress Disorder

	Another one where someone is fighting with me and I can't breathe, nobody helps me and I'm frightened	
11. School days happy or unhappy?	Unhappy, I had no self-confidence and hated school. I was always very shy	Low self-esteem Childhood depression
12. Traumatic incidents in childhood?	My mom was always dirty and/or drunk. I was too ashamed to bring friends home	SIE Self-image Shame
13. Habits: alcohol?	Drank a lot until I met my husband	Addiction
14. Habits: drugs?	Used to experiment. Maybe I'm a bit addicted to headache tablets at the moment	Addiction
15. Physical conditions?	Epilepsy till St.8; still get tension migraines	Psychosomatic illness
16. Attitude towards opposite sex?	I'm always ready for a fight, not very considerate towards men and their feelings	Relationship problems
17. For any reason have you ever thought it would be desirable to eliminate your sex drive?	Yes	Denial
18. Have you ever attempted suicide?	Yes, in primary school I took an overdose of tablets; tried to kill myself with Doom;	Suicide ideation

	wanted to jump in front of a car after dad's death	
19. What is the most disturbing emotional experience of your life?	The molestation and the fact that nothing was done about it	SIE SPE
20. Is there anything you feel guilty about?	Yes, not going to church regularly	Guilt

Through the History-taking certain symptoms/pathologies as well as possible SIE's and SPE's were identified. The hypothesis is that the symptoms/pathologies identified are the result of the SIE and SPE, and ultimately, of the ISE.

The patient's responses to the Word Association Test most relevant to this study are captured in Table 5.2.

TABLE 5.2: Word Association Test – Case A

Stimuli	Response	Remarks
1. Father	Dead	Bereavement
2. Mother	Home	Connection to mother
3. Fear	Breath	Afraid of dying
4. Life	Suffocating	Feels trapped
5. Anxiety	Chest	Physical manifestations of emotions
6. Chest	Rigid	Anxiety makes her rigid
7. Home	No love	Relational issues – mother
8. Dead	Sad	Bereavement
9. I	Five	Incident (SPE/SIE)
10. Sad	Comfort	Depression
11. My mother always	Drunk and Conflict	Relational issues – mother

12. Sex	Uneasy	Sexual trauma
13. Tongue	Sex	Sexual trauma
14. Teeth	Anger	Physical manifestations of emotions
15. Vagina	Uneasy	Sexual trauma
16. Drugs	Escape	Denial of pain – addiction
17. Escape	Prison	Addiction
18. Prison	Punishment	Guilt
19. Punishment	Guilt	Guilt
20. Between my legs	Don't go there	Sexual trauma
21. Stomach	Uneasy	Physical manifestations of emotions
22. Semen	Disgusting	Sexual trauma
23. Freedom	Alcohol	Addiction
24. Death	Pain	Bereavement
25. Pain	Lonely	Bereavement / Depression
26. Funeral	Dead	Bereavement
27. When I die	I'm scared I'll go to hell	Guilt
28. Please	No	Sexual / emotional trauma
29. Penis	Ugly	Sexual trauma
30. Need	Safety	Never experienced it
31. Belief	Sad	Depression
32. I'm stuck at age	Six	SIE
33. Depressed	Dark	Depression
34. Horrible	Ugly	Sexual trauma
35. It all started when	I was five	SPE
36. I felt hopeless	When I was small	ISE
37. My greatest fear	Sex	Sexual trauma
38. My greatest need	Love	Never experienced it
39. My greatest desire	For a mom	Never experienced it
40. Underneath it all	Pain	Bereavement / loss

These responses reflect subconscious conflicts related to childhood emotional and/or sexual trauma as well as her mother-child relationship. There is also the possibility of unresolved childhood grief related to the death of her father at the age of six.

The analysis of the Word Association Test responses (as stated in column 3 of Table 5.2) lead to the following themes or hypothesis:

TABLE 5.3: Word Association Test hypothesis

Event	WAT Indicators	Hypothesis
Age six (History-taking)	1; 8; 10; 24; 25; 26; 31; 40	Unresolved grief related to the death of her father
When I was small (WAT)	2; 7; 11; 38; 39	Unresolved issues in mother-child relationship, possible internalisation of *"bad mother"* object
Age five (WAT)	20; 22; 28; 29; 30; 34	Repressed sexual trauma
Age five (WAT)	12; 13; 15; 21; 37	Repressed sexual trauma and the relation between sexual trauma and her stomach pains
Adolescence and adulthood (History-taking)	4; 16; 17; 18; 19; 23; 27; 33	Use drugs/alcohol as means of escape from feelings of guilt – belief she deserves to be punished for something done wrong

Through the WAT–analysis it became evident that the presented problems were somatisations of deeper underlying sexual trauma (stomach pains just after having sex) as well as the internalisation of *"bad objects"* (relationship with her mother) and unresolved grief related to the death of her father.

At this point in all the case studies, the Word Association Test as well as the hypothesis were not discussed with the patients, but they were introduced to hypno-therapy and Ego-State Therapy.

5.2.1.2 Ego-states

The next step in the diagnostic phase is to build the patient's ego-strength in order to regress her safely to the SIE related to her unresolved grief (when her father died), and later on to the SPE and the ISE in order to determine the existence of ego-states associated with her childhood sexual trauma. During the following sessions two ego-states were identified as indicated in Table 5.4.

TABLE 5.4: Ego-states identified

Ego-State Identified	Function	Emotion Encapsulated
Hurt	Protect the personality from further relational pain and rejection	Hurt, disappointment and trust
Guilt	Punish the personality with the stomach pains after intercourse, for enjoying the bodily sensations during some of the childhood sexual incidents	Guilt

As discussed in Chapter 3 the activation of an ego-state during a regression session may result in the manifestation of an ego-state that thinks and feels as a child. In this case, both ego-states were still young and believed that the patient should be protected from men in general.

5.2.1.3 Therapeutic process

First Session: This session was spent building the patient's ego-strength using various imagery techniques (poor ego-strength is at the core of all dissociations).

Second Session: During this session the patient was regressed to the age of six years when her father died. No ego-states were identified related to this incident and the therapeutic process focused on the unresolved relationship between her and her father, cognitive distortions and her grief.

Third Session: The session started off with ego-strengthening after which the patient spontaneously regressed to the age of five (SPE) remembering an incident where the neighbour's son molested her sexually. After fondling her, he ejaculated on her stomach and left. It was at this point that the two ego-states were identified and asked to tell their version of the story. This was a critical incident in the therapeutic process as the patient experienced an intense catharsis.

Fourth Session: The patient was regressed to the same incident as in the Third Session and the ego-states asked whether their existence could be traced back to other incidents of sexual molestation and/or abuse. She then regressed to the ago of three (ISE) remembering such incidents with her one brother. The ego-states were encouraged to express themselves and cognitive restructuring commenced.

Fifth Session: At the beginning of this session the patient stated that the symptoms of stomach pains after sexual intercourse and the migraines have spontaneously disappeared. She also reported that her relationship with her daughter had improved and that her daughter's behaviour was more manageable and cooperative towards her. This session was then spent with the patient out of trance reflecting cognitively on the therapeutic process and her progress and understanding of her symptoms/pathology.

Sixth Session: The patient was in trance and relationship issues with her mother as well as unresolved grief related to her father were re-addressed through the ego-states. The sexual trauma was then linked to her symptoms/pathology and feelings of anger and forgiveness were worked through. Thereafter the influences of these two *"significant others"* - relationships on her past emotional and social well-being were cognitively explored.

Next Two Sessions: Focussed on ego-integration and termination of her therapy. During these sessions she reported that she re-established contact with her mother and that it was easier to relate to her mother and to give her affection (which sadly, due to the mother's pathology, she could not return).

5.2.1.4 Conclusion

Initially the patient lacked ego-strength (shown in her tendency to become addicted) and was unable to establish and maintain good relationships (as reflected in her history and complaints from her husband). This usually happens when an ego-state gets stuck in a certain developmental phase, as in the case of this patient. She was therefore unable to acquire the skill of trust (allowing people to get close to her) and showing affection. The problem was two-fold: emotional withdrawal (as the ego defense is protecting the patient from possible further rejection, encapsulating unresolved relational hurt); and secondly, a lack of social skills development. These unresolved traumas (relational as well as sexual) were encapsulated in one or more child ego-states causing the somatic and relational symptoms.

Her report on symptom alleviation as stated in the Fifth Session served as proof of her inner child ego-states maturing, *"re-living"* through the lost developmental phases (re-writing the blueprint of internalised objects and relations) and acquiring social skills (she experimented with trust, and the giving and receiving of affection). Not only did she work on her internal mother-child issues but also her external mother and her external child. The therapeutic relationship provided

a first-time external container for her internalised emotions, thereby allowing for individuation and self-establishment – sign of ego-maturation and ego-integration.

5.2.2 HISTORY: CASE B

The patient was a twenty-three year old, unmarried male student that came to therapy with complaints of feeling severely depressed and suicidal. He had difficulties studying due to his obsession with suicide and feared that he might fail his academic year. He further complained that he found it extremely difficult to make friends and to trust people and that he lacked confidence when it came to relationships with female students. He was addicted to dagga since the age of thirteen and at the time of therapy smoked marijuana at least once a week. He had also been on Prozac the past six months but felt that it wasn't helping him at all.

He was the only child in an unhappy marriage. His mother had a mental history and (according to the patient) was a paranoid schizophrenic that abused him physically as a child. She left the family a few years ago. He found it very difficult to bond and communicate with her and felt that he had made peace with the fact that she would never really be part of his life. His father was a *"workaholic"* and although they didn't have a deep emotional relationship, the patient knew that his father was there for him. He lived with his father.

During the first two interviews the patient was very aloof and distant and answered questions factually. Due to his severe suicide ideation, a suicide contract was drawn up with him, which he willingly signed. Another contract was established whereby he agreed not to come to therapy whilst under the influence of drugs or after smoking dagga.

5.2.2.1 Assessment

Table 5.5 shows the answers from the History-taking that are relevant to this study and indicate repressed trauma due to sexual, physical and emotional abuse and/or molestation.

TABLE 5.5: History-taking – Case B

Questions	Answers	Remarks
1. What is the problem?	I am very depressed and I can't stop thinking about committing suicide. I can't study, I can't focus and concentrate and I'm abusing drugs big time. I know I can quit but why should I? I am socially isolated and I constantly feel like a failure. I'm unable to establish a lasting relationship with a girlfriend	Depression Suicide ideation Addiction Low self-esteem Relationship problems
2. Duration of illness?	Since I can remember	ISE before or during birth
3. Conditions causing variations in illness?	Stress, like when I have to write a test or exam. Also when my mom comes into the picture or causes trouble at home	SIE SIE
4. What was unhappy about your childhood?	Everything from high school onwards. I don't remember a lot from earlier on	SIE Repressed memories

5. What was happy about your childhood?	Nothing that I can remember	Repressed memories
6. Early sexual incidents?	I had a few experimentation experiences in St.2 and St.5 (homosexual), but it is the homosexual abusive incidents in St.6 that has been bothering me the last two months	SIE
7. First sexual intercourse?	In St.8 – it was heterosexual	SIE
8. How do you feel about your body?	I'm not really connected to my body, I think I should never have entered this body	Dissociation
9. Traumatic incidents?	The sexual abuse and the time when I got stabbed by my mother's boyfriend - I thought I was paralyzed	SIE SIE Post Traumatic Stress Disorder
10. Nightmares or repetitive dreams?	None that I can remember, actually I never remember my dreams	Repressed memories
11. School days happy or unhappy?	I don't remember. There were a few teachers that I did have positive impressions of	Repressed memories
12. Traumatic incidents in childhood?	Every time a pet of mine died. I am closer to animals than to people	SIE Relationship problems
13. Habits: alcohol?	Don't like it	None
14. Habits: drugs?	Since age 13: coke, man drugs, marijuana, ecstasy,	Addiction

	heroin, acid, speed	
15. Physical conditions?	Migraines, irritable bowel syndrome, chest pains when I'm anxious	Psychosomatic illness
16. Attitude towards opposite sex?	I'm attracted to them but afraid at the same time. I'm afraid to show them who I really am	Relationship problems Low self-esteem
17. For any reason have you ever thought it would be desirable to eliminate your sex drive?	Yes, it feels way too strong	Excessive desires
18. Have you ever attempted suicide?	I was close to it; I had a loaded gun to my head in St.6 and St.8 after a fight with my mom. The only thing that is stopping me now is that I don't want to hurt my dad	Suicide ideation
19. What is the most disturbing emotional experience of your life?	Being stabbed. I felt incapable of defending myself, I should have been able to do more	SIE Self-blame (Guilt)
20. Is there anything you feel guilty about?	Taking so many drugs in my life	Guilt

Through the History-taking certain symptoms/pathologies as well as possible SIE's and SPE's were identified. The hypothesis is that the symptoms/pathologies identified are the result of the SIE and SPE, and ultimately, of the ISE.

The patient's responses to the Word Association Test most relevant to this study are captured in Table 5.6.

TABLE 5.6: Word Association Test – Case B

Stimuli	Response	Remarks
1. Patient's name	Pain	Depression
2. Surname	Father	Identifying with his father
3. Father	Protection	Self-protection
4. Sinner	Myself	Guilt
5. Mother	Pain	Relational issues: mother
6. Fear	Pain	Anxiety / Depression
7. Life	Confusion	Self-identity
8. Depression	Pain	Mother source of depression
9. Smoke	Addiction	Addiction
10. Anxiety	Chest	Physical manifestations of emotions
11. Death	Desire	Suicide ideation
12. White	Love	Never experienced it
13. Love	Desire	Never experienced it
14. Hate	My mother	Relational issues: mother
15. Red	Anger	Repressed emotion
16. Hell	Satan	Guilt
17. Living	Fear	Self-identity
18. Vagina	Women	Sexual trauma (factual)
19. When I die I'm really scared I'll go	To hell	Guilt
20. Penis	Sex	Sexual trauma (factual)
21. Please	Help me	Physical/emotional/sexual trauma
22. My problem	Black	Depression

in color		
23. Need	Love	Never experienced it
24. Belief	God	Sense of Higher Power
25. God	Creator	All knowing
26. I'm stuck at the age	Five	SPE
27. God always	Doesn't hear me	Repressed anger towards God (guilt)
28. Aggression	Mother	Relational issues: mother
29. Depressed	Constantly	Depression as punishment
30. Life is like	A ball of confusion	Self-identity
31. At the bottom of it all	Scared	Anxiety – trauma
32. Hostility	Mother	Relational issues: mother
33. Horrible	Mother	Relational issues: mother
34. I wish	For no pain	Dissociation
35. As a child I	Felt pain	Childhood trauma / depression
36. It all started when I was	Two years old	SPE
37. Guilt	Sex	Guilt
38. Punishment	Drugs	Addiction
39. Rejection	Women	Sexual problems Relational issues: women
40. Me greatest fear	To live	Self-identity
41. Greatest desire	To live	Duality: fear is desire
42. Underneath it all	Confusion	Self-identity
43. When I was born	Fear	ISE
44. I was near death when	I was stabbed	SIE

45. Homosexual	Guilt	Guilt
46. Baby	Alone	ISE

These responses reflect subconscious conflicts related to childhood emotional, physical and sexual trauma as well as his mother-child relationship, which involved a lot of fear and anger. His tendency to constantly dissociate from his pain causes his depression and (combined with intense feelings of guilt) a lack of self-acceptance and self-identity formation.

The analysis of the Word Association Test responses (as stated in column 3 of Table 5.6) lead to the following themes or hypothesis:

TABLE 5.7: Word Association Test hypothesis

Event	WAT Indicators	Hypothesis
Childhood (WAT)	5; 6; 8; 14; 23; 26; 28; 32; 33; 35; 36; 39	Physical/emotional abuse in relationship with mother
Prenatal and birth (WAT)	1; 12; 13; 31; 43; 46	Around the time of his birth felt unloved by his mother (ISE) therefore the relational issues with his mother
Self-acceptance and identity formation (WAT)	7; 11; 17; 19; 21; 29; 30; 38; 39; 40; 41	Lack of self-esteem, self-acceptance and own identity
Age 14 (History-taking)	1; 4; 6; 16; 18; 20; 22; 37; 45	Sexual trauma Depression
Adolescence/adulthood (History-taking)	3; 9; 10; 15; 27; 34; 38; 44	Dissociation and detachment from his body due to physical (stabbing) and sexual trauma

Through the WAT–analysis it became evident that the presented problems were somatisations of underlying prenatal and emotional trauma (constant depression throughout his life) as well as the internalisation of *"bad objects"* (relationship with his mother) and unresolved sexual traumatic experiences in high school at the age of fourteen.

5.2.2.2 Ego-states

The next step in the diagnostic phase is to build the patient's ego-strength and to facilitate his process of re-entering his body and taking ownership thereof in order to contain and manage his dissociation. The next step then would be to regress him safely to the ISE and later on to consequent SPE's and SIE's with regards to his relational issues with his mother. Thereafter, once the patient is more contained, he can be regressed to the sexual traumatic incident in order to determine the existence of ego-states associated with the trauma. During the following sessions three ego-states were identified as indicated in Table 5.8.

TABLE 5.8: Ego-states identified

Ego-State Identified	Function	Emotion Encapsulated
Provider (Id)	To provide instant gratification with good or bad, so that the patient will not feel needy at all on any level	Anger and self-hatred
Higher Self	To keep the patient alive through giving him the desire to be a good person and do good to other (breaking the pattern of pain)	Hope, forgiveness and self-love

Depressed (the Self)	Lets the patient feel something instead of nothing or pain. Is also punishing him for not liking himself	Pain, guilt and shame

During the course of therapy, the ego-states made it known that they came into existence when the patient was still very small (age two years) and that they were more related to the patient's relational issues with his mother and that the instances of physical trauma and sexual trauma were actually only re-enforcing their existence.

5.2.2.3 Therapeutic process

First Session: This session was spent building the patient's ego-strength whilst focussing on bodily awareness and re-inhabiting his body, using various imagery techniques.

Second Session: During this session the patient was regressed to the mother's womb (prenatal) to the age of two and a half months where he felt intense anger towards God for forcing him back into the pain of the physical world (the patient believed in past lives). He then progressed to the age of three and a half months in the womb where he felt unloved and unwanted by his mother, and a deep sense of sadness. Cognitive distortions were addressed and the patient was then guided through the reliving of the birth process.

Third Session: At the beginning of this session the patient reported that he never realized that he did not occupy his body and also expressed a desire to stop his addictive behaviour and to start taking better care of his new home – his body. Ego-strengthening followed and the patient was regressed to multiple incidents where he was threatened, and physically and emotionally traumatized by his

mother (at ages two, five and thirteen years). These incidents involved feelings of sadness, being unloved and of anger towards his mother. The patient experienced a silent abreaction and cognitive reframing followed. At this stage no ego-states were identified.

Fourth Session: The patient was regressed to the incident he experienced as the most traumatic during the previous session and three ego-states were identified. The ego-states were quite strong and each one nearly presented as a personality on its own. They each demanded enough time to speak and to tell of their existence and function within the personality. The therapist then negotiated symptom relief with the ego-states Provider and Depressed, and Higher Self was asked to be more assertive and to take its rightful place in the personality. The session ended with ego-strengthening.

Next Three Sessions: The patient was regressed to the age of fourteen to the sexual traumatic incident. He remembered being manipulated and lied to by a gay man and it ended up in sexual molestation. This incident caused more conflict between Provider and Higher Self as the one wanted sexual gratification and enjoyed the molestation while the other felt guilty, shameful and helpless. Depression then took over as a way to repress the conflict and the guilt feelings. The following two sessions were spent working with the ego-states as an internal family, in order to facilitate mutual understanding and acceptance of each other and ultimately ego-integration. Each session started and ended with ego-strengthening to allow for ego-maturation.

Eighth Session: The patient reported that his depression has lifted significantly and that he had not had any suicidal thoughts the previous few weeks. He was feeling more integrated and was able to keep the promise, which he had made to himself of not using drugs. This session was spend out of trance, working with the personality as a whole, reflecting cognitively on the therapeutic process and the understanding of his symptoms/pathology.

Ninth Session: From this session onwards, the patient preferred to be worked with as a whole personality (instead of the ego-states) as he felt that they were all working together and they've all found their rightful place in the personality. After ego-strengthening the patient was regressed to the stabbing incident where he felt he was going to die. This incident was cognitively reframed and the focus moved to his relational issues with his mother. Forgiveness was introduced.

Last four sessions: Focussed on maintaining the ego-integration and termination of therapy.

5.2.2.4 Conclusion

Initially the patient lacked ego-strength (shown in his tendency to become addicted) and was severely dissociated from his body and his past (lacked memories of his childhood). He struggled to establish and maintain good relationships (friendships) and isolated himself from social activities. His constant and intense exposure to physical and emotional trauma without any emotional support since his birth allowed for the differentiation of three ego-states that evolved into near individual identities and personalities. The sexual trauma and later physical trauma (the stabbing incident) contributed to further dissociation, the development of symptoms/pathology associated with post traumatic stress, depression and his suicide ideation. Although ego-states normally get stuck in a developmental phase, in this case, the ego-states developed to a certain degree with the personality and their growth caused further dissociation and differentiation (as seen in the more malevolent ego-state: Provider).

His report on symptom alleviation as stated in the Third and Eighth Sessions served as proof of his self-identity formation (as he took responsibility for his body) and his inner ego-states maturing and working towards more permeable ego-boundaries. His *"bad object"* internalisation was also addressed when ego-states were allowed to express their feelings and work together towards self-acceptance, self-love and self-nurturance. This was a sign of ego-integration.

5.2.3 HISTORY: CASE C

The patient was a twenty-five year-old married woman (without children). She was newly wed and complained of having difficulty adjusting to married life, as her responsibilities felt overwhelming. She felt inferior to her husband, as she was still a student and not *"bringing money home".* She was chronically fatigued, felt de-motivated with her studies and stated that she was not coping with the demands of life. Their sexual relationship was also deteriorating as she had a low sex drive and became more aware of a feeling of fear instead of enjoyment when having sex. She was further under pressure as they were to immigrate at the end of the year and she felt incompetent for the corporate world.

She was the youngest of four children with two sisters and one brother. Her father was a very strict person and she described him as unpredictable. Her mother was very controlling and would tell the patient (even just before marriage) what she was to wear and how to behave. Both parents believed in physical punishment, but the patient felt that they (as children) were too much unnecessarily physically disciplined, even for small things. She felt that her parents had suppressed them.

During the first two interviews she was quite teary, fairly depressed and mentioned thoughts about committing suicide. She had a low appetite and expressed a need for time to herself.

5.2.3.1 Assessment

Table 5.9 shows the answers from the History-taking that are relevant to this study and indicate the existence of a sexual crime committed against her when she was an adolescent.

TABLE 5.9: History-taking – Case C

Questions	Answers	Remarks
1. What is the problem?	I am de-motivated with my studies. I want to sleep all the time and I can't cope with everything. I love my husband but I just cannot adjust to married life. I hate sex and can't enjoy it. I'm not coping at all. I'm always trying to please other people	Depression Lack of ego-strength, self-confidence Adjustment issues Sexual problems Lack of self-esteem
2. Duration of illness?	Aaagh, since I can remember	ISE before or during birth
3. Conditions causing variations in illness?	Stress, when I have to hand in a project or write a test or exam. The sex part when we have intercourse	SIE SIE
4. What was unhappy about your childhood?	There was no money, my sisters and brother got all they wanted and I was always last in line. I didn't accept myself and my parents were very strict. Changing schools in high school – again the adjustment. I don't adjust easily	SIE SPE SIE
5. What was happy about your childhood?	I had good times with my one sister, and I used to do well at school and in sport	External locus of control
6. Early sexual	None	None

incidents?		
7. First sexual intercourse?	With my husband, when we met. Then we stopped sex just before marriage – to save it for marriage	SIE
8. How do you feel about your body?	I hate it to be naked, I don't like myself	Low self-image Low self-esteem
9. Traumatic incidents?	Seven years ago when I was drunk and raped by another student; moving schools in St.9; in primary school I was nearly run over by a train	SIE SIE SIE
10. Nightmares or repetitive dreams?	It's a nightmare, I'll dream that I have to go back to school, sometimes even primary school. There's always an academic challenge and I can't do it. It scares me and makes me anxious	Performance anxiety Lack of self-confidence
11. School days happy or unhappy?	Mostly unhappy, sometimes happy when I managed to do something right for someone	Childhood depression Low self-worth
12. Traumatic incidents in childhood?	Train incident, everyday not knowing whether my dad will be upset and hit me	SIE SIE
13. Habits: alcohol?	I try not to get drunk too often, my husband keeps a close eye	Addiction
14. Habits: drugs?	Will smoke dagga once a	Addiction

	week, maybe once a month something stronger. I'm quite rebellious	
15. Physical conditions?	Always tired. I seem to be happy when I'm unhappy. I don't know how life will be when I'm just happy…	Depression
16. Attitude towards opposite sex?	I like it to challenge them or argue with them, I'm close to my husband but my friends are girls	Relationship problems
17. For any reason have you ever thought it would be desirable to eliminate your sex drive?	I have no sex drive	Repression / Dissociation Depression
18. Have you ever attempted suicide?	Nothing serious, but I'm always fantasizing about it and how I would do it, you know, do a good job	Suicidal ideation
19. What is the most disturbing emotional experience of your life?	That rape incident	SIE
20. Is there anything you feel guilty about?	Ja, for getting drunk, entering their room and allowing that guy to rape me. I should have run away or screamed	Guilt Self-hatred contributing to lack of self-love

Through the History-taking certain symptoms/pathologies as well as possible SIE's and SPE's were identified. The hypothesis is that the

symptoms/pathologies identified are the result of the SIE and SPE, and ultimately, of the ISE.

The patient's responses to the Word Association Test most relevant to this study are captured in Table 5.10.

TABLE 5.10: Word Association Test – Case C

Stimuli	Response	Remarks
1. Me	Unsure	Self-concept
2. Sin	Forbidden	Guilt
3. Father	Punishment	Relational issues: father
4. Death	Escape	Suicide ideation
5. Unsure	Confused	Self-identity
6. Fear	Run	Dissociation
7. Tunnel	Dark	Depression
8. Dark	Fear	Dissociation
9. Hate	Forbidden	Repress emotions: anger
10. Sex	Anxiety and love	Duality – sexual trauma
11. My mother always	Criticized my	Relational issues: mother (and reason for self-concept and –identity problem)
12. Criticism	Me	Relational issues: mother
13. Desire	Forbidden	Repress emotions: desires
14. Mother	Unsure	Relational issues: mother
15. Vagina	Unpleasant	Sexual trauma
16. Forbidden	Critique	Repress *"self"*
17. Penis	Anxiety and love	Duality – sexual trauma
18. I am	Immature	Self-identity
19. Anxiety	Run	Dissociation / sexual trauma
20. I became	Whom I wanted to	Self-identity

	be but then the desire to be accepted by other changed me to someone they wanted me to be	Dependency
21. Alone	Dark	Dissociation
22. Guilty	Sinful deeds	Guilt
23. Pleasure	Alcohol, drugs, food	Dissociation
24. My biggest fear	To fail	Dependency
25. My biggest desire	To be a good mother and wife	Never experienced it
26. My biggest need	To love myself and others more	Self-acceptance
27. I punish myself with	Self criticism and thought of not being good enough	Guilt Relational issues: mother Dependency
28. Sad	Me, broken	Depression
29. My biggest sin	Is my desires	Repress emotions: self
30. When I was born	I was just another child	SPE – felt unloved Relational issues: father and mother
31. In the hole	Between my legs	Sexual trauma
32. Semen	Husband and pain connected with another person	Duality – sexual trauma
33. Between my legs	I don't want to think about it	Sexual trauma
34. Touch	Uneasy and pleasure	Duality – physical trauma
35. Anus	Forbidden, pain	Sexual trauma

36. To lie	Escape	Dissociation
37. Divorce	Sin	Guilt
38. Anal sex	Hatred, pain	Sexual trauma
39. Home	Supposed to be safety, but a place I always wanted to escape from	Dissociation
40. Dirty	Sex	Sexual trauma
41. When I'm naked	I'm unsure, scared and feels unsafe	Self-acceptance/ -identity Physical trauma
42. Horrible	Unaccepted	Repress emotions: pain
43. Everything started	When I was 3	SPE
44. Fear	Sex	Sexual trauma
45. When I die	I'll go to hell	Guilt

These responses reflect subconscious conflicts related to relational issues with her father and mother as well as a repression of her emotions (in order to please others) inhibiting her self-identity formation and growth towards self-acceptance. There is also the possibility of sexual and/or emotional and/or physical trauma as reflected in her tendency to dissociate.

The analysis of the Word Association Test responses (as stated in column 3 of Table 5.10) lead to the following themes or hypothesis:

TABLE 5.11: Word Association Test - hypothesis

Event	WAT Indicators	Hypothesis
Birth, age three (WAT)	3; 30; 43	After birth she felt unloved by her parents thereafter the relational issues with parents

Self-concept Identity formation (WAT)	1; 2; 5; 11; 12; 14; 16; 18; 20; 24; 25; 26; 27; 28; 29; 39; 41	Tendency to please her mother and an inability to detach from her and establish her own identity. Her *"self"* is repressed
Adolescence (History-taking)	6; 10; 15; 17; 23; 31; 32; 33; 34; 35; 38; 40; 44	Sexual trauma Depression
Adjustment (changing schools / disappointments: History-taking)	4; 6; 8; 9; 13; 19; 21; 22; 23; 36; 39; 45	Dissociation from emotional and relational hurt; fear intensity of emotions

Through the WAT–analysis it became evident that the presented problems were the result of unresolved sexual trauma (the fear she experienced while having sex); the internalisation of *"bad objects"* (relationship with her parents inhibiting her self-exploration, -establishment and identity formation) as well as a lack of self-acceptance and self-confidence.

5.2.3.2 Ego-states

The next step in the diagnostic phase is to establish a strong rapport between the patient and therapist and to built her ego-strength in order to regress her safely to the SPE related to her relational issues and later on to incidents associated with her fear of expressing and accepting herself and her emotions. Thereafter, she can be regressed to the event related to the sexual trauma in order to determine the existence of ego-states associated with her sexual trauma. During the following sessions two ego-states were identified as indicated in Table 5.12.

TABLE 5.12: Ego-states identified

Ego-States Identified	Function	Emotion Encapsulated
Sadness	Dissociates the *"self"* from emotional pain and hurt. It protects her from intimacy in relationships (possible hurt)	Sadness, physical and emotional pain The fear of trusting people
Anger	Protects her from relational rejection through the pleasing of others	Anger towards herself and the perpetrator Self-blame and guilt

5.2.3.3 Therapeutic process

First Session: This session was spent building the patient's ego-strength (using imagery and encouraging her to express all thoughts and emotions during the course of therapy as it is an integral part of herself) and thereafter regressing her to the age of three where she remembered a traumatic incident in nursery school. This was dealt with by reframing core beliefs. Other childhood emotional traumatic incidents in her relationship with her father was also remembered and dealt with in the same manner.

Second Session: The session started with ego-strengthening and thereafter the patient was regressed to incidents in high school where she experienced relational hurt and disappointment and other traumatic relational incidents. Although she experienced a catharsis during this session, no ego-states were identified. Cognitive distortions were addressed before closing the session with ego-strengthening.

Third Session: After ego-strengthening the patient was regressed to the age of nineteen, accessing the incident where she was sexually abused. This was a painful process for her as she remembered it in detail and experienced an

intense catharsis. At this point the two ego-states were identified. They confessed that they were actually much younger than nineteen as they came into existence when the patient was four years old and at a stage when the feeling of not being loved by her parents became intolerable.

Fourth Session: The patient was reluctant to regress back to the sexual trauma and the session was spend focussing only on ego-strengthening and later on discussing the therapeutic process on a cognitive level while she was out of trance.

Fifth Session: The patient expressed the desire to go back to the sexual incident and this time the therapeutic focus was on the ego-state that called himself *"Anger"*. Issues related to self-blame and shame was addressed and both ego-states encouraged continuing their maturation and integration processes.

Sixth Session: During this session the focus was on the patient herself, on her emotions of sadness, anger, hatred, forgiveness and self-acceptance. Concepts with regard to the establishing of herself as a separate individual with her own thoughts, feelings and actions were also addressed. Thereafter, symptom alleviation was negotiated with the two ego-states and the patient taught to find her own inner strength and inner confidence.

Seventh Session: This session focussed on the integration of all the preceding sessions and cognitive discussions on the patient's progress in relationships (and the establishment of healthy boundaries) as well as her feelings (physically and emotionally) during sexual intercourse with her husband. Her feedback was very positive. Her relationship with her mother was also re-addressed as well as her self-acceptance, self- establishment and self-forgiveness.

Eighth Session: Relational issues with her parents were addressed and the practical implications of new relational thought patterns were investigated. At this point she reported on feeling more content and happy within herself as well as

with the person she sees herself growing into. Termination of therapy was introduced.

Last Session: Focussed on ego-integration and termination of her therapy.

5.2.3.4 Conclusion

Initially the patient lacked ego-strength (shown in her tendency to dissociate, as well as in her need to please others and gain their acceptance). She was overly dependent on her mother and lacked self-identity and self-esteem. Her relationship with her husband seemed to be a source of unconditional love and acceptance (something she desperately needed) but her sexual difficulties in their relationship were detrimental to her gaining a corrective emotional experience within this marital environment.

Two ego-states were stuck in a certain developmental phase and their differentiation enforced with every SIE she experienced after the age of four and ultimately with her sexual traumatic experience. These ego-states grew so strong that they inhibited the patient's inherent growth toward adulthood and sense of self. Therefore they were not only associated with the sexual trauma but also with her identity confusion and general relational issues.

Her report on symptom alleviation as stated in the Seventh Session served as proof of her inner child ego-states maturing and acquiring social skills. As they worked through their encapsulated trauma moving towards integration, the patient experienced a sense of finding, expressing and accepting herself and her own identity with her own boundaries – signs of ego-maturation and ego-integration.

5.2.4 HISTORY: CASE D

The patient was a twenty-one year old, unmarried female student that came to therapy with complaints of feeling depressed and unsure of her direction in life. Her grandmother had recently died and that caused her to re-evaluate her life. She had difficulty establishing boundaries in her relationships with males and that made her feel like a little girl – insecure with men. She remembered an incident of being sexually molested at the age of seven, but never really acknowledged that it had happened to her. It was only recently that she kept on thinking about it and that made her even more depressed. She became bulimic at the age of fifteen, but felt it was under control at the time of coming to therapy.

She was the oldest of four children with nine years between her and the second born (a sister). She saw herself as the maid in the family as she was tasked with taking care of the three siblings. Her father was an alcoholic and used to hit her mother when he was drunk. The patient didn't have a good relationship with him. Her mother was an unpredictable person and although the patient felt closer to her mother, she mentioned that she felt her mother wasn't able to meet her needs as a child. She was unhappy in the family and felt that everything revolved around her three sisters.

5.2.4.1 Assessment

Table 5.13 shows the answers from the History-taking that are relevant to this study and indicate the existence of the traumatic aftermath of childhood sexual crimes committed against the patient.

TABLE 5.13: History-taking – Case D

Questions	Answers	Remarks
1. What is the problem?	My grandmother died seven weeks ago and I need to re-evaluate my life. I feel depressed and struggle to study. I was sexually molested when I was seven and it never really bothered me, but nowadays it does. I'm just recently so unhappy and fed-up with life. Everything seems purposeless	Depression Sexual trauma
2. Duration of illness?	Only recently, no, actually since I was a small child. I have always been unhappy and depressed	SPE
3. Conditions causing variations in illness?	Stress related to studies, fights at home with my parents, relationships with guys	SIE
4. What was unhappy about your childhood?	The molestation, my parents fighting, dad drinking, the bulimia	SIE Psychological symptoms
5. What was happy about your childhood?	I don't know, maybe the friends I had	Need to belong
6. Early sexual incidents?	Apart from the molestation, at age 16 I fell in love for the first time	SIE
7. First sexual intercourse?	I've only had oral sex	None

8. How do you feel about your body?	I feel too fat, I have always had issues with food and with my weight	Self-acceptance Body-image disturbance
9. Traumatic incidents?	The molestation and my high school relationships, especially the one with the teacher	SIE Relational problems
10. Nightmares or repetitive dreams?	When I was nine years old I saw a movie about Satan, I had nightmares about him for more than a year	SIE Guilt
11. School days happy or unhappy?	Mostly unhappy, I had difficulty with relationships and friends, I always felt like the odd one out	Relational problems
12. Traumatic incidents in childhood?	None other that those already mentioned	None
13. Habits: alcohol?	Occasionally	None
14. Habits: drugs?	No	None
15. Physical conditions?	Weight issue and the obesity, stress headaches	Low self-esteem Psychosomatic illness
16. Attitude towards opposite sex?	I like men but I struggle in relationships, I fall in love too easily	Relational problems (sexual trauma)
17. For any reason have you ever thought it would be desirable to eliminate your sex drive?	Yes, I'm very sexual and I know to indulge in sex is actually very negative and that makes me feel bad	Promiscuous tendencies as defense against pain of sexual trauma
18. Have you ever attempted suicide?	Yes, once at the end of St.7 when I was so severely bulimic	SIE Suicide ideation

19. What is the most disturbing emotional experience of your life?	The molestation and I think the conflict in my family	SIE Relational problems
20. Is there anything you feel guilty about?	All my sexual experiences and relationships	Guilt – sex

Through the History-taking certain symptoms/pathologies as well as possible SIE's and SPE's were identified. The hypothesis is that her bulimia and relational problems identified are the result of the SIE and SPE, and ultimately, of the ISE.

The patient's responses to the Word Association Test most relevant to this study are captured in Table 5.14.

TABLE 5.14: Word Association Test – Case D

Stimuli	Response	Remarks
1. Patient's name	Movement	Fight / Flight response
2. Surname	Red	Emotion in color
3. Father	Different dark	Relational issues: father
4. Mother	Home	Relational issues: mother
5. Fear	Breath	Fear of dying
6. Life	Suffocating	Feels trapped
7. I	Three	SPE
8. Sad	Comfort	Depression
9. Mother always	Conflict	Relational issues: mother
10. Sinner	Blue	Emotion in color
11. Blue	Cold	Denying emotions
12. Red	Insensitive	Relational issues: insensitive father
13. Live	Love	Need love to feel alive

14. Sex	Uneasy	Sexual trauma
15. Tongue	Sex	Sexual trauma
16. Vagina	Uneasy	Sexual trauma
17. When I die, I'm scared I'll go	Back to the hole	Guilt
18. My father never	Does anything	Relational issues: father doesn't meet needs
19. Penis	Unsure	Sexual trauma (penis is core of problem)
20. Please	Don't	Sexual/physical trauma
21. Lovely	Girl	Needs female love
22. Suck	Ugly	Sexual trauma
23. Breast	Penis	Sexual trauma
24. Need	Safety	Never experienced it
25. God	Rigid	Needs God's forgiveness
26. Unsure	Often	Sexual trauma (penis is core of problem)
27. I'm stuck at the age	Nine	SPE
28. Confinement	Freedom	Guilt
29. Homosexual	Sex	Sexual trauma
30. Anger	Red	Deny anger
31. Depressed	Dark	Depression
32. My mother never	Love	Never experienced it
33. As a little girl	I screamed	Relational issues: parents - needs not met
34. I screamed when	I was sad	Childhood depression
35. I felt hopeless	When I was small	ISE
36. I became	Love	Sexual trauma

37. Dark	Blue	Depression
38. It all started	When I was five	SPE
39. Punishment	Sore	Guilt
40. I resent	Me	Self-acceptance
41. Greatest obstacle to my happiness	Me	Guilt
42. Virgin	Guilty	Guilt
43. Pain	Sex	Sexual trauma
44. Between my legs	Don't go	Sexual trauma
45. Semen	Disgusting	Sexual trauma
46. Freedom	Chains	Guilt

These responses reflect subconscious conflicts related to childhood emotional and sexual trauma as well as her parent-child relationships. She struggles with self-acceptance as her guilt is constantly punishing her (bulimia).

The analysis of the Word Association Test responses (as stated in column 3 of Table 5.14) lead to the following themes or hypothesis:

TABLE 5.15: Word Association Test - hypothesis

Event	WAT Indicators	Hypothesis
Age three (WAT)	7; 13; 31; 33; 34; 35	Emotional/sexual trauma
Age five (WAT)	2; 3; 10; 11; 12; 18; 30; 38; 40; 41	Self-identity problems (not allowed to feel/express her emotions)
Age seven (History-taking)	14; 15; 16; 19; 20; 22; 23; 26; 29; 43; 44; 45	Sexual trauma

Age nine (WAT)	9; 28;	Relational issues: emotional trauma
When I was small (WAT)	5; 6; 7; 17; 24; 32; 35;	Relational issues: prenatal/birth trauma
Adolescence (WAT)	1; 8; 28; 36; 37; 39; 42; 46	Relational issues: men (promiscuous tendencies and guilt resulting in depression and bulimia)

Through the WAT–analysis it became evident that the presented problems were behavioural manifestations of underlying sexual trauma (promiscuous tendencies and sense of being very sexual) as well as the internalisation of *"bad objects"* (relationships with her parents – she never felt loved/wanted) and the belief that she was not allowed to express her emotions.

5.2.4.2 Ego-states

The next step in the diagnostic phase is to work on the patient's trust and relational issues through hypnotic suggestions and ego-strengthening. As she gradually builds trust in herself and in the therapist, she will be ready to regress safely to the ISE (which according to the WAT analysis, is either prenatal or during the birth experience) and thereafter to other SIE's related to her relational issues, and eventually to the sexual molestation at age seven in order to determine the existence of ego-states associated with her childhood sexual trauma. During the following sessions three ego-states were identified as indicated in Table 5.16.

TABLE 5.16: Ego-states identified

Ego-State Identified	Function	Emotion Encapsulated
Hurt	Protects patient against sexual relational hurt	Hurt, pain, feelings of not being good enough

	through promiscuous behavioural tendencies	and of being rejected
Anger	Represses the emotions so that the patient will not express them and upsets her mother (that will consequently lead to rejection or physical abuse from mother). Protects patient from love as well.	Anger and hatred towards sexual perpetrators and mother
Guilt	Punishes patient for her promiscuous behavioural tendencies and believed that the patient brought the abuse upon herself	Guilt, self-hatred

5.2.4.3 Therapeutic process

First Session: This session was spent building the patient's ego-strength using various imagery techniques related to bodily boundaries and boundaries in relationships.

Second Session: During this session the patient was regressed to various promiscuous relationships in high school where she experienced intense hurt and anger. Through an affect bridge she was regressed to the age of nine where her mother physically abused her and where she felt unloved and unwanted. These incidents were cognitively reframed.

Third Session: The session started off with ego-strengthening followed by a prenatal regression to the age of two months, where the patient felt for the first time, unwanted by her mother. After the patient experienced a catharsis,

negative core beliefs were reframed and the patient guided through the birth experience. There was no birth trauma involved.

Fourth Session: At the beginning of this session the patient reported that her relationship with her mother was improving and that she felt less depressed and happier. During this session the patient was regressed to the age of five and later nine years (when her sister was born) where she felt rejected by her mother. An affect bridge was again used to regress her to the age of seven where she experienced the sexual trauma. After experiencing an intense catharsis, the existence and purpose of the three ego-states were established. The session ended with ego-strengthening.

Fifth Session: The session started with ego-strengthening and thereafter the patient was regressed to the sexual traumatic incident at age seven and Ego-State Therapy commenced. It emerged in this session that the ego-states came into existence when the patient was three years old. The patient was then regressed to the age of three where she recalled another sexual traumatic incident with her mother's boyfriend. After another less intense catharsis, the ego-states were encouraged to express themselves and cognitive restructuring continued.

The Next Three Sessions: Family therapy with the three ego-states continued and the sexual trauma as well as relational issues with her mother were further addressed. Specific attention was given to the two stronger ego-states (Anger and Hurt) as they were very young and encapsulated intense emotions. Symptom alleviation was also progressively negotiated with the ego-states. At the end of the third session (of these three) whilst the patient was out of trance, her therapeutic process up to this point was cognitively reflected upon in order to facilitate her conscious understanding of her symptoms/pathology.

Ninth Session: The focus of this session was on the third ego-state (Guilt) and the theme of forgiveness was addressed. The ego-state was encouraged to

allow the patient to forgive the perpetrators, her parents and ultimately to forgive herself and to let go of the self-punishing behaviour.

Next Two Sessions: Focussed on ego-integration and termination of her therapy as the patient's urges to binge was under control, she was feeling more integrated and happy and was able to end an unhealthy sexual relationship during the course of therapy. She reported that her relationship with her father had improved and that she was less needy of her mother's constant affection, attention and approval. Her relationship with her siblings was also improving.

5.2.4.4 Conclusion

The patient's basic needs for love, nurturance and acceptance were not met as a child as she felt unloved and unwanted at the age of two months in her mother's womb. From there on, the sexual trauma experienced at age three resulted in the development of three ego-states as defence against emotional and relational hurt and pain. Repetitive incidents of relational hurt and a consequent sexual traumatic event resulted in her pro-active tendencies towards promiscuous behaviour. However, her lack of ego-strength, repressed feelings of guilt and lack of external support resulted in the need for a stronger ego-defense, hence the development of an eating disorder (bulimia) and the suicide attempt at age fifteen. This was the subconscious mind's only way to protect the patient against the unresolved hurt, anger and guilt, as the ego-states were stuck in a younger developmental phase and therefore very immature.

Her report on basic symptom alleviation as stated in the Fourth Session served as proof that inner core beliefs accepted by the subconscious whilst in her mother's womb were successfully reframed. A reduction in her eating disorder symptomatology as well as changes in feelings related to her relational issues and depression served as proof of her inner child ego-states maturing and integrating into the greater personality, as sexual, physical and emotional (relational) trauma were worked through.

5.3 SUMMARY

In this chapter the underlying dynamics of four cases were discussed, focusing on determining the root causes of the symptoms/pathology they presented with at the time of therapy. Indicators of childhood sexual trauma were found in the History-taking and confirmed with the Word Association Test. These indicators formed the structure for therapeutic intervention, as the patients were directly regressed to the relevant traumatic incidents. In each case, ego-states causing the presentation of the symptoms/pathology were identified and dealt with on an individual and integrated level.

It was interesting to note that ego-states were not in all cases identified with childhood sexual crimes only, but that in two cases, the ego-states developed at other relational traumatic events and became stronger at the time the patients experienced the sexual trauma. In each case, the main purposes of the ego-states were to dissociate patients from feelings such as pain, hurt, anger, guilt and shame.

The next chapter will discuss the integration of the two hypnotherapy models into one model. It will also focus on the application of this model within the field of psycho-education when working with patients suffering from childhood sexual crimes.

“I was grown-up as a child and childlike as an adult. Now at last I’m a woman.” (Alison in Cameron, 1992:275)

CHAPTER 6

A HYPNOTHERAPY MODEL FOR ADULT SURVIVORS OF CHILDHOOD SEXUAL CRIMES

"Each person's map of the world is as unique as their thumbprint. There are no two people alike. No two people who understand the same sentence the same way… So in dealing with people you try not to fit them to your concept of what they should be…"

- Milton Erickson, 1992.

6.1 INTRODUCTION

The previous chapter has indicated that the hypnotherapy model used (the combination of Ego-State Therapy and Medical Hypno-analysis) can facilitate and be successful in the working through of unresolved childhood sexual crimes, developing the patient's own internal resources and strengths and enhancing their growth towards happiness, internal harmony and health on all levels.

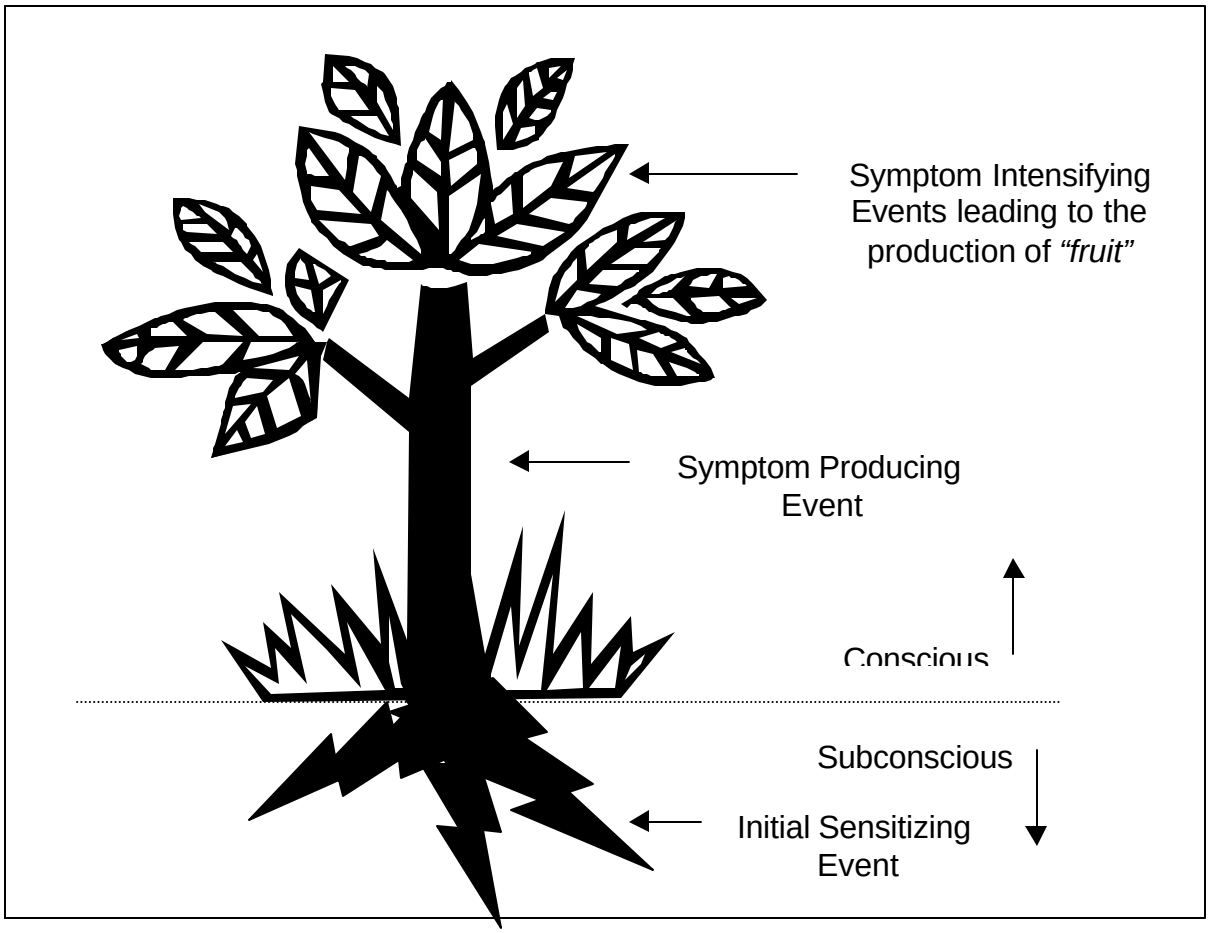
This chapter will discuss the hypnotherapy model and its application within the field of psycho-education when working with patients suffering from childhood sexual crimes. Although this model may seem to be very structured and uncomplicated in its application, it needs to be emphasized that the therapist must be trained in the field of hypnosis and specifically within the fields of Medical Hypno-analysis and Ego-State Therapy, as this study does not include detailed descriptions of the dynamics involved in both modalities.

6.2 A HYPNOTHERAPY MODEL

As stated in Chapter 1 the Medical Hypno-analysis model is a structured model based on the process of diagnosis and therapy. In diagnosing the root causes of all presenting problems, pathology are investigated and explained through a thorough and detailed case history and the Word Association Test.

The *"Triple Allergenic Theory"* refers to the development of a *"psychological allergy"* that is viewed to be the equivalent of the development of a visible medical allergy, starting with the **Initial Sensitising Event** (past trauma of which the conscious mind has no memory); the **Symptom Producing Event** (a subsequent incident triggering the previous incident with its full emotional consequences); and the **Symptom Intensifying Event** (event(s) that intensify the symptoms that have occurred previously and usually the symptom the patient suffers from). Figure 6.1 illustrates the concept of the Triple Allergenic Theory.

FIGURE 6.1: Triple Allergenic Theory



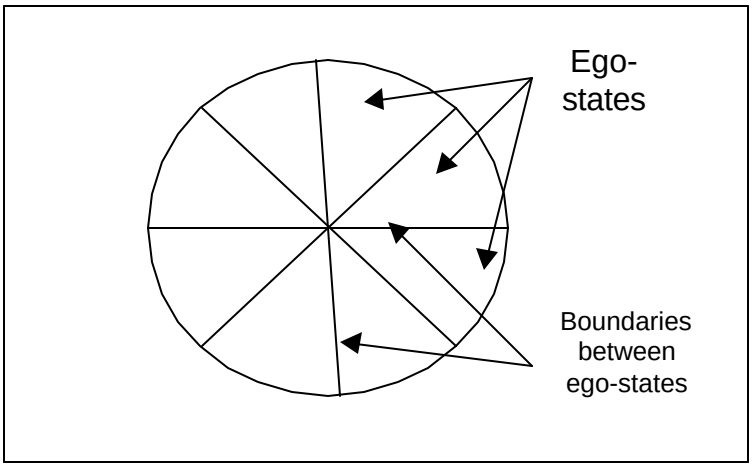
The fruit of the tree is the actual symptoms/pathology the patient suffers from and the reason the patient seeks treatment or therapy. The branches and leaves of the tree represent the Symptom Intensifying Event(s) necessarily for the visible manifestation of the symptoms/pathology associated with the repressed trauma and malevolent ego-states. The stem of the tree represents the Symptom Producing Event(s) as consequent events bearing the same threat to the patient's survival as he/she initially experienced it.

The roots of the tree indicate the Initial Sensitising Event(s) and therefore the root causes of the presenting symptoms/pathology. According to the Medical Hypno-analysis model, a person's sense of self and self-concept is developed and influenced through experiences from the time of conception up to the age of six years. Should a child experience any sense of threat to his/her emotional, spiritual, psychological or physical survival during these initial developmental years, a defense response will be activated as a means of survival. The defense is often a repression of the memory of the traumatic event into the subconscious mind so that the patient suffers no conscious recollection of the event.

It is at this level (according to the researcher) that malevolent or maladaptive ego-states develop. These ego-states often get stuck at certain developmental phases, enhancing encapsulation of trauma, causing it to be unresolved. Each relevant ego-state needs to work through the trauma in order to be able to mature and integrate into the greater personality. Only through regressions can the ego-states and trauma be accessed and addressed in order to alleviate symptoms/pathology associated with the problem.

As stated in Chapter 1 and Chapter 3 are ego-states related to the concept of personality segmentation. Personality is seen as a collection of perceptions, cognitions and affects organized into clusters or patterns, called ego-states, with boundaries more or less permeable. Figure 6.2 illustrates the personality (the complete circle) consisting of different parts called ego-states (like the slices of a cake).

FIGURE 6.2: Personality segmentation and ego-states

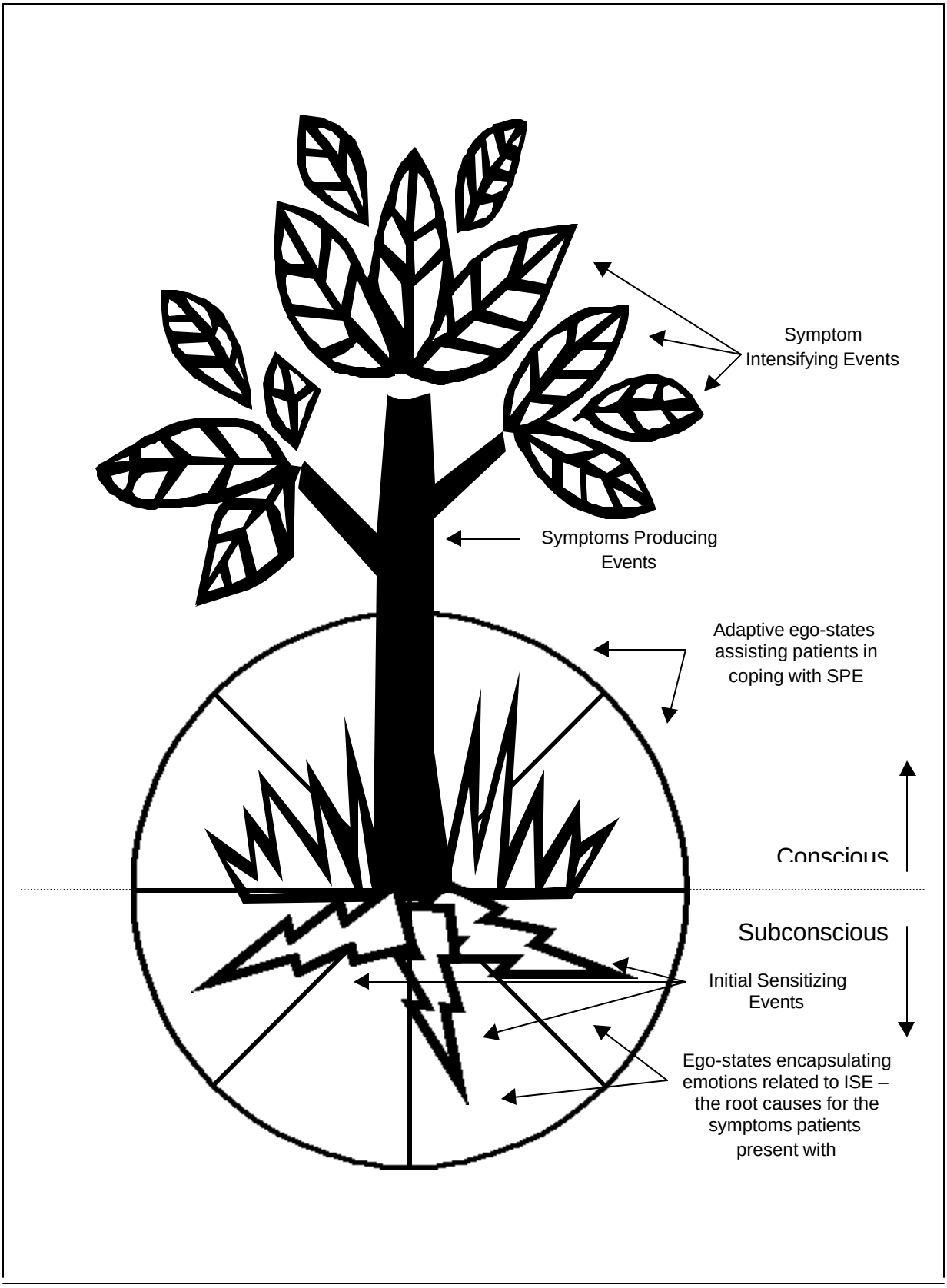


An ego-state is *"executive"* when it is invested with ego energy and is aware of the other ego-states as objects (invested with object energy). It becomes the *"self"* in the here and now. However, an ego-state is malevolent when its boundaries are not permeable therefore dissociating it from the rest of the personality and integrated ego-states.

The use of Ego-State Therapy (as discussed in Chapter 3 and Chapter 5) can bring about dramatic resolution of inner conflicts and achieve symptom relief, especially when dealing with patients suffering from symptoms related to trauma. Through the recognition of the meaning and usefulness of observed symptoms, otherwise enigmatic material is allowed to provide crucial information about the patient's deepest struggles.

Dissociated parts of the self (malevolent and maladaptive ego-states) can be accessed through regression and hypnotically facilitated towards abreaction and catharsis. Conflict resolution, re-negotiation of interpersonal and intra-personal relations and ultimately ego-state adaptation and integration into the greater personality can be achieved. The model that the researcher is proposing is a combination of the two models and can be illustrated as indicated in the diagram, Figure 6.3.

FIGURE 6.3: Diagram of the Hypnotherapy model



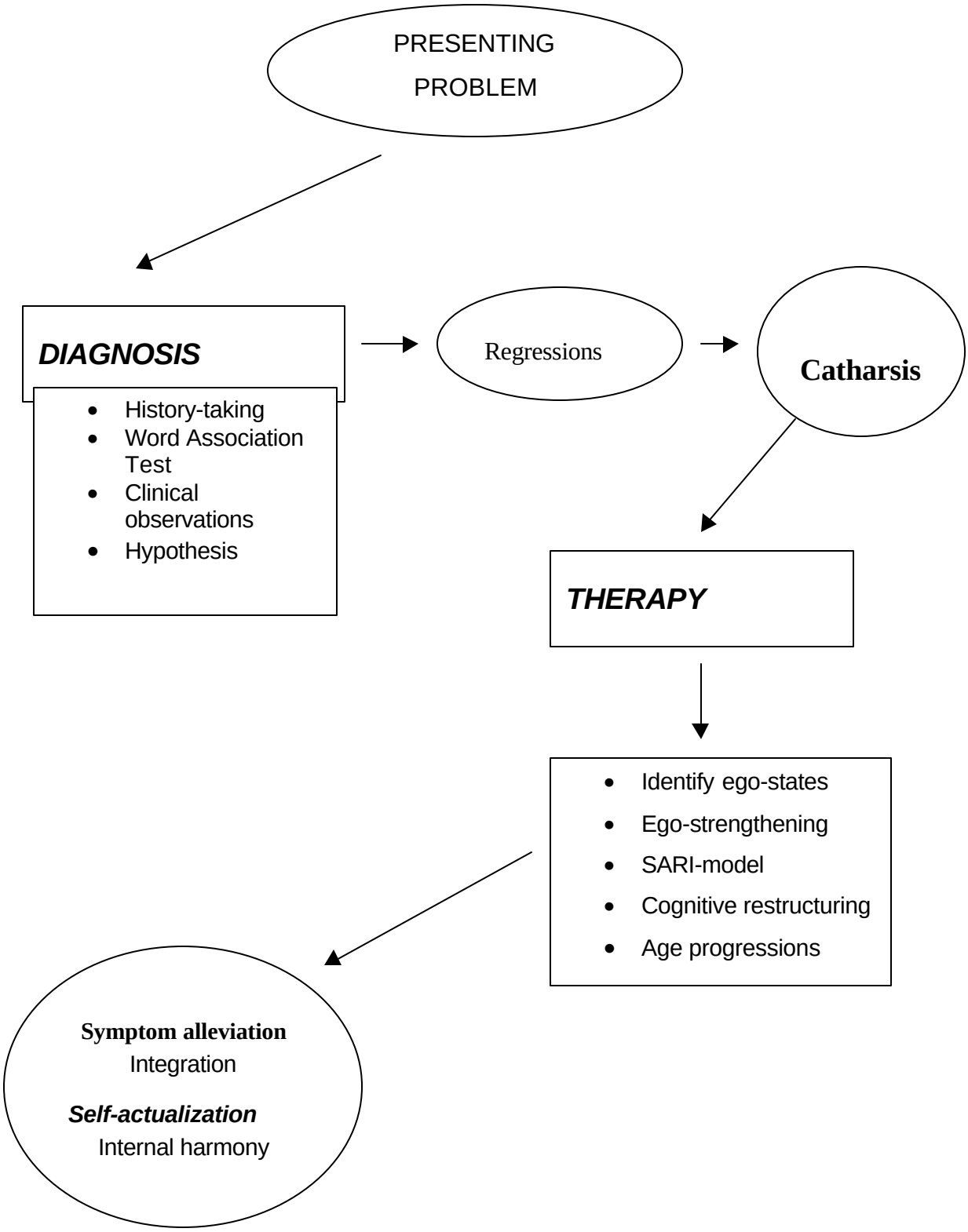
Ego-states causing the observed symptoms/pathology are often repressed and not consciously known (therefore the segments of the circle underneath the ground with the roots of the tree, in the area of the subconscious). A single ego-state may be related to more than one repressed traumatic incident and more than one ego-state may be associated with a single traumatic event. Integrated and well-adjusted ego-states are above the ground overlapping the stem and the branches indicating that those emotions are consciously accessible and known to the whole personality.

6.3 APPLICATION OF THE MODEL: THE THERAPEUTIC PROCESS

The treatment model starts off with determining the patient's complaints, the presenting problems and the patient's version of the events that lead up to the production of the current experienced symptoms/pathology (the Symptom Intensifying Events) as illustrated in Figure 6.4. Thereafter, the History-taking of the Medical Hypno-analysis model is used as the first diagnostic tool in determining the Symptom Producing and Initial Sensitizing Events. The History-taking usually provides a clear indication of the Symptom Producing Events but not the Initial Sensitizing Event. To determine the Initial Sensitizing Event (which harnesses the history behind the development of the malevolent or maladaptive ego-state(s) causing the presenting problems) the patient is introduced to hypnosis and the Word Association Test conducted while the patient is in trance.

The analysis of the History-taking as well as the Word Association Test indicates hypothesis for the possible existence of maladaptive ego-states and repressed sexual trauma related to the patient's present complaints. It highlights different ages where trauma was experienced and left unresolved – information needed for effective and sufficient age regressions. This concludes the diagnostic phase of the treatment model.

FIGURE 6.4: Treatment model



The hypnotherapy phase of the treatment model starts off with the SARI-model (Safety and Stabilization; Accessing Trauma Material; Resolving Traumatic Experiences and Integration and New Identity - see Chapter 3) alternating between ego-strengthening sessions and age regressions to the relevant incident(s) as hypothesized in the diagnostic phase. Regressions often lead to patients experiencing spontaneous catharsis, as repressed pain is accessed for the first time.

During the regressions the therapist determines the existence of ego-states and focuses on building therapeutic alliances with every ego-state as well as with the main personality. Cognitive distortions and misbelieves are simultaneously addressed and restructured and if symptom alleviation do not occur spontaneously, then symptom reduction is negotiated with the relevant ego-states. Once the therapist is convinced that there is a strong working relationship between all the internal parts of the personality, (reflecting on the process of ego-maturation and ego-integration), age progressions and themes around the termination of therapy may conclude the therapeutic process.

Specific aspects for consideration during the application of this treatment model will be discussed in more detail in the following paragraphs.

6.3.1 THE THERAPIST

When working with patients who have experienced any form of childhood sexual trauma, it is of utmost importance for the therapist not to ask any questions that may come across as leading or suggesting, as this may have severe ethical and even legal implications. The therapist should guard against interpreting any information given by the patient to the patient, as this may also enhance the possibility for the creation of false memories related to sexual crimes (see Chapter 2).

When working with survivors of sexual crimes, the therapist should keep in mind that his/her main role is to facilitate the therapeutic process and to focus on the integration of traumatic material into the personality (as traumatic material is split off or dissociated from the greater personality – see Chapter 2) and not on the justification of memories as false or true. The therapist should therefore also guard against pursuing the validity of recovered memories, and rather encourage the patient to focus on the experience itself, regardless of its factual truth.

Working with sexual trauma is emotionally very intense and personal and it can often be very traumatic to the therapist him/herself. It is therefore imperative that the therapist should be comfortable with traumatic material and emotional intensity, as a great deal of the patient's emotional healing will depend on the therapist's ability to maintain and contain the therapeutic environment. The positive utilization of transference and counter transference and the therapist's skillful ability to combine mirroring and cognitive restructuring, will also facilitate the patient's inner healing.

The therapist should further be properly trained in hypnotherapy and the two modalities used in this study and he/she must also be able to use metaphors and visualizations to the benefit of the patient (the therapist in other words should be skillful in both the language of the conscious mind (words) and the language of the subconscious mind (images, colors and sound)).

6.3.2 THE PATIENT

It is the therapist's responsibility to inform the patient about hypnotherapy and the model that the therapist is going to use. Hypnosis should be demystified and the patient's expectations of hypnosis should be brought in line with reality. The therapist should also ensure that the patient understands that the focus of the sessions will be on the subconscious mind and that it may therefore sometimes not be logical to the conscious mind. The patient is encouraged to allow for the flow of thought whether logical or not and to express his/her inner feelings,

impressions and thoughts as he/she becomes more in touch with his/her inner self.

Not all patients are suitable candidates for hypnosis and hypnotherapy. If the patient is not open to experience trance, hypnotherapy will be unsuccessful, as the core of trance is the patient's ability to relax him/herself and to allow for trance. A patient with poor visualization ability and concentration difficulty will also struggle with hypnotherapy and it is recommended that conventional approaches be followed with such patients.

6.3.3 INDUCTION OF TRANCE

There are many different techniques for the induction of trance. These techniques involve direct suggestions, guided imagery, dissociation and bodily relaxation. There is no set rule for the use of techniques other than to mobilize the patient's natural auditory, visual or kinesthetic preferred style of interacting with the environment. Consequently, in this study, the researcher made use of any technique that she saw fit at a specific time and place and based on the patient's specific needs.

The main purpose of the induction of trance is to get the patient in a comfortable state of bodily and mental relaxation. Bodily relaxation is achieved through specific breathing and muscle relaxation techniques, whilst mental relaxation is the creation of a safe and pleasant place in the patient's mind's eye where he/she can visualize the tranquility, peace and harmony in that place and allow him/herself to experience the same emotions in the therapeutic room, as visualized in the safe place. Once this is achieved the patient is in trance and the therapist may proceed with the deepening of trance.

During the induction of trance ideomotor signals are established. This is standard procedure for hypnotherapy and involves the establishment of a *"yes", "no"* and *"I don't want to say"* finger with the patient's dominant hand. The patient is now

able to communicate freely through the lifting of the relevant fingers – a preferred style of communication for patients who are initially scared or insecure. It also serves as means of subconscious communication during intense regressions or deep trance, when some patients may find it difficult to speak or when an ego-state prefers not to communicate verbally. The patient's hand is dissociated from the body and allowed a will of its own whereby the subconscious mind can communicate with the therapist.

6.3.4 DEEPENING OF TRANCE

As with the induction of trance, there are also several deepening techniques. The deepening of the trance is a middle ground between the place of safety (as discussed in 6.3.3) and the regression to the traumatic event. Without sufficient deepening, the patient will not be able to regress to the Initial Sensitizing Event and sometimes the Symptom Producing Event(s). The following dissociation technique was used in this study as a deepening procedure:

"From your special and safe place, there's a little footpath on the one side. This little footpath takes one on the most beautiful easy scenic walk, along trees, bushes, flowers, ferns, and even a little stream. You are now going to follow this footpath still feeling safe and comfortable. The sound of the birds relaxes you even more. And then, there's a patch where the sun is shining through and you can see a rainbow. It's the most beautiful and complete rainbow that you've ever seen. And at the other end of this rainbow is a timeline. This timeline will lead you back into your own history and when you follow the timeline it will be as if you are walking back into time, becoming younger and younger… but, you are now at this end of the rainbow and that's all that matters to you.

See the brightness of the colors, all the colors of the rainbow, so complete, so relaxing. In a short while I'm going to take you through each color of the rainbow as you move along the rainbow to its other end. And first you enter the color red. Bath yourself in the color red and feel how the vibrations of the color red, touches

you and relaxes you deep in the core of your being. Then the color orange, reminding you of early morning sunrise – the beginning of a new day. And then you move up to the color yellow. What a lovely bright and warm color. Full of energy and inner healing and you realize that its warm glow touches the center of your being.

Then you plunge into the color green, all the shades of green. The light green of a newly grown little stem through to the richness of dark green, growth, ongoing complete, perfect. And you know that life is about gardening, taking out the dirt, planting and sowing new seeds, allowing for growth, transformation, new beginnings. Up to the color blue. You can feel yourself engulfed by the color blue, peaceful, quiet, calm.

And you know now that there's only one color left before you get to the other end of the rainbow, and that's the royal color, the color lilac or purple. This is the color of kings and queens, important people, people of value and virtue, and you are completely covered in the color purple. And then alas, at the end of the rainbow, what a magnificent experience. And you are now at the bottom of the rainbow and at the beginning of your own history, your timeline going back into the past. And you are still feeling safe, comfortable and totally relaxed.

The patient is then asked to walk back in time up to the very first age or incident that has something to do with the symptoms/pathology he/she presented with. The therapist then starts counting the ages backwards from the current age of the patient, leaving a few seconds for the patient to respond at each age interval. This is the first procedure for effective regressing to the Initial Sensitizing Event and the Symptom Producing Event(s), as patients at this stage usually regress to the Symptom Intensifying Event(s).

6.3.5 REGRESSION TO TRAUMATIC EVENT

For the therapeutic process to be complete it is essential that the initial event associated with the sexual trauma be accessed and reframed through the use of ego-states and Ego-State Therapy. The Word Association Test results will often indicate two or three traumatic events of which the sexual crime might not necessarily be the very first traumatic event. Although this study mainly focused on the trauma related to childhood sexual crimes, two of the case studies described in Chapter 5 indicated the birth process as the Initial Sensitizing Event and it was addressed accordingly. Whether the sexual crime was the Initial Sensitizing Event or not, regression should include the sexual traumatic event in order to identify the ego-states responsible for the symptoms and to eliminate false belief systems set in the subconscious mind.

After the deepening technique (as described in 6.3.4) and the patient regressed to the age where (according to the patient at that stage) the trauma occurred for the first time, the therapist may use any of the *"bridging"* techniques as described in Chapter 3. In this study the therapist made use of the affect bridge (where an emotion is used to trigger memories related to the same emotional experience the patient is experiencing during trance) and the somatic bridge (where a bodily sensation is used to regress to a situation where the patient experienced the same bodily discomfort).

The affect and somatic bridges in this study immediately regressed patients to the very first traumatic incident where the ego-states related to the sexual crimes, came into being. After trauma was resolved in these incidents, the patients were regressed to the Symptom Producing Events to complete the therapeutic process.

It is however imperative to keep in mind that the therapist should only progress with the regressions to the sexual traumatic incidents once he/she is sure that the patient has enough ego-strength to work through the intense catharsis without being re-traumatized. It is sometimes necessary to regress to less traumatic

incidents (as illustrated in Case A, Chapter 5) before doing the actual regressions to the sexual crimes. Working through less traumatic material first allows the patient to gain inner strength and mastery over intense and perceived overwhelming emotions and builds confidence within the patient and the therapeutic relationship. Should a patient regress to the repressed trauma without enough ego-strength, the patient will be re-traumatized and the therapeutic process will be sabotaged, as the patient might be overwhelmed and develop a fear not only of regressions but also of hypnosis.

6.3.6 EGO-STATES

The traditional way of accessing and determining the existence of ego-states is to ask the question *"Is there any part of (patient's name) that knows anything about her problem or difficulty?"* This question is asked directly after the first induction of trance and the deepening procedures. When the patient answers positively, the therapist inquires further about the name, age and reason for the existence of that particular part of the person, thereafter referred to as an ego-state. The patient is then regressed to the relevant traumatic incident(s) through the ego-state, when the ego-state is asked to tell about the circumstances related to its coming into existence.

In this study the researcher determined the existence of ego-states after the regression to the first (latest) traumatic incident, as the first regression usually takes patients to the Symptom Producing Event. At this stage the ego-states involved with the sexual traumatic incident already existd and regressions to the Symptom Producing Event are less traumatic and painful to patients than the subsequent regression to the sexual traumatic event (the Initial Sensitizing Event).

After the first regression the therapist then asks whether there's a part of the patient that knows more about this incident, about what happened and the patient's feelings involved. When the patient answers positively the therapist

asks permission to speak to that part. The same procedures as the traditional method is then followed, when the therapist asks the name of this part, its age and the reason for its coming into existence. The age of the ego-state is an indication of the existence of an Initial Sensitizing Event and should be used in conjunction with the responses the patient has given during the Word Association Test and the therapist's hypothesis derived at from the Word Association Test.

It is quite possible that more than one ego-state may exist and be involved with the sexual traumatic incident. It is important to initially treat each ego-state as an individual and to ensure that all ego-states feel valued and appreciated (even the malevolent and maladaptive ego-states). The therapist should acknowledge that each ego-state came into being in order to assist and help the patient coping and surviving the sexual traumatic incident, and therefore served a very important purpose in the patient's life. To devalue the ego-state's purpose and function in the greater personality will result in the ego-state sabotaging the therapeutic relationship and process, as it may perceive it as a threat to its existence. An ego-state is most likely to do this through *"unexplainable"* emotional or behavioural changes in the patient outside of therapy.

After working with an ego-state in therapy, the therapist should thank the ego-state for communicating with the therapist and greater personality, and then ask the ego-state to go back to its original place in the greater personality. At the beginning of consequent sessions it is advisable to first speak to and acknowledge all ego-states before presuming therapeutic work with selective ego-states. This is specifically important during the initial phases of establishing contact with ego-states, as most ego-states will be premature and childlike in their thinking and interpreting of the therapeutic relationship and may easily feel rejected or left out. As ego-states mature and merge with the greater personality, the patient will reflect on a feeling of integration of all ego-states and an experience of being a whole.

6.3.7 SARI-MODEL

The SARI-model was thoroughly discussed in Chapter 3; however, there are a few considerations to bear in mind during the application of the SARI-model:

1. **Safety and stabilization:**

This stage commences with the beginning of therapy and forms an integral part of the History-taking and Word Association Test procedures. As the Word Association Test enquires about repressed subconscious material, it may destabilize a patient even more if not enough attention was given to ego-strengthening and the managing of overt symptoms such as addictions and severe depression. If a patient presents with poor ego-strength, the therapist should rather dedicate a few sessions to relationship building and ego-strengthening before conducting the Word Association Test.

2. **Accessing the trauma and related resources:**

In this stage it is important that the therapist focuses on the gathering of detailed information as trauma causes dissociation, which fragments feelings and thoughts related to the sexual crime. It is this fragmentation and distortion of information that causes the encapsulation of the different aspects of the trauma as a defense mechanism, resulting in non-integration. Questions should be directed in such a way as to establish awareness of the environment when the sexual crime occurred, the patient's emotional responses, cognitive responses as well as behavioural responses to the sexual crime.

3. **Resolving traumatic experiences and restabilization:**

In this stage the therapist is working with a younger ego-state and the therapist should talk to the ego-state according to his/her age as well as cognitive and emotional development. Cognitive restructuring should be very

concrete and tangible, explaining and elaborating on a child's physical, emotional and behavioural responses to sexual trauma. The ego-state needs to comprehend the impact of the sexual crime on the greater personality in order to understand its own functioning within the system as a whole.

4. Personality integration and creation of new identity:

Ego-states should constantly be reminded of the fact that the greater personality is grown-up, mature and has survived the sexual crime. The ego-state is hereby encouraged to mature, as maturation is needed for successful integration into the greater personality. The new identity is created through age progressions, where the patient and ego-states visualize a near future as a symptom free, healthy and happy integrated person.

6.3.8 THE FIELD OF PSYCHO-EDUCATION

This study has indicated that exposure to sexual crimes during childhood results in dissociation as coping mechanism. This is a normal human response to any traumatic incident. However, when sexual trauma is so severely experienced that it seems to be physically, emotionally and psychologically overwhelming to the child, ego-states will develop to assist and support the child in its survival. These ego-states then encapsulate the trauma and therefore are unable to develop and mature with the rest of the personality as they get stuck at the child's developmental phase during the time of the sexual traumatic experience. This inhibits the growing child's sense of self, self-development and identity formation and inevitably, the child's growth towards self-fulfillment and self-actualization.

As indicated in this study, symptoms/pathology in adulthood are often not only just the result of unresolved sexual trauma but also of immature ego-states and a lack of a sense of self-identity and self-value. Fear often governs the adult's relationships, influencing the adult's ability to associate and dissociate in intimate relationships as his/her sense of integration and adaptation depends greatly on

his/her sense of self and self-acceptance. Sexual crimes deprive children from a sense of being in control of their bodies and of their environment. This model teaches adult survivors how to regain a sense of not only internal but also of external control – an important part of self-confidence and identity formation.

How a child presents itself to the world is greatly influenced by the way the world presents itself to the child. If a child has learned through experiencing sexual trauma that the world is an unsafe place to be in, the adult needs to learn that there are two sides to the coin, and that the world can indeed also be a safe place to be in.

This model provides not only a therapeutic structure for dealing with adult survivors of childhood sexual abuse, but incorporates the development and maturation of childlike ego-states through cognitive restructuring. It can therefore be a useful psychotherapeutic tool within the field of psycho-education.

6.4 SUMMARY

This chapter proposed a hypnotherapy model for survivors of sexual crimes. It indicated the importance of finding the root causes of presented symptoms/pathology in order to determine and identify the existence of ego-states related to the sexual trauma and the presented symptoms. It is only through hypnosis and regressions that repressed sexual trauma can be recalled and the dissociation of the relevant ego-states be addressed. Once ego-states are willing to reveal their secrets, the therapeutic process towards resolving the encapsulated trauma can commence.

This chapter also voiced points of concern and recommendations in the application of this model within the field of psycho-education.

The next chapter will conclude this study with a brief summary of the study, conclusions from the literature, findings emanating from the empirical investigation, contributions, limitations and implications of the study.

“It’s not the mountains we conquer, but ourselves.”

- Sir Edmund Hillary

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS OF THIS STUDY

“There is a point in life where one gets to say: I choose life, I deserve better. Survivors get there. Victims don’t.”

- **Author, 2002.**

7.1 INTRODUCTION

The first chapter of this study focuses on the awareness of the problem of survivors of childhood sexual crimes’ struggles with symptoms/pathology in adulthood, and the motivation for this study. In the researcher’s practice as counseling psychologist, she became increasingly aware of patients seeking treatment for relationship and/or sexual problems, which were actually the result of the aftermath of childhood sexual trauma, of which they often did not have any conscious memory. The first chapter highlights the research problem from different theoretical perspectives, stated the aim of the study as well as the clarification of the concepts.

Chapter 2 includes a literature survey on the subject of sexual crimes as well as the signs and physiological, psychological, and spiritual symptoms in, and the aftermath of childhood sexual crimes on adult survivors. It elaborates on memory, the concept of memory storage and recovering, and relational (including object relations) problems. It furthermore discusses in short, conventional treatment models usually followed when treating survivors of sexual crimes.

Chapter 3 provides a discussion on hypnotherapy and an outline of the hypnotherapy models, Medical Hypno-analysis and Ego-State Therapy, used in

this study. It elaborates on the differences between the conscious and the subconscious minds and the importance of understanding the Triple Allergenic Theory and the development of ego-states when working with symptoms/pathology related to sexual crimes.

Chapter 4 outlines the research design and methods applicable to this study. A qualitative approach is proposed and the relevant procedures and techniques discussed.

Chapter 5 reports on four case studies, their diagnosis and the therapeutic processes followed with each patient.

Chapter 6 discusses the proposed hypnotherapy model and its application within a psycho-educational perspective. It includes points for consideration when working with adult survivors of childhood sexual crimes within this proposed model.

This chapter will conclude this study, and will discuss findings, conclusions and recommendations of the study. It will highlight contributions made by the study as well as the limitations and implications of this study.

7.2 CONCLUSIONS FROM THE LITERATURE STUDY

7.2.1 SEXUAL CRIMES

Research has shown that sexual crimes and the trauma associated with it can have a tremendous impact on the survivor's physiological, psychological and mental development and functioning. Children exposed to sexual trauma often retain symptoms/pathology related to the crimes in adulthood. As children are not mentally and emotionally equipped to work through and deal with sexual trauma, they often dissociate as a means of escape. Their dissociation during

the sexual abuse is a defense against the powerful negative affect associated with the experience.

When dissociation is severe, the memory of the sexual trauma is encapsulated in one or more ego-states and repressed from conscious recollection. This repression may be **complete** (the patient doesn't have any idea that they were at a younger age subjected to sexual crimes) or **partial** (where patients have fragmented flashbacks or a vague suspicion that they may have been subjected to sexual crimes at a younger age). The impact of the sexual trauma is not processed and worked through and often results in relational or sexual problems later in life.

7.2.2 MEDICAL HYPNO-ANALYSIS AND EGO-STATE THERAPY

Hypnosis is believed to be an altered state of consciousness whereby access to the subconscious mind can be achieved, as conscious defense mechanisms are being bypassed. Repressed memories related to sexual crimes can be recalled and unresolved trauma worked through. Another advantage of the use of hypnosis is that the affect elicited can be so powerful that most patients do not need to remember every single sexual traumatic event.

The therapist may help the patient consolidate the memories in a constructive way, thus facilitating recovery. This cognitive and emotional restructuring allows patients to shift their perception of self, thus changing their self-image from that of a victim to one of a survivor. Hypnotic exercises can also be utilized in which the survivor's memory, usually as a child, is comforted, cared for, and loved by the adult self, thus fostering the process of self-acceptance, learning, and growth.

The Medical Hypno-analysis Theory refers to the Triple Allergenic Theory, which includes the Initial Sensitizing Event, the Symptom Producing Event and the Symptom Intensifying Event(s). Its focus is on finding the root causes (the Initial

Sensitizing Event) and identifying and reframing of core faulty beliefs, within the subconscious for the presented symptoms/pathology. In working with sexual crimes, the root causes will be the repressed memories of the crimes that need to be recalled and restructured.

Ego-State Therapy suggested the existence of internal personality segments, called *"ego-states"* which represent bodies of functions that have been developed for better adjustment and in some cases for the purpose of survival of the individual. It can therefore be defined as an organized system of experiences within the ego. These so called clusters are separated by the degree of dissociation, with mild dissociation resulting in permeable, flexible boundaries and severe dissociation resulting in less permeable and rigid boundaries.

As sexual crimes often involve a severe degree of dissociation, it may happen that ego-states develop and encapsulate emotions such as pain, fear and anger. This encapsulation of destructive ego-energy, results in the ego-state's maladaptive and malevolent behaviours causing the symptoms/pathology later in life. These ego-states function as separate entities within the greater personality and often do not cooperate with other ego-states or the greater personality.

It is only in working through the trauma with the relevant ego-states that the destructive forces within the individual can be disarmed. This is done through the utilization of family and group therapy techniques for the resolution of the internal conflicts between and within the different ego-states that constitute the *"family of self"*. The goal is to work through the sexual crime's traumatic impact with the ego-states and then to facilitate healthy ego-integration within the greater personality through improved internal communication between ego-states resulting in better cooperation, harmony and more permeable boundaries amongst them.

7.3 FINDINGS EMANATING FROM THE EMPIRICAL STUDY

The aim of this study was to explore the feasibility of a combination of Medical Hypno-analysis and Ego-State Therapy modalities as integrated treatment modality for survivors of sexual crimes, and to determine the existence of ego-states related to the sexual trauma in order to resolve encapsulated sexual traumatic memories.

Four case studies were discussed and in each case maladaptive ego-states related to the sexual crimes existed, which were the main causes for the symptoms/pathology patients came to therapy with. In two cases the sexual traumatic incidents were the Initial Sensitizing Events that lead to the development of the ego-states and the patients did not have any memories related to the sexual crimes.

In the other two cases the Initial Sensitizing Events that lead to the development of the ego-states at a very young age were (in the one) severe physical and emotional abuse by a mentally ill mother, and (in the other) a very unstable family home with multiple incidents of rejection by her parental figures from birth up to the age of five. The latter patients had vague memories of childhood sexual trauma, but were not able to connect the childhood sexual trauma to their symptoms/pathology experienced in adulthood.

In all four cases the therapeutic processes were discussed as they demonstrated the effective removal of faulty core beliefs set in the subconscious and the resolution of unresolved childhood sexual trauma using the hypno-analytical techniques of Ego-State Therapy, resulting in effective symptom/pathology alleviation. These discussions addressed the research objectives as stated in Chapter 4 and proved that the proposed hypnotherapy model (as stated in Chapter 6) can be highly effective in the alleviation of symptoms/pathology associated with sexual crimes when working with adult survivors. The Medical Hypno-analysis model's diagnostic tools, combined with the hypno-analytical

techniques of Ego-State Therapy provide a successful short-term intervention when working with dissociation and sexual trauma.

7.4 CONTRIBUTIONS MADE BY THE STUDY

Although it is common knowledge within the field of psychology that most symptoms/pathologies, which patients suffer from may have its origin within the subconscious, training in the field and language of the subconscious and hypnotherapy as means of accessing the subconscious, seems to be lacking.

Apart from the traditional projective psychometric tools such as Rorschach, Thematic Apperception Test, Sentence Completion Test and Draw a Person, there aren't many structured diagnostic tools available whereby insight in the subconscious mind can be achieved. This model (through its combination of Medical Hypno-analysis's diagnostic tools and the hypno-analytical techniques of Ego-State Therapy) provides the trained clinician with another structured short-term treatment modality, whereby the root causes of pathology and the existence of ego-states within the subconscious can be identified. Its focus on the therapeutic process from the Ego-State Therapy and psycho-educational perspectives further provides therapists with a fresh look at the subconscious and healing for survivors of childhood sexual crimes.

The researcher reiterates the fact that although this study's main focus was on the aftermath of childhood sexual crimes on adult survivors and the therapeutic intervention, it is important to note that the study also concluded that the after-effects of sexual crimes cannot be isolated and treated as such. It is important to determine the Initial Sensitizing Event or the root cause of the symptoms/pathology as seeded in the subconscious, as harmony and communication amongst ego-states is a prerequisite for ego-integration. This can only be achieved once all maladapted or malevolent ego-states have been identified and encapsulated emotions worked through.

When working within the Ego-State Therapy framework, it is further important to bear in mind that although an ego-state causing the symptoms/pathology could only be related to the sexual crime, it might not be the only ego-state responsible for the symptoms/pathology. If the sexual crime incident is not the Initial Sensitizing Event, complete symptom alleviation will not be achieved unless the Initial Sensitizing Event and ego-states related to this event are identified and trauma worked through. This model therefore highlights that sexual trauma cannot be dealt with in isolation, but the patient's whole history should be acknowledged and incorporated into the therapeutic intervention.

Another significant contribution this study has made (as illustrated in Chapter 5) is that object relations and interpersonal relationships with significant others (especially with the core external family – the patient's mother and father) is of great importance when working with survivors of sexual crimes. In all four cases relationship issues were identified that needed to be addressed in order to successfully work through the sexual trauma. Unresolved relational anger, hatred and even guilt had to be addressed and reframed before the patient could achieve internal harmony, inner peace and forgiveness.

7.5 LIMITATIONS OF THE STUDY

In evaluating the study certain limitations were identified of which the following are the most likely:

- Firstly, although four subjects were chosen from a much larger sample, the test sample was still limited due to the in-depth analysis of each case and the consequent magnitude of the study.

- Secondly, as this study was done over a two-year period and although subjects showed a remarkable improvement and alleviation of symptoms/pathology they initially presented with, no long-term documentation on the permanency of symptom alleviation is available.

7.6 RECOMMENDATIONS FOR FURTHER STUDY

The researcher proposes the following recommendations against the background of this study and the results obtained:

- ***For the field of psychology:*** Specialized training in trauma work and Ego-State Therapy should be given to all Master level students training to become psychologists in South Africa. South Africa is a country with specific needs when it comes to mental and emotional health as its violence and crime rates are amongst the highest in the world. People are often exposed to hijackings, snatch and grab robberies, rape, murders and taxi accidents, causing a high incidence of post-traumatic stress syndrome sufferers amongst South Africans. As this study indicated, dissociation is a mechanism for coping with trauma. Ego-State Therapy specializes in dissociation and should therefore be more readily acknowledged as treatment modality for post-trauma work.

  When working with survivors of sexual crimes and other trauma, the importance of retrieving repressed memories should not be underestimated and psychologists should be well equipped and trained in the recovering of memories and related therapeutic work on a subconscious level.

- ***For the field of community work:*** The physical, psychological and spiritual after-effects of sexual trauma should be made known to laypersons, as prevention is often better than cure. Not only should the community (teachers, parents, youth workers and so forth) be made aware of the incidence of sexual crimes, but also educated in the seriousness of the damage it may cause (even in adulthood) if left unattended and untreated. Psycho-educational programs need to be implemented in communities and treatment needs to be readily available, not only for children but also for adults that were sexually traumatized.

7.7 IMPLICATIONS OF THE STUDY

This study made it clear that unresolved sexual crimes often result in the development of maladaptive and malevolent ego-states causing destructive behaviour (manifested in physiological and/or psychological symptoms/pathology) even in adulthood. These ego-states get stuck at the time of the crime and their development (usually in the patient's childhood), and are therefore immature and childlike. Their mere existence is a hinderage to the patient's development, self-concept and identity formation thereby inhibiting the patient's sense of self-acknowledgement, self-love, self-acceptance and self-actualization. This study also proposed a treatment modality to assist psychologists in working with these survivors of sexual crimes.

7.8 CONCLUSION

A sexual crime is a violation of physical, emotional and behavioural boundaries. It is the only crime committed against a victim that penetrates and takes place within the victim's body. It is therefore understandable that such a violation cannot be without severe psychological consequences as indicated in this study.

It is the researcher's opinion that therapists engaging with patients on this inner and inward journey, working with their pain, turmoil and unhappiness accompanying their sexual trauma, should be well aware of the multitude of complications and implications such endeavours hold. It is a journey that has to be completed, a road that has to be followed right to the end. The application of the proposed model will elicit a large component of clinical intuition and it may be at times an emotionally draining experience, but never the less, it is the hope of the researcher that such journeys will ultimately prove to be the most successful intervention strategies possible and mutually rewarding experiences, to both patients and therapists.

To all my patients who allowed me to, just for a while, become part of their internal families, to see what they did not want to see, and yet could not deny seeing; to hear their stories and witness them confront and conquer their pain; who allowed me to help them find their own internal healing and harmony: It was a privileged.

“The ultimate challenge is to inspire the inspired, to further the limits of the limitations, to dive deep into one’s soul and bring forth the purest of the pure, in the genesis of yet another journey…”

- **Author, 2002.**

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