Corrective Emotional Experience in the Therapeutic Process

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Abstract: While we are using Alexander's work as a beginning point for this analysis of corrective emotional experience in the therapeutic process, we extend the concept beyond the level of ego experience (emotion, memory, and cognition) to that of Self or Soul experience (the transpersonal realms of collective unconscious, subtle energy, and the spirit world). Our analysis is grounded on the basic premise of our developmental theory, which is existential, transcendent, and karmic. Healing unresolved traumas from early life requires accessing the events that produced the trauma, re-experiencing them cathartically in the original ego state, and reframing the meaning of the experience through corrective emotional experiences. We identify more than twenty types of corrective experiences, and suggest that they all fit into one of three categories: (1) building ego strength through release of shame and reclaiming worthiness; (2) building agency through release of helplessness and reclaiming personal power; and (3) building authenticity through release of dissociation and identification and reclaiming self-reflective identity.

"There is only one disease, congestion. And only one cure, circulation."

Catherine Ponder

We will survey the myriad forms of corrective experience that can potentially be provided in the process of therapeutic healing. Essentially all of these forms of correction provide the means for an individual to open up to what has been suppressed, oppressed and repressed; and to retrieve and circulate the psychical energy that has been unfocused, bound up and disconnected from.

History of "corrective emotional experience"

Freud established the basic formula for resolving trauma: accessing the memories, cathartic expression of emotions, and "working through" the residue still remaining in the individual's life. Franz Alexander (Alexander & French, 1946; Alexander, 1961) revised the psychoanalytic orthodoxy of the times, suggesting that a further step was necessary in the therapeutic process after cathartic release, and called it "corrective emotional experience." Alexander speaks of some of Freud's significant discoveries:

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that hysterical symptoms have their source in emotional disturbances of the past; that these disturbing events are capable of undergoing complete repression from consciousness; and that although discharge of repressed emotions (abreaction) gives temporary relief, it has no lasting therapeutic value in itself.

One of the principle and pioneering elements of Freud's psychotherapy is the recovery of repressed memories. Alexander believed that the recovery of memories was not the *cause* of therapeutic progress but its *result*, and that recollection of repressed childhood memories occurs after the same type of emotional constellation has been experienced and mastered in the therapeutic situation (Alexander, 1930).

Once the memories are uncovered, the individual re-experiences the event differently than he did originally, because he experiences the relationship with the therapist differently than he did the relationship as a child with his mother and father. The curative powers of psychotherapy lie in the fact that he can express his aggressiveness and his vulnerability with the therapist without being punished, and can assert himself without being censured. The undeniable reality of this experience allows the client to know that he is no longer a child facing an omnipotent father. This type of emotional experience in treatment Alexander called "corrective emotional experience" and he considered it the most important factor in all uncovering types of therapy. "Merely remembering an intimidating or demoralizing event does not change the effect of such an experience. Only a corrective experience can undo the effect of the old" (Alexander, 1946).

Alexander recognized his work as a continuation of ideas first proposed by Ferenczi and Rank (1924), because they advocated an emphasis on emotional experience instead of intellectual understanding of the sources of the patient's symptoms. They held that emotional experience should replace the search for memories and intellectual reconstruction.

For Alexander, the most basic therapeutic principle is to re-expose the patient, under more favorable circumstances, to emotional situations which he could not handle in the past, and to repair the traumatic influence of previous experiences with the intervention of a corrective emotional experience. What is the nature of such an all-important corrective emotional experience? We devote this article to answering this question.

Basic assumptions

While we are using Alexander's work as a beginning point for this analysis of corrective emotional experience in the therapeutic process, we

are extending the concept beyond the level of ego experience (emotion, memory, and cognition) to that of Self or Soul experience (the transpersonal realms of collective unconscious, subtle energy, and the spirit world). Our analysis is grounded on the basic premise of our developmental theory (Zimberoff & Hartman, 2001), which is existential, transcendent, and karmic. For the first part of life, from conception through adolescence and early adulthood, one develops internal working models, or schemas, based on what we brought into this life as innate tendencies, traits and consequences of previous choice (samskara and karma), and on life circumstances in the environment. These schemas lead to more or less advanced (that is, functional or dysfunctional) levels of maturation, security and autonomy – constructing and strengthening the ego functions. Growth occurs in predictable stages, with each human age having primary developmental tasks. The extent to which those tasks in a given stage are incomplete, or arrested, limits the person's ability to complete subsequent stages. All stages continue to be negotiated throughout the lifespan.

Then in the second part of life, one deconstructs that framework through increasing self-reflectivity and mindfulness, surrendering the subjective identity aspects of ego, the rigidity of established schemas, to allow for child-like receptivity and openness to experience, tolerance for ambiguity and paradox, and ultimately transcendence of "normal life" into "greatness." This is the progression identified by Maslow (1954) from attending to biological needs, then social needs, to the autonomy need for self-actualization. Maslow suggested toward the end of his life that people ultimately can transcend self-actualization, and attend finally to transcendence needs (1969/1971), i.e., identifying "self" with something greater than the purely individual personality, seeking communion with the Divine, moving through peak experiences to a consistent plateau experience.

This is the two-phased process of individuation identified by Jung: in the first phase, from childhood to middle adulthood, we are becoming individuals, learning the ways of the world and asserting ourselves in the demands of family, work, and society. In the second phase, which begins according to Jung with the midlife crisis, we begin turning inward, reconnecting with the center of our being. In the first phase we build and develop our ego and in the second phase we transcend and surrender it (Metzner, 1998). This final developmental stage is focused on creating meaning in one's life beyond what we can *do* and based instead on who we *are*.

This conception of development represents a form of the *liberative* (Loevinger, 1977) or *transcendent* (Levenson & Crumpler, 1996) model of development. Development proceeds by discovering and acknowledging inner conflicts and resolving them through embracing a transcendent self-experience and transpersonally expanded self-identity. Development is the unfolding, unique to each individual, of an indefinite and unlimited range of possibilities, always reducing the individual's previous conditioning and expanding self-awareness and freedom of action.

Organization of this article

Welwood (1984) provides a framework for three overarching principles of psychological (and spiritual) healing: (1) grounding; (2) letting go; and (3) awakening the heart. He speaks of human beings standing on the earth, oriented toward the open sky. Over-absorption in either one results in leading an unbalanced life: our head is either buried like that of an ostrich, or our head is in the clouds. Balance midway between earth and the open sky resides in the heart. Repairing damaged balance requires attending to the practical, the somatic and the "here and now" experience; it also requires letting go of old patterns, beliefs and structures. Then we are able to experience an "open heart," where we allow the vulnerability of taking others in as well as putting oneself out to others: "I took him into my heart" and "My heart went out to her." Welwood describes this open hearted balance as the interplay of courage, humor, and compassion. We will use this structure to examine the ways in which our therapeutic interventions provide corrective emotional experience: each one involves grounding, letting go, and awakening the heart.

We identify more than twenty types of corrective experiences, and suggest that they all fit into one of three categories, related to the three primary existential themes of worthiness, personal power, and identity (Zimberoff and Hartman, 2001b):

(1) building ego strength through release of shame and reclaiming worthiness;

(2) building agency through release of helplessness and reclaiming personal power; and

(3) building authenticity through release of dissociation and identification and reclaiming self-reflective identity.

The article explores in detail each of the following forms of corrective experience.

Forms of Corrective Experience

Release of shame (reclaiming worthiness)
1. abreacting feelings - overcoming early inhibitions
2. "informed child" process, self-awareness, acknowledgement and compassion for oneself
3. legitimizing experience (reducing self-blame through retrieving memories)
4. learning appropriate and realistic self-expectation
5. affect attunement in interpersonal relatedness
6. re-nurturing and re-parenting the inner child

Release of helplessness (reclaiming personal power)
7. learning to discriminate between past and present
8. unlearning helplessness, achieving mastery
9. accepting healthy support
10. reforming and repatterning experience
11. mourning the losses, incorporating the lessons

Release of dissociation and identification (reclaiming self-reflective identity)
12. embracing compassionate self-acceptance
13. increasing ego resiliency
14. learning to discriminate between self-definition and introjection
15. giving meaning to past events that were experienced as bewildering
16. reconnecting memories and emotions to events
17. practicing being in the "here and now"
18. increasing the capacity to be self-reflective
19. reframing the early erroneous conclusions/ decisions
20. reclaiming "lost" parts of the self - reclaiming inner resources and soul retrieval
21. expanding into the transpersonal realm

Table 1. Forms of Corrective Experience

Build ego strength: Release of shame (reclaiming worthiness)

Building ego strength is a vast topic in itself. We have discussed it in relation to preparation for a transpersonal surrender of ego (Zimberoff & Hartman, 2000) and in relation to ego state therapy (Hartman & Zimberoff, 2003b). Here we will present the idea that ego strengthening is essentially a process of releasing shame, and reclaiming the "real self" identity that was lost in trauma. Freud (1923/1964) spoke of the ego being built on the residue of previous identifications (quoted in Slap & Saykin, 1983). To the extent that this formulation is true, and it lies at the core of our developmental approach, then it follows that strengthening the ego requires going back to discover the mistaken beliefs upon which its subsequent development rests. We all "adapted" to the kind of child who got his/her needs met in our families, and then identified with that creation. Call it the "false self." Healing, and "strengthening the ego," means first *dis-*identifying with what we were not in the first place, and then identifying with who we really are.

All of the false self was created out of shame. Put another way, the forces that one reacted to in creating a false self were all shame-based. This is one of the primary existential themes: *worthiness* (the degree to which "I accept myself and embrace life fully") or *unworthiness* ("I am not worthy to exist"). This soul is struggling with God for justification of its existence. Am I significant? Am I worthy to express my true feelings? to enjoy abundance in life? to move through life with ease rather than struggle? to have an intimate relationship with God? Ultimately, am I worthy to exist? Unworthiness is ego-centric, manifested either as inferiority or as grandiosity. These two *seemingly* polar opposites are really one-in-the-same.

Abreacting feelings

Children can only experience their feelings fully when there is a caregiver available to accept and support the expression of those feelings (Miller, 1981). The same is true of an individual who is re-experiencing an intense childhood event in age regression. When children do not receive empathic attunement from their caregivers, their feelings become fragmented and an identity split begins (Kohut, 1977). When certain feelings in the child (e.g., anger, jealousy, fear) elicit anxiety in the caregiver, the child learns to identify these feelings and behaviors as "bad," feels shame, and the self-judgment becomes "I am bad."

"Shame is, of course, the affect that signals a loss of personal identity," yet "the word fails to capture the full magnitude of the experience when one was threatened with traumatic loss of selfhood" (Bromberg, 2003, p. 567). There is sublime release of shame when one is able to experience *in the original regressed ego state* overcoming what was inhibited, forbidden or impossible in that past experience, and expressing it in the present situation. For this to occur in a therapy session, the therapist must give permission, on several levels. Verbal permission may come in the form of changing the word "anger," since many people have been told it is wrong to express anger. For example, the therapist may instead invite the client to express their "resentments. Social permission comes in the form, "It is okay for you to express what you're feeling." Moral permission comes in the form, "You have a right to speak your truth." The therapist also conveys permission by creating an environment that is safely contained on an energetic level. The therapist modulates the intensity of long-buried feelings as they surface by suggesting useful and appropriate methods of doing so. The therapist may keep the aggressive expression localized in one place ("Just hit the pillow and nowhere else"), or call a time out when the client begins to feel overwhelmed ("Let's take a break and you can come back to this in a few minutes"), or suggest a partial activation of the repressed emotions ("Is there *one* of his behaviors that you can express your anger about?") or encourage him/her to continue when they get tired or self-conscious.

The art of psychotherapy may be observed in the ability to maintain balance between encouraging this newfound willingness to connect with threatening emotions, without pushing it past the fragile level of tolerance, triggering heightened shame or fear and the resulting inhibition and dissociation.

> In the session, the threatening dissociated affect must be activated to some degree, but in trace form, regulated sufficiently so as not to trigger new avoidance, and with some transformation of meaning. The questions of how much and when to activate or to permit this activation, so as to repair the dissociation rather than to reinforce it, must be addressed specifically for each patient (Bucci, 2002, p. 787).

The therapist's job in effectively facilitating the client's healing is to provide to the age-regressed "child" what he/she needed originally, i.e., empathic attunement, acceptance and support. We do this by *containing* the client's experience, i.e., empathically experiencing the client's affective

expression and transmuting or digesting it into a more useful form (Bion, 1962).

Modulating the client's activation and expression of previously threatening emotional material also requires the ability to distinguish between *traumatic* reactions and *shock* reactions (Castellino, 2000). Because the topic lies beyond the scope of this article, we will only address this distinction briefly here. Trauma is an injury that occurs during an event that, to some degree, propels an individual toward mental, emotional or physical overwhelm. Shock is a physiological process that occurs in response to trauma when the individual goes into overwhelm. Both levels of injury are deeply embedded in the body and unconscious, shock more pervasively so. When a current experience triggers the embedded shock memory, the body responds as if it is actually reliving the original imprinting experience, a recapitulation of the trauma. Because the response is a reaction to overwhelming personal assault, the recapitulation of it often is an activation of the parasympathetic nervous system, i.e., shutting down and withdrawal of attention, and dissociated loss of conscious awareness.

Providing corrective experiences to repair shock requires slow and steady reconnection with the inner resources which were left behind, abandoned in the tradeoff for the illusion of control. With sufficient safety and corrective attachment experience, the client's shock can be modulated.

One of the aspects of the developmentally arrested ego that we are strengthening through the release of shame is the commitment to life, passion for life, libido. The process of splitting away from the 'true self' has at its foundation shame ("If I was adequate, if I was worthy, I would be accepted as is and wouldn't need to change into somebody different, or stop being altogether"). It has as a primary consequence loneliness, or aloneness. When the child ego state experiences connection and acceptance from the therapist and from the person's adult ego state, and release of the underlying shame, it brings relief from the loneliness. However, there is a deeper level of disconnection than the social disconnect of loneliness: there is fundamentally a disconnect from libido. As Winnicott stated it, "The state prior to that of aloneness is one of unaliveness, and the wish to be dead is commonly a disguised wish to be not yet alive" (1988, p. 132). Releasing the abandoned child ego state from its purgatory of perpetual limbo between life and not-life brings spontaneity, playfulness, creativity into the daily life of the now-unified client.

The expression of anger deserves a special note, because it is so inhibited or uncontrolled in some clients as well as in some therapists.

Anger unexpressed is self-destructive, causing depression and physical disease. According to Blume (1990), the consequences of repressed anger include acting out (i.e., lashing out at or abusing others), acting in (abusing the self), depression, eating disorders, chemical dependency, ulcers, sleep disturbance, anxiety, physical stress symptoms, and suicide. Research by Scott and Day (1996) suggests that adult survivors of childhood sexual abuse who suppress their angry feelings have significantly more fear and anxiety, vulnerability and isolation, detachment, powerlessness, and intrusive thoughts than those who appropriately express their anger. Further, there is evidence that suppressed emotion causes memory loss or distortions (Richards & Gross, 1999, 2000) and immunological compromise (Petrie et al., 1998).

The corrective emotional and somatic experience of expressing the anger fosters an empowering cognitive-emotional shift. "When the client experiences the healthy unleashing of repressed anger toward her perpetrator(s), or others in her social surround, she claims a boundary, or a piece of personal entitlement to certain rights involving safety and protection, personal integrity, emotional reality, and the outward expression thereof, and reinstitutes feelings of personal efficacy and power" (van Velsor & Cox, 2001, p. 618). Claiming that boundary, recognizing the proper attribution of responsibility, occurs naturally in the course of becoming fully conscious of and expressing anger at the perpetrator (Brown, 1998; Cox et al., 1999; Jack, 1999).

Exploration and expression of feelings also thwarts the defense of intellectualization, i.e., continually setting aside being with feelings in the moment in order to gather up more insight and more awareness, called "awareness gluttony" by Enright (1978).

"Informed child" process

The treatment technique of the "informed child" process involves informing the child ego state what his/her erroneous beliefs are, and assisting the client's adult ego state to teach the truth to that child within. One of the most important truths that the child needs to hear and accept is a reattribution of responsibility (Hoagwood, 1990; Morgan & Cummings, 1999). "It was not your fault. There was nothing you could do to stop it from happening. The responsibility and blame belong to the perpetrator." According to van Velsor & Cox (2001, p. 618):

Studies suggest that sexual abuse survivors often take personal responsibility for the abuse (e.g., Courtois, 1999; Mannarino & Cohen, 1996; Morrow, 1991) and that this self-blame relates to poorer adjustment (Hoagwood, 1990); interpersonal problems (Hazzard, 1993); and psychological symptomatology (Feinauer & Stuart, 1996; Hazzard, 1993; Mannarino & Cohen, 1996), including depression and self-destructive behaviors (Morrow, 1991; Peters & Range, 1996).

For example, a client was being berated and shamed at age four for spilling a glass of milk on the kitchen floor. The age-regressed four-year-old boy believed exactly what his father yelled at him, that "I am clumsy, and I am no good." He needed to be informed by an appropriately loving and compassionate authority that all little boys spill things, and that his accident doesn't diminish his value as a person. Often, we have the client access a new adult to teach the child, a parent who appreciates the inner qualities of the child. This can be in the form of someone who was literally available in the four-year-old's life, e.g., a grandmother or a neighbor or an older sibling. The therapist asks the regressed client, "Who is there in your life at age four that could come into the kitchen with you and help you feel safe?" The new adult can also come in the form of the client's adult ego state. However, it is generally preferable to find someone in the first category, since the client probably has a lifetime of experience of attempting to meet his own needs for nurturing. Every four-year-old child needs the experience of receiving nurturing care and loving attention from an *other*. So even though the individual may not immediately find someone in his life in the age regressed situation, really probe and explore for someone before retreating to the second option of bringing in the person's own adult.

Legitimizing experience (reducing self-blame through retrieving memories)
One of the beneficial consequences of age regression therapy is the retrieval of memories that have been repressed, or the experience of bringing greater concreteness to memories that have been hazy or uncertain. First we will speak about explicit, autobiographical memories.
People who have a history of trauma in general, and PTSD in particular, tend to have *overgeneral* memories (McNally et al., 1994; McNally et al., 1995; Kuyken & Brewin, 1995). That is, rather than remembering specific events (e.g., "the day he chased me through the house with a knife"), the traumatized individual tends to retrieve categoric memories (e.g., "when he scared me"). This is true for both positive and negative memories. Searching for specific events can be frustrating,

because a long time period, such as childhood, feels like a blur of run-together and overlapping experience.

Difficulty in retrieving specific episodic memories is associated with poor problem-solving skills, probably because it hampers one's ability to learn from experience. The traumatized person tends to keep repeating the same behavior pattern over and over for this reason.

The gradually increasing ability to retrieve specific memories is gratifying to the traumatized individual. It brings understanding and therefore legitimacy to patterns that have not made sense to the person until now ("No wonder I have always been that way! Everything really makes sense now"). The increased understanding brings a reduction in self-blame, of course. Bringing greater concreteness to memories also can be validating of "hunches" the individual has had, e.g., amorphous body (implicit) memories of sexual abuse becoming specific episodic (explicit) memories of what happened and who the perpetrator was.

Learning appropriate and realistic self-expectation

Often in regression to a traumatic event in childhood, the individual discovers that his deeply embedded sense of failure, inadequacy or unworthiness originated in the inability to perform a task that was, in fact, impossible. For example, a child might develop the strategy of trying to be perfect with a rejecting parent to avoid the pain of rejection. The child is doomed to fail, and yet to keep trying. The tendency then continues through life of having unrealistic expectations, guaranteeing a consistent sense of failure.

On the other hand, many people find in regression to a traumatic event in childhood that they learned to expect too little from themselves. They may have been conditioned to believe that they were more limited than they in fact were. Hearing that "You are not musical – you can't carry a tune" may have resulted in someone avoiding music when they really had musical talent. A highly significant corrective experience is the release of erroneous beliefs that are either too limiting or too demanding, and a refocusing on one's realistic potentials.

One way to understand these two polar opposites is the current work on perfectionism (Wei et al., 2004). Perfectionism can be either adaptive or maladaptive (Flett & Hewitt, 2002). Adaptive perfectionism involves setting high (but achievable) personal standards, a preference for order and organization, a sense of self-satisfaction, a desire to excel, and a motivation to achieve positive rewards. Maladaptive perfectionism involves

unrealistically high standards, intense ruminative concern over mistakes, perceived pressure from others to be perfect, a perceived large discrepancy between one's performance and personal standards, compulsive doubting of one's actions, and motivation to avoid negative consequences (Enns & Cox, 2002).

The individual who is "adaptively perfectionistic" is likely to have a positive working model of herself. However, so is the person who is attachment-avoidant ("I can do whatever I need to do. I always have. I don't need others"). What is the difference in the positive model of self held by these two individuals? Persons with avoidant attachment have a "brittle" or "defensively maintained" positive sense of self (Fraley et al., 1998). They maintain a precarious balance, and when they judge that they have fallen short of the high standards they set for themselves, a sense of despair and hopelessness results.

The adult who has a lifelong pattern of unrealistically high or low expectations is struggling with maladaptive perfectionism. The corrective experience for that person's child in the age regression is to recognize the futility of the attempt to be a "perfect little boy or girl," or alternatively to recognize the folly of having given up striving for legitimately achievable goals. The result of such a corrective experience will be the capacity to distinguish between adaptive and maladaptive perfectionism in oneself.

Incidentally, we would choose different language than Flett & Hewitt to distinguish these two approaches to standards, self-assessment, personal expectations, and motivation to achieve. Because the word perfectionism has a maladaptive connotation inherently, we prefer to see the continuum one of unrealistically high or low self-expectations. At one end of the continuum is the classical perfectionist (Flett & Hewitt's maladaptive perfectionist). At the other end is the individual who has become resigned to unrealistically low standards, a "slacker" in today's slang. The synthesis of these two polar opposites, then, we might label one who is *intrinsically motivated* (Deci and Ryan, 1985, 1991), striving to master challenging but realistic pursuits for the satisfaction of doing so, for personal growth, affiliation and intimacy, and contribution to the community. We discuss the concepts of intrinsic and extrinsic motivation later in this article, relative to the corrective experience of unlearning helplessness and achieving mastery.

Sandy is a young woman who has struggled with relationship addiction for many years and then with the subsequent challenge of wanting to have a baby and being unable to get pregnant. As she began doing the Heart-

Centered hypnotherapy work, we uncovered a long history of never feeling good enough about herself. At the time of her conception, she was considered "an accident" and in the womb Sandy mentally pleaded with her mother to love her. In return she promised to be the perfect little girl and would do everything that her mother wanted. In hypnotherapy work we call this the "unconscious agreement" she made with her mother.

Sandy's mother was young, filled with anxiety, and she had very little ability to bond with her young baby. In fact when Sandy was regressed back to being that baby, she was often left alone in the crib, hungry, scared and feeling very lonely. As Sandy got older she became compulsive in her attempts to be perfect. She anticipated others' needs, studied hard, always trying to get straight A's so that her mother would love her. She controlled what she ate even to the point of developing an eating disorder so that she could look perfect to the outside world. When she felt too fat at 90 pounds, she began throwing up as a means to further control her weight.

By the time Sandy began dating, she was even more desperate to be loved. She tried to be the perfect female, had sex when she didn't want to, and sold her soul for love. When relationships went wrong, she only concluded that she had to be more perfect. Sandy finally met the man of her dreams and immediately wanted to have a child. In her desperate search for love, even if he didn't love her, she felt that surely a baby would. They began attempting to get pregnant, and were unsuccessful over a two-year period of diligently trying. Eventually they went for tests, which showed that nothing physical with either of them was preventing a pregnancy.

Through the hypnotherapy work Sandy began to realize that it was her pattern of perfectionism that was stopping her from getting pregnant. She was unconsciously afraid that she would make the same mistakes her own mother had made and thus not be the perfect mother. The pattern was so clear to her now, she had an amazing and profound realization: ever since the moment of her conception she had been bargaining for her very existence, driven by shame and the fear that she did not deserve to live. Over time, she became clear on how to release this old pattern through self-acceptance, "warts and all" as she said. Now Sandy feels very adequate and no longer demands perfection of herself; she really is ready to welcome a new baby into her life.

Affect attunement in interpersonal relatedness

Affect attunement incorporates the experience of being witnessed and tracked; intimately understood through an interpersonal relatedness; having dissociated feelings identified by name, and words given to one's experience ("You look scared," or "I feel how shameful that was"); and having those feelings validated and normalized ("You have a right to feel angry," or "No wonder you are so frightened"). It is the intimate communication that enables a parent to share and amplify her child's positive emotions and share and soothe negative ones (Siegel, 2004).

Affect attunement is the term used first by Stern (1985) to designate the sharing of affective states in an intimate relationship. It is related to, and sometimes referred to, as mirroring, empathic responsiveness, or affect synchrony. During the first year of life, it is the predominant mode of communication with caregivers and others; the newborn infant experiences everything, objects and events, mainly in terms of the feelings they evoke. Indeed, Stern asserts that "most of the infant and parent's time together is spent in active mutual regulation of their own and the other's states, in the service of some aim or goal" (Stern et al., 1998, p. 906).

Affect attunement continues to be a central need and focus of activity in relationships through the lifespan. When there has been consistently unrepaired misattunement in the infant's experience, the result is disruption in an ability to enter and maintain healthy intimate relationships during the first few years of life, which in turn is related to difficulties in later years in forming close relationships (Fonagy et al., 1991; Rutter & Rutter, 1992; Slade & Aber, 1992). Importantly, the converse is true: close relationships later in life can compensate for an earlier lack of same (Quinton & Rutter, 1988, cited in Rutter & Rutter, 1992). The original lack is recorded emotionally, cognitively and somatically; the later compensation must work on each of these levels to be effective.

Prolonged disruption of the needed attunement in relationships results in the person experiencing a sense of emptiness, anxiety, frustration and aggression (Erskine, 1998). "Early attunement failures are experienced as shameful by the infant/child, and without repair they form a nidus for later destructive adult interpersonal relationships, 'social blindness,' and depression. . . . The role of empathic attunement experienced in the unique setting/structure of psychotherapy emerges as the single critical variable for a successful outcome" (Spiegel et al., 2000). The "social blindness" is a primary symptom of this pervasive underlying developmental deficit, and is the reason treatment in a group setting can be so effective. Not only does

interaction in the group bring the pattern to the surface, but it is also the group relationships that can begin to compensate for the earlier deficit.

Through affect attunement the therapist and/or group members enter the client's "developmental spiral," reactivating and revitalizing the client's thrust to continue his/her development when it has been fixated, distorted, or derailed (Elson, 1991).

The act of telling one's story, the truth of one's experience, is healing in itself. For example, the simple act of writing daily in a personal journal improves people's general health (Pennebaker, 1999). Having one's telling witnessed by someone else who bears witness to your truth increases the power of the healing. In fact, Laub (1995) discusses the difficulties of Holocaust survivors in experiencing how profound was their trauma: "This loss of the capacity to be a witness to oneself and thus to witness from the inside is perhaps the true meaning of annihilation, for when one's history is abolished, one's identity ceases to exist as well" (p. 67). We often see the self-doubt that arises for an individual who encounters troubling memories in age regression. The person's identity itself is at stake in how the encounter is resolved. Will the experience be discounted and denied as it was originally, carrying the message and the legacy, "Don't believe your experience; doubt yourself." Or will the individual find supportive validation from a respected other, the authority and caregiver. Trauma survivors often cite the importance of their therapist's validating role (Herman, 1992; Phelps et al., 1997).

Of course, it is not helpful to the client to have experiences *that did not happen* validated. That promotes confusion and damages his/her reality testing. For example, in psychodrama we refer to "reforming" a character when we have the client experience in regression positive interactions when in historical fact they were negative. Using this technique, the client in psychodrama might encounter his father as being supportive after losing the "big game" as a senior in high school, whereas in reality his father was shaming and rejecting on that occasion. That is one of the traditional psychodrama techniques that we see as counterproductive in Heart-Centered Energetic Psychodrama, and we do not use it.

The therapist usually cannot know with certainty the historical accuracy of remembered experiences in age regression. However, in Heart-Centered therapies, when the client has a clear emotional connection with the childhood regressed experience, it is much easier for the therapist to validate the memory than if it is just a mental conjecture about what might have happened in a less experiential modality of therapy.

Van der Hart and Nijenhuis (1999) suggest that the therapist maintain a reflective belief in the client's memories, meaning that the therapist is supportively open to what the client reports while analyzing any corroborating evidence of aftereffects of traumatization (PTSD symptoms): emotional, behavioral, and somatosensory responses such as conditioned startle response, anesthesia and freezing, dissociation, and sensory-level re-experiencing of the event. With this approach, the therapist bears witness *and* promotes reality testing, and in the process assists the client to reclaim a sense of personal narrative memory and identity *and* an enhanced capacity for reality testing. The process of being witnessed and validated is most crucial to healing.

Hoskins (1999) describes useful principles of "cultural attunement," i.e., working across differences with ethnic and cultural diversity. The proscriptions are to acknowledge the other's pain of oppression, to engage with humility, reverence, and mutuality, and to come from a place of "not knowing." These are similar to the "reflective belief" procedures advocated by van der Hart and Nijenhuis.

It is the process, the context of communication rather than the content of the communication that provides the foundation for therapeutic change. Lyons-Ruth and colleagues assert that what makes for personality growth is change in *procedural* memory (knowing *how* rather than knowing *that*) and "process leads content, so that no particular content needs to be pursued; rather the enlarging of the domain and fluency of the dialogue is primary and will lead to increasingly integrated and complex content" (Lyons-Ruth & Boston Change Process Study Group, 2001, p. 16).

A healthy therapist/ client relationship helps to correct the client's old patterns of interpersonal relating, be they rescuing, avoiding, ambivalent, controlling, etc. The space created by the therapist to nurture such a healthy relationship is one of inclusion, a term Buber (1965) used to designate a bold swinging of one's being into the life of the other. Buber (1958) speaks of this space as a "category of the between," not I and not Thou, but I-Thou, a mutuality of intimacy. The client's experience of I-Thou provides a correction to the experience of I-It, in which the person has traditionally experienced relatedness superficially, as role to role, as two personas interacting. Trauma can be understood as the experience of being made into an object in relationship (Spiegel, 1997), and the experience of being in an attuned relationship helps to heal the residual damage of that trauma. "It is the moments of *real* and genuine meeting that

make psychotherapy work" (Portnoy, 1999, p. 32), the *being with* (O'Brien & Houston, 2000) that is so crucial in the therapeutic endeavor.

Effective therapists use their awareness of their own experience in response to the client's experience during the session, as a clue to what the client's experience is. This somatic and emotional attunement is a therapeutic tool to discern the difference between the client's reactions and their own. Such a conscious awareness also protects the therapist against "vicarious traumatization" (Rand, 2002). We believe that the best protection for the therapist against vicarious traumatization is to do their own personal therapy work. As therapists progress in their own release of trauma, they are much more able to be fully present and supportive for their clients, and much less likely to have their own issues triggered by those of their clients.

Re-nurturing and re-parenting the inner child

The client's "internal family of ego states" includes various ages along the lifespan, from prenatal, newborn and toddler states through adolescent and adult states. That family also includes introjected parental figures, those who nurtured the child as well as those who were abusive, neglectful, or abandoning (Watkins & Watkins, 1997). The individual who comes to therapy or seeks personal growth has a developmental deficit in both the current reality ego state as well as in various child states. This person did not complete the introjection of a healthy nurturing caregiver, or the healthy introjections were outweighed by unhealthy introjections.

Before such an individual can re-nurture and re-parent his/her own inner child, a transitional corrective experience (Phillips, 2004) must be provided to bridge the gap. Her adult must experience being nurtured and parented sufficiently to allow it to, in turn, re-nurture and re-parent the inner child.

The therapist or a group therapy member can provide that transitional corrective experience, lending ego strengths to the client's underdeveloped reality ego, which in turn is utilized as the "good enough" parent to re-parent the child ego state (Dungee-Anderson, 1992). This is a stepwise process: first, the client is taught to recognize and differentiate both the underdeveloped reality ego and the developmentally arrested child states by their affective and behavioral characteristics. Then the therapist re-parents the client's adult ego state, strengthening him/her sufficiently to be capable of finally re-parenting the client's own child ego state. The ultimate outcome of this process is the completion of the introjection of

positive models of mature nurturing which was not completed in childhood due to the unavailability of such a model (Phillips & Frederick, 1995; Frederick & McNeal, 1998).

Murry-Jobsis (1990a, 1990b) has offered specific suggestions on assisting a regressed client to activate self-nurturing with early bonding, forming a positive sense of identity in the early weeks and months of life, discovering a more secure experience of being held, soothed and fed, and beginning to enjoy separateness.

Catherine was a fifty-year-old woman who had been incested by her father from the age of four to eight. The abuse typically took place with her father saying to her, "Okay, Catherine, now go into my bedroom, take off your clothes, and lie on the bed." In a psychodrama regression to age five, Catherine responded to a man playing the role of her father saying those words by automatically moving forward to obey. There was not a strong enough adult Catherine present to support the five-year-old Catherine to invent a new response. We immediately stopped the action of the psychodrama, and introduced a surrogate parent to provide what the five-year-old needed: parental nurturing that emphasized love and respect, safekeeping and appropriate affection. The surrogate told her, "You are a beautiful little girl, you are innocent. You do not ever have to go into your daddy's bedroom like that again. What he did was wrong, and I will keep you safe. You deserve to be treated with respect, and to receive real love." It took twenty minutes of being held and hearing these statements for Catherine to return to her body from the emotional distance of her dissociation. With the safety provided by the surrogate parent, five-year-old Catherine was able to say "No" to her father's command. She expressed her outrage at him. Then we "grew her up" from the five-year-old state to an adult state, and helped her to integrate that ego strength. Now the adult was strong enough to re-nurture and re-parent the child. We allowed her to hold a surrogate five-year-old Catherine, comforting her and keeping her safe from her father. The experience of the adult relating to the inner child reinforced Catherine's adult ego strength, bringing full circle her introjection of a positive model of mature nurturing.

Build agency: Release of helplessness (reclaiming personal power)

A human need critical for the achievement of higher-order needs of autonomy and individuation is that of *agency*, the individual's experience that he freely chooses his actions and that he can potentially make the

choices based on the dictates of his own intrinsic needs and strivings (von Broembsen, 1989a). One of the common dysfunctions in the developmental process is identity created as other-centered, leaving the child (and eventually the untreated adult) helplessly dependent on the other for validation of the self. Reclaiming one's identity as self-directed releases the helplessness and brings a sense of sovereignty, or agency. We use the term personal power interchangeably with agency.

If the caretaking adult's needs become the reference for the self-definition of the child prior to the child's developing a sense of agency, the result is an other-centered role identity. This developmental phase coincides with the prenatal period from conception through differentiation/individuation (at two weeks after conception). The child's self splits, leaving the child helplessly dependent on the other for validation of self. Rather than "I choose to do this because it fulfills an intrinsic striving of my self," the person experiences "I get to do this (because you allow me to)" or "I have to do this (because it is your will)." At this stage of development, abandonment is realistically tantamount to annihilation (von Broembsen, 1989b). The child's worth is determined by her usefulness to the caregiver. If the role performed loses its value, the self's legitimacy is threatened. It is clear how the child's role identity is experienced as necessary for continued existence; to attempt to grow out of the limitations of the role equate with annihilation. Because this pattern is embedded at the level of survival itself, it continues unconsciously and stubbornly resistant to change through the lifespan, until it is reformulated.

This individual in therapy, attempting to change her self concept is literally unable to move forward until accessing the ego state in which her self-definition was linked to the demanding other, and then changing it. How can it be changed? Three factors are crucial (von Broembsen, 1989b). First, the individual must recognize the other-centered nature of his role identity, and accept that he need not continue to accept it as central to his own identity and existence. Second, the person must recognize that the role itself can serve both healthy and pathological needs, and that he can choose when and how to play that role. And third, the individual makes a deliberate and conscious choice of whether to keep specific aspects of the role *for the self's sake*. "This factor is the keystone that secures the self's entire structure. It involves examining the role and redefining it, if necessary, so that it supports and expands the healthy aspects of the self, and extinguishes its maladjustive conditioning. . . . [T]aking possession of the role transposes the locus of control, and therefore the power to validate

the self, from the other to the self. . . . This conscious, *intuitive* adjusting of role demand and self identity is the ultimate experience of agency. . . . It expresses the self's acceptance of its separateness and of its connectedness" (p. 336).

Bringing the choice of role and identity into active consciousness results in the experience of agency, or personal power. Agency brings movement away from contingent self-esteem, dependence of social approval, and psychological defenses, and toward greater openness, awareness, and self-acceptance (Rogers, 1961).

Viewing the world as a safe and predictable place and seeing oneself as a competent agent in that world are important psychosocial resources for handling stress (Turner & Roszell, 1994).

Learning to discriminate between past and present
Alexander and French (1946) asserted that the principal curative power of treatment occurs as the patient gains the emotional perception that he is no longer a child and no longer subject to the unconscious behavior patterns put in place at that time. The patient makes that shift when he can express his aggressiveness toward the therapist without being punished, and can assert himself without being censured. Alexander offers the example of a patient's early expressions of aggression having been intimidated by a father who required complete submissiveness from his son. As a result the patient has become inhibited in all situations in which he faces a person of authority. By reviving the past emotional reactions toward the father in a now-corrected circumstance, we enable the patient to develop the power to differentiate between the original childhood situation and his present status, to discriminate between the past and the present situation. He will then realize that he is no longer helpless and can assert himself with others. The actual corrective emotional experience is needed in order for the patient to gain the new perception that he is no longer a child facing an omnipotent father.

The corrective experience allows an individual to experience a difference between the way it was, and the way it was as he/she is now able to experience it. His perspective is changing; he may be perceiving more support than he did at that time; he may recognize benefits of having the experience that he couldn't at that time; etc. The corrective experience provides a transitional space, activating a *transitional state*, in which the person is not caught up in the old, nor is he yet ensconced in the new. Bromberg (1998, p. 278) describes this space as "a twilight space in which

'the impossible' becomes possible; a space in which incompatible selves, each awake to its own 'truth,' can 'dream' the reality of the other without risk to its own integrity." In other words, the client's here and now self shares consciousness with the earlier perceptions of self which were dissociated because they were so painful. The self of today, the reality ego, strengthens the fragile regressed ego state. This transitional state is analogous to the process, for a Dissociative Identity Disordered (MPD) person, of bringing co-consciousness to multiple dissociated states on the way to integration of those disparate states.

In this process, the client is taught to recognize and differentiate both the underdeveloped reality ego ("This is now") and the developmentally arrested child ("That was then") components of the split-ego structure by their affective and behavioral characteristics. The therapist systematically applies ego strengths to the underdeveloped reality ego, the ego state who has sought out therapy. This ego, reinforced by the therapist through various ego-strengthening methods, is then utilized as the available new nurturing parent to re-parent the child ego state. The reality ego, called on to "be there for" the child ego, is strengthened in the process. In this "twilight space" of incompatible selves, both ego states prop each other up, bringing growth to the developmental arrest of the child state, and empowerment to the underdevelopment of the adult state (Dungee-Anderson, 1992).

James was a man of about forty who had a history of many short-lived relationships with women. He seemed to be looking for someone to help him feel complete, but soon after falling in love with a woman he began finding fault with her. When he made his growing dissatisfaction clear, as if to say "You are not the one," the woman felt hurt and betrayed, and left. In hypnotherapy age regression, James went back to very early in his womb experience, within weeks of conception. He realized that he had a twin in the womb with him, and he felt intimately connected and complete. The fetus that was his sister could not survive, however, and he experienced profound despair at the inexplicable loss. In the session, James grieved the loss of his twin that he had never consciously known about. He felt that he was able to contact that Soul in the spirit world and make peace with his huge sense of loss. The pattern in his adult relationships of endlessly trying to recreate that feeling of sharing the womb with a twin became crystal clear. And he discovered over the coming months that grieving that previously unknown prenatal loss allowed him to be fully

present in relationships. He no longer had the gnawing sense with his current girlfriend that "You are not the one."

Bringing yesterday into today happens quite often when people spontaneously regress without knowing it. They may be "triggered" by a person or a situation which takes them back to their childhood and suddenly, *back then* becomes *right now*. A woman we will call Lara, was sitting in a class of approximately 30 professionals when it was discovered that some students had differently numbered pages in their notebooks. There was some flurry of discussion in an attempt to get everyone "on the same page." Lara became obviously upset about this situation, began yelling about how unprofessional the institution was, jumped up and ran out of the room.

She was obviously triggered by this situation and as the teacher in the group I said to her as she left the room, "It looks like you have a clearing to do, do it in your head." A clearing is a process that we have designed for this exact situation so that the person can go back into their childhood and see what was *then* that has been brought into the *now*.

Lara, because her past was intruding on her current experience, heard me say, "It looks like you have a clearing to do, go to the head." In other words she thought that I, as the teacher, was sending her to the bathroom because she had acted out in class. Later that day, Lara did a hypnotherapy session on this and it took her back to being in kindergarten at age five. The children were supposed to go home and watch television to find out about the weather. Because there was so much chaos in her alcoholic family, she was unable to concentrate on the news program to get the information she needed. She had so much shame at failing. When she went to school the next day without the information, the teacher further shamed her and told her to go home and "Don't come back until you get it." The next night she tried to quiet her family down so she could focus on the six o'clock news on the television set in the living room. Her mother was so angry with her that she said, "If you want quiet, go to the head," referring to the bathroom. Lara's reaction in the classroom that day was her kindergartener reliving a traumatic experience that happened long ago, but that was still present for her because it had never been resolved.

The healing begins with understanding and building resource states so that the adult can tell the difference between then and now. It is also important for people to know when they are spontaneously and unconsciously regressing, and how to bring themselves back to the present.

Unlearning helplessness – achieving mastery

Mastery is a generic construct under whose wings are the related concepts of self-efficacy, locus of control, empowerment, positive future thinking, trust and hope, ego strengthening, self-resourcing, and psychical energy and vitality. These ways of experiencing life are incompatible with early fatalistic conclusions that one is helplessness in a threatening world.

The work on self-determination theory by Deci and Ryan (1985, 1991) is useful in understanding the process of achieving a sense of mastery in one's life. Motivation can be intrinsic or extrinsic: "sometimes people act out of their deepest, most whole-hearted and growth- oriented motives and needs, whereas other times, they act out of feelings of pressure, coercion, or bad faith" (Sheldon & Kasser, 2001, p. 36). Extrinsic motivations are primarily defensiveness and security needs, reflected in the pursuit of wealth, possessions, status, popularity, attractiveness, and image. The three forms of extrinsic motivation are external (acting to get rewards or avoid punishment), introjected (acting to avoid self-imposed guilt or anxiety), and identified (acting in accordance with felt personal values) (Ryan & Connell, 1989). Sheldon and Kasser (2001) give the following examples: a man might change his baby's diaper only because he knows his wife will scold him if he doesn't (external), only because he will feel bad about himself if he doesn't (introjected), or only because he cares about the baby and endorses hygiene as a value (identified).

Intrinsic motivation is the authentic, self-organized state in which the individual strives to master environmental challenges purely for the satisfaction of doing so. Intrinsic motivations direct one toward personal growth, self-acceptance, affiliation and intimacy, a sense of generativity and contribution to the community. When people are intrinsically motivated, they typically feel intense interest and absorption in their activities, are passionately committed to them, and may lose track of time and self while engaged in them. The state is similar to the "peak experiences" described by Maslow (1968). Intrinsic motivation is most likely to occur when the individual's needs for autonomy, relatedness, and competence are met. The corrective emotional experiences described in this article all contribute to one or more of these three human needs, and ultimately to the individual becoming free of defensiveness and security fears, free to pursue intrinsic motivations.

Sexual, physical, and psychological abuse disrupts the development of certain cognitive components of the self, such as self-agency (Harter, 1999). For example, a sexually abused child is more likely to compare

himself less favorably with his peers and incorporate beliefs that he is inferior. Trauma disrupt the individual's ability to perceive emotional stimuli because the abused child is compelled to direct his attention to external threats rather than developing self-awareness skills, such as the ability to attend to one's own needs, thoughts, and desires. Another way that child sexual abuse hinders the development of self-efficacy is through the proliferation of negative self-evaluations and negative core beliefs. Research indicates that children who experience serious maltreatment and abuse describe themselves in more negative terms, report greater feelings of inadequacy and incompetence, and manifest lower self-esteem (Bagley & Mallick, 2000; Dinwiddie et al., 2000; Gagnon & Herson, 2000; Higgins & McCabe, 2000).

Those feelings of inadequacy and incompetence in childhood become a lifetime pattern unless treated. Long-term correlates of childhood sexual abuse have been identified, including depression, fear, anxiety, guilt, anger, and poor interpersonal functioning. Research (Paunovic, 1998) on the cognitions of adults who were sexually abused as children indicates that they more frequently generated statements of self-blame and self-denigration or lowered self-efficacy. For example, women with a history of child sexual abuse were more likely to blame themselves for negative events while attributing external factors over which they had no control as the causes of positive events. Research by Gagnon and Herson (2000) on adults who were sexually abused as children indicates that, because abuse may arrest specific childhood developmental tasks (e.g., ability to form secure attachments, autonomy) or facilitate development of coping strategies that are maladaptive when outside of an abusive environment (e.g., generalized interpersonal distrust, avoidance, dissociation), the survivor may be at risk for developmental vulnerabilities in adulthood.

Some symptoms of trauma generally take a long period of time to develop. Levine (1997, p. 149) suggests such symptoms include: excessive shyness; muted or diminished emotional responses; inability to make commitments; chronic fatigue or low physical energy; immune system problems and certain endocrine problems such as thyroid dysfunction; psychosomatic illnesses, particularly headaches, neck and back problems, asthma, digestive, spastic colon; depression, feelings of impending doom; feelings of detachment, alienation, and isolation; fear of dying, going crazy or having a shortened life; abrupt mood swings, including rage reactions, temper tantrums or shame; exaggerated or diminished sexual activity; feelings and behaviors of helplessness; inability to love, nurture and bond

with other individuals; difficulty with sleep; reduced ability to deal with stress and to formulate plans.

Emotional self-efficacy is the belief that one is in control of one's emotional experiences from the perspective of mastery and positive self-regard. "Self-efficacy research indicates that emotional competence can be learned" (Diehl & Prout, 2002, p. 262). Corrective experiences will challenge people's self-evaluations of inadequacy and incompetence, and their negative core beliefs, by providing a convincing perspective of the individual as masterful. This will, of course, increase his/her sense of personal power.

Elizabeth is an example of a woman who came to us with very low self-esteem, generalized distrust of authority, and was complaining of memory loss. She felt as if some wires had been "fried" in her brain since, although very intelligent, she kept losing words, names and important events in her life. She described herself as "scatter-brained."

In the hypnotherapy she went back to being in a very strict school where she was severely admonished by the teacher for making a reading mistake in class. She was made to pull down her underpants in front of the whole class, bend over and pull up her dress while she was whipped with a switch. The shame and humiliation hurt thousands of times more than the whipping itself. In that experience, she went into shock and could no longer express herself at all in school. Each day, from then on, she dreaded going to school. Each time the teacher called on her, she withdrew more and more. She was continually whipped, shamed and humiliated by this same teacher for two years.

During the abreactive emotional portion of the session, Elizabeth was, for the first time in her life, given permission to speak back to this authority figure. She was able to take back her power for the young school girl that never had a voice. Her corrective emotional experience was so powerful that, in the end, she was able to reclaim her brain. She recognized the young girl as intelligent and fully capable of a high level of cognitive functioning. We worked on visually reconnecting all the disconnections she experienced during the emotional shock of the teacher abuse. It seemed to her literally like an electrical wire that gets "fried" when too much voltage is shot through it. Several weeks after the hypnotherapy session, Elizabeth reported a great and steady improvement in her memory as well as a reduction of anxiety. She also reports a growing increase in her self-esteem and self-confidence, and no longer identifies herself as "scatter-brained."

Accepting healthy support

One of the tragedies of a traumatic childhood is the loss of the vitally important experience of being supported, nurtured, and kept safe. The more pervasively absent are these experiences in the child's life, the more severe his/her psychopathology. It is very important for the age-regressed ego state to experience appropriate and healthy support. If, in the hypnotherapy session, support is not available at the moment of a traumatic event, we must bring it in for the child to experience. That support can come in the form of one of the adults in the child's life at the time (a grandmother, teacher, policeman), an older sibling, a make-believe substitute, a spiritual connection, or the client's own adult ego state. The most preferred option is for the age-regressed ego to experience a supportive adult who was actually in the child's life at the time, coming into the traumatic scene to provide safety, nurturing, and bonding. In this way the individual's child state experiences healthy re-parenting in a manner that comes closest to "real life," and requires the least suspension of disbelief.

Resorting to the other alternatives listed (an older sibling, a make-believe substitute, a spiritual connection, or the client's own adult ego state) is progressively less satisfying to the child ego state, with the re-parenting aspect experienced less viscerally and more conceptually. Yet each alternative does provide the needed transitional object, bridging the gap between the needed (but unavailable) parent and the not-yet sufficiently developed self. When God or a spiritual connection is the support provided, God becomes the transitional object (Winfrey, 2000). In addition to the "re-parenting" effect, this also offers the opportunity for a re-imaging of the client's views toward God and a repositioning of his/her trajectory of faith.

The timing of bringing in such support in the regression is delicate but vital. If the facilitator rescues the client by rushing in too soon with help, the client is cheated out of sufficient re-experiencing to clarify the unconscious life pattern. If the facilitator delays too long in bringing help, the client is re-traumatized.

The adult must relate with compassion and a sense of nurturing bonding with her own age-regressed inner child. It sometimes happens in initial sessions that the adult rejects the child he/she discovers in the age regression to a traumatic memory. He cannot abide the whiny little seven-year-old (who is abused and then laughed at) who is mortified by shame,

and can see him only as a cry-baby. She cannot tolerate the little four-year-old girl who has been sexually abused, and can only see her as dirty and disgusting. Each of these clients needs to find a "transitional object" to allow compassion to grow, first with an outside "other" and then eventually with the inner child.

Reforming and repatterning experience

Alexander and French (1946) claimed that "re-experiencing the old, unsettled conflict *but with a new ending* is the secret of every penetrating therapeutic result." The actual experience of a new solution to an old problematic pattern convinces the person that a new solution *is possible*, inducing him to replace the old neurotic patterns. Through repetition, these corrected reactions gradually become automatic and evolve into a new higher level pattern of functioning.

The child has few alternatives available in response to traumatic circumstances. He can avoid through dissociation or compulsive behavior. He can attempt to control through age-inappropriate caretaking. Or he can identify with the aggressor, and become self-abusive and/or a bully with others.

In returning to the early traumatic moments in age regression, however, the individual has vastly more life experience with which to gain perspective on what happened, how it happened, and why. He brings with him an expanded menu of behavioral options to choose from. An important aspect of the corrective experience is to recognize and act on that expanded menu of choices, while compassionately recognizing the child's plight, without blame for the choices made at the time. He also has the decisive benefit of having a facilitator along for the journey, to guide the changes to the re-experiencing that will guarantee it has a "new ending." Some of the methods we employ in that facilitation are the behavior modification and NLP techniques of systematic desensitization, modeling, reinforcement and in particular anchoring, rehearsal, and reframing.

Utilizing behavior modification techniques in the ego-regressed state of trance amplifies their effectiveness in changing behavior (Hartman & Zimberoff, 2003a, pp. 115-119), even somatically embedded behavior patterns (Hartman & Zimberoff, 2003b, pp. 77-80).

One behavioral technique that is extremely effective in the trance state is extinguishing an unwanted symptom, a form of systematic desensitization (Wolpe, 1958). The method rests on the premise that a person cannot experience two incongruent mental states simultaneously.

Therefore, the person creates a positive mental state that is incongruent with the unwanted dysfunctional state, and anchors that resource state for easy retrieval. Then when experiencing the unwanted negative state, the client uses the anchor to bring back the resource state, shifting the hypnotically focused attention, and thus supplanting the unwanted state. Thus, the client rehearses and becomes proficient at readily entering a self-induced hypnotic trance state, even in the presence of previously distracting stimuli. This enhanced capability for self-control is itself reinforcing. This process works well to alleviate such unwanted dysfunctional symptoms as shame, guilt, self-blame, unworthiness, phobias, anxieties and fears. Performing desensitization within the trance state is more powerful than nonhypnotic desensitization because the capacity for visualization is enhanced in hypnosis (Deiker & Pollock, 1975; Glick, 1970); because posthypnotic suggestions can influence the client to make contact with the phobic stimulus in real life (Gibbons et al., 1970); and because information processing in hypnosis is nonsequential, allowing the client to master progressively more difficult items on the hierarchy simultaneously (Spies, 1979).

Another important behavior treatment is *modeling*, or social reinforcement (Bandura, 1965). Modeling is a technique to induce a subject to imitate a constructive behavior so that it can be further positively reinforced. We use modeling in cathartic expression by raising the voice and using demonstrative language, for example, and in empowerment experiences by using assertive statements. The client in hypnosis is highly receptive to such modeling by the therapist.

One of the most important behavior modification techniques used in our hypnotherapy is that of *anchoring* (Bandler & Grinder, 1979). Based on the process of *paired associates* from learning theory, anchoring associates a feeling of being powerful with a mental or visual image which represents a desired behavioral outcome for the client. In the therapeutic setting, the client mentally rehearses the desired behavior (which is itself helpful), and experiences an independent sense of empowerment simultaneously. Thus, a link is established between doing the behavior and feeling powerful. This greatly increases the probability that the client will exhibit the desired outcome behavior subsequently in his/her life. We use anchoring in virtually every session to embed the client's newly reclaimed inner resources for predictable retrieval.

It is essentially important to anchor the state produced by the corrective experience in order to reinforce the access route to it for future

use in times of stress, confusion or re-triggering. The process of anchoring itself can be corrective, in that it is a deliberate act of self-nurturing and self-care.

One of the benefits of utilizing the trance state is the realness of rehearsal when the individual has suspended disbelief. Rehearsal can take the form of imagining, "acting as if," and fantasizing circumstances of a feared experience in a removed and relatively safe manner. Rehearsal sometimes occurs in the context of age progression also. Mental rehearsal techniques enhance coping abilities by increasing the individual's self-efficacy expectations for the specific situations that have been rehearsed (Marlatt & Gordon, 1985).

Reframing is the process of releasing what no longer serves and converting it to something that does. Bandler (1978) elaborated seven steps in his reframing model of ego state therapy which correspond to sequencing in the Heart-Centered therapy process. Bandler's steps are:

1. Identify the dysfunctional behavior that needs to be changed
2. Identify the ego state responsible for the dysfunctional behavior.
3. Establish communication with the ego state responsible for the dysfunctional behavior.
4. Separate the behavior pattern from the intention
5. Negotiate with the responsible ego state to replace the old pattern with a new pattern of behavior that is appropriate to the individual in the present reality and that satisfies the original intention.
6. Ratify the new behavioral pattern with the responsible ego state.
7. Conduct an ecological review of the entire system to confirm the acceptance of the new behavioral pattern and get a commitment for action.

These steps are very effectively accomplished with age regression in the trance state. The behavior that was initially experienced includes the environmental conditions encountered as well as the individual's reaction to those conditions. The reaction, or behavioral decision, is what can be changed by bringing to bear the resources and support brought to the early experience by the returning adult. The new behavioral decision is chosen to meet, in a more effective way, the original intention. The six-year-old girl who begins wetting the bed, knowing she cannot tell her parents about being sexually abused by Uncle Fred because she knows they would believe him and not her, chooses that behavior to fulfill the intention of communicating her dilemma in the best way available among highly

limited choices. A new behavioral choice in the age regression, with new resources available, is to tell the parents everything; not just what happened, but also her feelings of disgust and shame at the betrayal, and her anger and hurt at not being protected.

The repatterning can also take place on the somatic level. We consistently keep the individual's attention focused on her emotional *and* somatic experience: "What emotions are you feeling? Where do you feel that in your body? What is the sensation?" Helping the person to become aware of and to label the body experiences ("body memories") aides in providing a clear bridge to follow back to the source trauma. The bridge works because the body memories create a replicating supply of traumatic energy. It also provides a baseline of somatic symptoms from which to launch the somatic healing. Emerson (2002a) provides the example of trauma posture (emotional responses "crystallized in the body"). Certain postures tend to be associated with trauma, and these postures remain as somatic memories, embodied throughout life, until the foundation trauma is resolved and until the postures are identified and repatterned. As trauma and trauma postures are resolved, "the tenets of the old belief systems begin to shift and loosen their grip on dysfunctional facets of the personality" (Emerson, 2002a, p. 70).

Rebecca has always had patterns in her life of creating stress and making things more difficult than they need to be. She struggles through situations which need not be a struggle at all. After years of therapy, Rebecca finally found her way to Heart-Centered Hypnotherapy. Her sessions almost immediately went back to her very difficult breech birth which lasted for hours and she was literally "pulled out" butt first by the doctors. This was extremely painful and terrifying for her as well as for her mother.

We combined her hypnotherapy with breathwork, which is a technique designed to take clients even more directly into their birth experience. She spent many sessions re-experiencing her painful breech birth, struggling to be free. Each time she "struggled" to change her life experience, but seemed to be unable to do so. Finally she became clear that she needed to "redo" her birth experience. In the regressed state during her breathwork session, Rebecca became clear that she could now have a head-first birth experience. She asked for help to be turned around in the womb, and then used her legs to push herself out through the birth canal. She has done that in her last several sessions to recreate a new birth pattern at the deeply imprinted cellular level. She is finding an amazing experience in her life

with this repatterning. She is no longer struggling in her relationships, and her stress level has been greatly reduced in her daily life.

Another example of reforming experience is Judy. Judy had spent thirty years in an abusive marriage with a husband who had numerous humiliating sexual affairs and on one occasion raped her in a drunken rage. Feeling totally helpless in this relationship, she had retreated emotionally into a pervasive state of shock and dissociation over almost the entire thirty years. She functioned very well in her profession and socially among the many well-to-do acquaintances in her upper-middle class life. How could this happen? How can an intelligent, educated professional woman live in a state of confusion with an abusive man for so long and not confront the situation? The answer lies in her self-replicating supply of somatic memories and what Freud called repetition compulsion.

In a particular psychodrama that we did with Judy, she began working on a persistent feeling of choking, which went back to her husband choking her as he was raping her. This is a body memory. This memory carries somatic energy which lives in the system and resonates and attracts whatever is similar in the system. As she regressed on the somatic bridge, Judy went back to other times in her life in which she had that same choking feeling. This took her back to many times in childhood when her own mother was abusively choking her, and she dissociated from the shock of the betrayal. We began to realize that Judy had a long childhood pattern of going into shock because of the abuse suffered from her borderline mother. The energetic somatic memories of what happened in childhood had literally set the stage for Judy's passive acceptance of her abusive husband in adulthood. Judy's unconscious conclusion was that "I am bad, and I don't deserve to live," and her behavioral decision based on that absolute unworthiness, was that she was just going to have to be quiet and endure. She was not living, she was enduring; rather than thriving, she was merely surviving.

Through her healing work, Judy gradually was able to redirect the energy in her throat from that of choking to the energy of assertiveness and freedom. The physical sensation in her throat became a trusted barometer for her of how passive or assertive she was in situations in her life. The more passive she was, the more her throat constricted. The more assertive she was, the more her throat relaxed. Soon, she took her personal power with her husband by divorcing him and demanding an equitable settlement. Judy says she has gotten her life back, that she is not just enduring any more. She has reclaimed her dignity, and her faith in humanity. She is

releasing the shock that kept her confused for so many years. She is now vibrantly alive, and making healthy choices for herself in her new life.

Mourning the losses, incorporating the lessons

Mourning the losses of traumatic experience in age regression is essential to healing, and is a prerequisite to embracing the lessons of the experience. The losses may be of qualities, such as innocence, courage, or trust. Losses may be of relationships, through death, divorce, or betrayal. The loss may be of a potential that will never be realized, such as a woman acknowledging the loss of her virginity at the time of child sexual abuse, the loss of a gift she had hoped to offer one day to her husband. Mourning those losses is a process of inner transformation that affects the images of both the self and of the lost trait, relationship, or potential in the mourner's inner world. Mourning involves the transformation of the lost attachment into reclaimed personal traits, forgiven and reconnected relationships, or a sustaining internal presence.

Horowitz (1990) has developed an elaborate framework for the internal changes that occur following a significant loss, how the mourner's "schemas" about his or her important relationships come into conflict. The individual wants to hold onto the old schemas or belief systems that existed before the loss, but he or she is also confronted by reality. Horowitz suggests that mourning involves a "working through" process in which the individual's schemas of self and what has been lost come into line with the demands of reality, and the individual is able to accept a new image of himself or herself consistent with the current circumstances.

Baker (2001) discusses the necessity, in successful mourning, for the individual to undergo an internal separation/ individuation process in which certain aspects of the self are no longer tied to or identified with that which has been lost. The person who experienced trauma at the loss of a significant relationship or personal quality or worldview must come to see himself differently than he has since that time. It may be difficult for him to let go of a self-image as untrusting, or shameful, or as one who is abandoned by the people he is closest to. But resolution of the loss through mourning requires that he let it go and move on to reengage in life.

The failure to let go and move on leaves the individual to some degree unengaged in life. According to Guntrip (1969, 1971), severe disappointments or trauma force a piece of the ego into objectlessness. This regressed ego is remote and withdrawn, renouncing attachments forever. It is characterized by the profound helpless despair and longing for

death that we sometimes encounter in incest survivors (Grand & Alpert, 1993) and other "Holocaust survivors."

Completion of grieving that has been unresolved is always corrective. Women often regress to a time of making the life-or-death decision about abortion, and very often have never had the supportive setting within which to grieve the heartbreaking loss. Miscarriages also have very often gone unacknowledged, and it is deeply healing to grieve them as well. In both cases, the hypnotic trance state is conducive to the client contacting the departed soul in the spirit world. The same procedure is helpful when the client revisits a time of saying goodbye to any loved one, e.g., a deceased parent, sibling, child, or friend. Regression to the historical time of their last farewell brings up the feelings that need to be dealt with. Those feelings may include more than sadness, of course; there is often anger, regret, hurt, or shame. It is such a blessing to have the opportunity to enter into a spontaneous dialogue, experienced as here and now, with the departed.

Clients who were given up for adoption carry immense grief for all their losses. The age regression offers a vehicle for accessing the events surrounding their birth, and often the individual will actually feel an intimate connection with the birth mother. Being consciously present for the abandonment brings all the feelings of rage, shame, and betrayal to the surface, where they can be acknowledged, expressed, and released. This may be the first time that he/she has taken the risk of experiencing those feelings, and may also feel like a "first introduction" to the birth mother that until now has only been an anonymous enigma.

As we shall explore in detail later, one of the most profound losses for some people is the sense of "*Divine homesickness*," in which the soul experiences loss, rejection, inadequacy and shame at leaving the spirit world, and longs to return, or "*Divine exile*," in which the soul experiences being expelled from or forced to leave Heaven, with resulting feelings of loss, rejection, inadequacy, anger, guilt, shame and confusion. Such a loss of spiritual connection can happen at conception, or it can happen subsequently in the face of overwhelming chaos and trauma. People often comment after their first or second hypnotherapy session that they have returned to a level of intimate relatedness spiritually that had been missing in their life for many, many years. Healing one's separation from spirit requires first recognizing that it has slipped away; only then can one reclaim what has been lost.

In the same way, only when one acknowledges a significant loss and grieves for it can the next and vital step occur. Then the object of attachment becomes internalized. What has been lost can be reclaimed ultimately as a sustaining internal presence. The meaning of the relationship, and of its loss and transformation, provides nourishment for further personal growth. The lesson is incorporated.

Build authenticity: Release of dissociation and identification (reclaiming self-reflective identity)

Effective therapy is the process of becoming free of the repetition of the painful old dramas that became the script for one's life. As we disengage from the old conflicts, we are freed to explore new possibilities. One *dis*identifies from the limited beliefs of who he/she is, exorcising the ghosts of the past, changing the deeply embedded patterns that have invisibly controlled choices from the beginnings of life. In order to become free, in order to release the shame and the helplessness, we must emerge from whatever degree of dissociation holds us back from being present in our actual experiencing.

Dissociation is a disturbance in the integrated organization of identity, memory, perception, or consciousness (American Psychiatric Association, 1994). It is a normal aspect of everyday living, for example when one selectively attends to a fascinating conversation or a thrilling mystery novel in a crowded room by tuning out the extraneous visual, auditory and kinesthetic input. The phenomenon of hypnosis is another example of normal dissociation.

Memory is created, and its retrieval reinforced, through associations of related co-occurring events. You remember someone you were introduced to last year by recalling the associated memories: the location of the meeting, the circumstances, others who were present, your emotional reaction to this individual, etc. In traumatic dissociation the individual's mental processes segregate one set of associations from another; the child being sexually abused focuses her attention on the wallpaper next to her bed, or on a fantasy playground that provides sanctuary. This segregation of associations, or dissociation, impairs memory storage and retrieval. Memory records of traumatic events are disorganized and fragmented (Foa & Riggs, 1993), and typically consist of representations of intense emotions, incomprehension, and confusion (Kilpatrick et al., 1992).

The state of mind at the time of trauma is narrowed through selective attention, and thus the range of associations is limited. Those memories that do exist are experienced, stored, and retrieved as emotionally intense (Cahill et al., 1994). Research documents that mood congruence between the state in which memories were stored and that in which they are retrieved improves recall (Bower, 1981). Therefore, utilizing hypnosis to access traumatic memories is highly effective because (1) it simulates the original dissociative state, and (2) it facilitates uninhibited access to states of emotional intensity (Spiegel, 1997).

Helplessness is a fundamental element in the experience of trauma. As Spiegel (1997, p. 227) puts it: "Trauma can be understood as the experience of being made into an object, a thing, the victim of someone else's rage, of nature's indifference. Traumatic stress is the ultimate experience of helplessness and loss of control over one's body." Trauma presents the child with a "biological paradox" (Siegel, 2004), motivated to move toward safety and soothing when it is not available. Main and Hesse (1990) call it "fright without solution," and in numerous forms it is experienced by children as helplessness.

The diagnosis of acute stress disorder (American Psychiatric Association, 1994) requires that at least three of the following five dissociative symptoms occur within one month of the traumatic event: depersonalization (experiencing the self as an observer detached from the body), derealization (unreal surroundings of a dream-like quality), amnesia (loss of memory of the event or of subsequent time periods), numbing (loss of interest and inability to feel deeply about anything), and stupor (dulling of the senses and decreases in behavioral responsiveness). If the symptoms persist beyond one month, the diagnosis is changed to dissociative, anxiety, or posttraumatic stress disorder. An individual's dissociation response to a traumatic event may be healthy and adaptive in fending off the immediate devastating emotional impact, allowing for focus on survival coping strategies. However, such a response loses its adaptiveness and becomes debilitating over a period of days, weeks or years.

What about persistent dissociation is debilitating? The dissociative state allows for reactivation of traumatic memories, in hyperaroused anticipation, without the potential for processing and controlling them. The individual, through chronic numbing, detachment and avoidance, does not process the memories through the systems of the brain that facilitate integration of experience, and therefore healing. These areas of the brain are:

- the hippocampus, which contextualizes information, creating a cognitive map that allows for the categorization of experience and its connection with other autobiographical information (van der Kolk et al., 1997);
- the thalamus, which links sensory inputs to cognition;
- the corpus callosum, which links left and right hemisphere functioning, integrating emotional and cognitive aspects of experience, i.e., the logical, linguistic processes of the left and the autobiographical, self-soothing, mentalizing processes of the right (Siegel, 2004); and
- the frontal cortex, which reprocesses information, serving as a "supervisory system" for the integration of experience.

Yet the person's vigilant hyperarousal causes persistent intrusive reactivation of the traumatic memories. "Thus, the lack of control, dysphoria, and helplessness that typifies the traumatic effect is reinforced rather than modulated by repetition. . .   Traumatic memories are reactivated rather than transformed, thereby reinflicting trauma rather than working it through" (Spiegel, 1997, p. 233).

Sadly, dissociation and hyperarousal also limit the *positive* experiencing and expression of people with PTSD, according to research by Litz et al. (2000). Individuals with PTSD, in their attempt to cope with their responses to traumatic contexts, may be unwittingly subject to suppressed expressive reactions to positive stimuli. Cognitive processes activated by trauma cues also lead to reduced expressive behavior to positive stimuli. Also, individuals with PTSD tend to appraise neutral stimuli as more negative than other people.

Four general categories of variables appear to be related to the range of traumatization observed among childhood sexual abuse survivors (Beitchman et al., 1992; Kendall-Tackett et al., 1993; Neumann et al., 1996): (a) characteristics of the sexual abuse; (b) characteristics of the sexually abused person; (c) characteristics of the sexually abused person's response; and (d) characteristics of the social support response.

Characteristics of the sexual abuse that have been associated with poorer outcomes include abuse perpetrated by a person in a position of trust, guardianship, or authority with the sexually abused person (Beitchman et al., 1992). Some research has also found invasiveness of the abuse to be associated with greater trauma (Kendall-Tackett et al., 1993).

Characteristics of the sexually abused person that have been associated with greater trauma include prior exposure to other traumatic events, such as being involved in or witnessing a natural disaster, a major accident, or violence (Briere, 1996). Nonsexual childhood maltreatment has also been implicated.

Characteristics of the sexually abused person's response that have been substantially correlated with posttraumatic distress focus on dissociation, particularly peritraumatic dissociation (Johnson et al., 2001).

Appropriate social support has consistently been found to be one of the significant factors mediating the negative effects of sexual abuse (Runtz & Schallow, 1997; Spaccarelli & Kim, 1995). Conversely, social support networks that fail to acknowledge and protect the child significantly on her disclosure, create more trauma and result in increased distress (Briere, 1997; McNulty & Wardle, 1994).

What are the elements, then, of effective treatment of traumatic dissociation? What are the corrective experiences that will lead to healing? Foa (1997) suggests that they are (1) emotional engagement with the traumatic memories, i.e., reversing the dissociative avoidance and emotional withdrawal; (2) special processing of the traumatic memories to organize, streamline, and articulate them; and (3) adjustments in the person's core schemas, or beliefs about the world being unsafe and oneself being incompetent, i.e., helplessness.

The importance of emotional engagement with the traumatic memories is documented by the Cahill et al. (1994) and Bower (1981) research cited earlier in this section, and by Foa et al. (1995). Being in the same state of mind as existed at the time of trauma, that is intensely emotional and dissociated, facilitates access to the potential to change the original programming.

Special processing of the traumatic memories is necessary because of the special way in which they were laid down. The memories must be processed through the systems of the brain that facilitate integration of experience. The healing processing provides the context within which the traumatic event occurred, e.g., an attribution of responsibility ("It wasn't your fault; he was the one who did the bad thing"). The healing processing links sensory inputs to cognition, e.g., clarifying the meaning of body sensations and responses ("That gnawing discomfort in your sexual parts whenever your husband suggests sex is anxiety, and it is very understandable"). The healing processing links left and right hemisphere functioning, e.g., validating one's intuitive knowing as well as deductive

reasoning ("You are learning to distinguish between gut feelings that you can trust and those that are holdovers from the hyper-alertness"). The healing processing allows for experience to be reflectively reprocessed, not simply reflexively reacted to, e.g., learning from experience and problem-solving new solutions to old challenges ("What are some ways that you can respond to his sexual advances *and* honor your need for safety?")..

The person's core beliefs in his/her helplessness must be addressed and changed for resolution of the traumatic symptomology (Epstein, 1991; Janoff-Bulman, 1992; McCann & Pearlman, 1990).

Foa (1997, p. 420) summarizes the benefits of the process of reliving the trauma:

> Foa and her colleagues (Foa & Jaycox, 1997; Amir et al., 1998) suggested that several cognitive modifications take place during treatment by repeated reliving of the trauma. First, the victim who, during repeated reliving of the trauma, experiences habituation of anxiety rather than the anticipated emotional breakdown will cease to interpret her symptoms as signs of incompetence. Second, repeated recounting of the trauma narrative reinforces discrimination between remembering the trauma and actually encountering it again and thereby promotes the notion that remembering itself is not dangerous. Third, prolonged exposure to the trauma memory promotes differentiation between the traumatic event and and similar but safe events, thereby fostering the interpretation of the trauma as a unique event rather than as typical of a dangerous world. Fourth, repeated exposure to feared memories fosters an association between PTSD symptoms and mastery rather than incompetence. Finally, repeated reliving is thought to promote organization of the trauma narrative, thus facilitating integration of the traumatic experience into existing knowledge structures. These modifications directly correct the victim's perception that the world is entirely dangerous and the individual is entirely incompetent, the two dysfunctional cognitions that are thought to underlie PTSD.

Katrina is a young woman who has had persistent PTSD symptoms as well as a long history of alcohol and drug abuse. She described her childhood and adolescence as painful. Even though she is intelligent and a successful professional, she nearly lost her whole career due to her inability to stop using drugs. She was desperately attempting to numb her own pain, although she was totally unaware of where the pain had originated. During the hypnotherapy, she regressed back to a time when she was very young and had a severe rash in her vaginal area. Her mother took her to the doctor, who used her as a teaching resource by inviting several other doctors to observe his treatment of her. Her mother did nothing to protect her, even though she violently expressed her wishes not to be treated in this way. She was tied to the table, something put over her mouth to quiet her, and her legs tied to the stirrups. You can imagine the trauma for this young girl aged three years old. Katrina was not only

traumatized, but the experience was so overwhelming that she went into shock. She then became mute for several years and was unable to speak, an expression of stupor in clinical terminology. This response to trauma brought her the label of being emotionally withdrawn and hysterical. Actually, her dissociative defense against the trauma had become "crystallized in the body" (Emerson, 2002a), and she was physically and emotionally unable to penetrate through that blanket of shock.

Katrina's hypnotherapy has been focused on helping her to release the dissociation that accompanied the trauma of her abusive loss of control over her body and the resulting shame and helplessness. It is a gradual process of supplanting early experiences of helplessness with new corrective experiences of agency and personal power. She has been able to reclaim her voice and express the feelings that went unheard by her mother and the doctors. Katrina is learning to trust again, allowing her therapist and group therapy members to serve as transitional figures in her journey toward bringing in her healthy adult to re-parent this young child. She is now clean and sober from drugs and alcohol and committed to continue her self-exploration and healing.

The path of healing for Katrina will be slow and difficult, because of the degree to which the traumatic imprint of helplessness and overwhelm was crystallized in her body. The depth of her early dissociation segregated mental and emotional associations, disturbing the integrated organization of her identity, memory, and consciousness. The result has been varying degrees of depersonalization, amnesia, numbing, and stupor. Facilitating Katrina's healing, the release of her identification with helplessness, requires creating immense safety for her, insuring that she has many, many corrective experiences of controlling her own body and her life experience. Her healing can be measured in her growing self-identity as a fully developed and fully present young woman with an internal locus of control.

Embracing compassionate self-acceptance

One of the most basic outcomes of successful therapy is self-acceptance. Healing leads us from a contingent self-acceptance to an all-inclusive self-acceptance. Honest and realistic self-assessment is necessary to avoid narcissistic grandiosity and inflation. Thus, we may judge certain traits or tendencies as admirable, and others as undeveloped, immature or in disrepair. However, too often that process is highjacked by unworthiness into one of welcoming the former and disowning the latter, identifying

with the persona and repressing the shadow. When in the course of therapy the repressed and rejected is accessed and acknowledged, it becomes available for dialogue, and ultimately to be embraced and welcomed home to a self with now-expanded boundaries. The self-compassion that is necessary for this is especially easy to access when one goes to the age-regressed true source of dysfunction, and discovers a traumatized child. It is easy to open one's heart to the scared and shamed three-year-old that initiated the behavior pattern that developed over decades into the thoughtless, ravaging addict. It is much easier to embrace the three-year-old, and much easier to revile and reject the adult. Recognizing them as one in the same accelerates the healing process.

Effectively facilitating corrective experience in therapy requires that we provide a space to our client that is non-judgmental, welcoming to the previously rejected parts, and open-ended to the person's unimagined potentials. That is one measure of effective therapeutic corrective experiencing: "We are called to stretch beyond ourselves – the self that each knows as 'me' – and include more in our self-definitions than we had previously, making room for the varied and contradictory ways in which we express our being" (Goldfarb, 1999, p. 86).

One of the first and most glaring measures of the new client's ego strength is the way in which he/she responds to the inner child encountered in age regression. Let's say that an individual goes back to age six, to an experience of feeling humiliated and betrayed by a trusted caregiver. Sometimes the adult blames the six-year-old, seeing him/her as dirty and bad, carrying the internalized judgment that was introjected at the time of the original incident. The adult is unable to embrace the child with compassion. Sometimes, of course, the adult can see that six-year-old as an innocent victim, just as objectively as the person would see someone else's abused child. When the adult opens her heart to that child, an important milestone of progress is passed in her therapy.

For a client who rejects the age-regressed inner child with blame and judgment, a transitional object is needed to bridge the gap, leading to compassion and acceptance. That can be provided in several ways. Sometimes in such an age regression we can ask the person to see the traumatized child as another child of that time, e.g., a younger sibling, a same-aged friend or neighbor, or even an unknown anonymous same-aged child. If the client can find compassion for the other child, then we encourage him/her to bring in the adult to take the action of expressing the outrage and protecting that child.

A woman named Marilyn came in complaining of nightmares and insomnia. She had no idea what the dreams were about, but once woken up in the night, she could not seem to go back to sleep. She agreed to begin hypnotherapy treatment.

At the beginning of our sessions we often ask the participant to bring in a healthy adult ego state in order to strengthen it. Marilyn was unable to do this, which often means that the individual is a survivor of serious abuse, and that the client has been living predominantly in an emotionally regressed child ego state. This is not always immediately apparent, because people can learn how to "act like an adult." When she regressed, Marilyn went back to several unpleasant memories of being left alone with her grandfather who was performing oral sex on her. This occurred periodically from the age of three to six. The conclusion she drew about herself there was that she was filthy, bad and dirty and that's why her grandfather did that to her.

She believed that to be the only love and attention she deserved to get. At the end of the session, we usually give the client a teddy bear to hold, representing the inner child. Marilyn initially threw the child (teddy bear) away with disgust. She felt that little girl was shameful and repugnant. "Is there anything about that little girl that you can accept, that you like?" we asked. Marilyn said that she liked her dress and her hair, even though she was not able to let go of seeing her as filthy, bad and dirty. In subsequent sessions, she gradually found more about the little girl that she could accept, and eventually she was able to really open her heart to the child. Marilyn's identity had changed, and she no longer believed herself to be filthy, bad and dirty. Rather, she experienced herself with unconditional love. The sleep disturbance melted away without a trace.

Increasing ego resiliency

A useful conceptualization is "ego-control" (Block & Block, 1980). People with high ego-control are rigid and inhibited, disposed to repress impulses and emotions, to feel anxious in new situations, and to reject unexpected information. Those who have weak ego-control are impulsive and distractible, and do not have the discipline to concentrate on one task for very long. The synthesis of these two polar extremes is not moderate ego-control, but rather "ego resiliency." Ego resiliency is the ability to respond flexibly but also persistently to challenges.

Faced with the threat to self that trauma represents to a small child, some children react by adapting high ego-control in order to attempt to

keep themselves safe, while others adapt a weak ego-control strategy in order to distract themselves from the threat. As the individual in ego regression changes the early reactive behavior patterns, he/she corrects the imbalance of ego control that was adapted by the traumatized child.

Current brain research (Crawford, 1994) sheds light on the topic as well. The literature suggests four main attentional dimensions: (a) focused and sustained attention (the ability to focus and sustain attention over time without distraction); (b) selective attention (the ability to select and discriminate between stimuli); (c) divided or dual attention (the ability to divide attention between two tasks, often one primary and the other secondary); and (d) ambient attention (the ability to attend to one task but also to have diffuse attention in preparation to respond to other stimuli). Ambient attention is that state which, while taking care of the business at hand, keeps open to other interpretations, including those which may be mutually exclusive. It combines *focal* and *diffuse* attention, and is also related to *cognitive flexibility*, a primary ingredient of the trait "openness to experience."

John Welwood (2000) describes how focal attention screens out wholes in favor of differentiated parts, becoming preoccupied with the foreground content, e.g., with the waitress' inattention or the performance anxiety preceding a lecture or the discomfort of being in a crowded elevator. Focal attention is a telephoto lens through which to concentrate on selective details. It is very useful, but over-reliance on it leads to obsessive mentation, narrow-mindedness, and disconnection from purpose and meaning in life. Diffuse attention is receptive, alive, a wide angle lens through which to experience the whole context all at once. The two forms of attention represent thought (focal, the contents of consciousness) and awareness (diffuse, consciousness itself).

Cognitive flexibility permits expanded awareness through simultaneous consideration of opposite poles of bipolar meaning structures, e.g., life/ death, intimacy/ isolation, purpose/ meaninglessness, abdication/ responsibility (Slife & Barnard, 1988). In other words, cognitive flexibility permits one to accommodate multiple solutions, even mutually exclusive ones. It carries the ability to shift cognitive strategies and states of awareness, shifting from details (attending to selected content and disattending to other content and to the context) to a holistic view (attending to both content and context) and back again. Complex, novel or unpredictable events are appraised as opportunities for growth rather than as personal threats requiring reflexive response.

Appropriate corrective experience in therapy increases the client's ego resiliency and cognitive flexibility through a balanced use of focal and diffuse attention. For example, one of the ingredients of almost every hypnotherapy session is the emergence of a new perspective based on insight regarding an overarching behavior pattern. Virtually every client session that we have cited in this article traces the client's developing ego resiliency and cognitive flexibility. A common technique that we employ in treating self-defeating behavior patterns is to ask the client, after the cathartic work produces clarity about the current pattern and how it developed, to identify three new behaviors to meet the person's real needs and avoid the old pattern. For example, a client gets clear that her compulsive overeating is her four-year-old's way of resisting her mother's intrusive attempts to control her and her bodily functions. In the trance state, with diffuse attention in the healing culmination of the session, her unconscious mind is easily capable of identifying three new ways for the adult to bring herself a sense of self-assertiveness (the real need) in healthy and rewarding ways. The client's ego is stretched by the experience of allowing her unconscious mind to provide new solutions, perhaps complex, novel or unpredictable ones.

Learning to discriminate between self-definition and introjection

One of the most thrilling moments of insight in a deeply experiential session is the client's recognition that a self-destructive habit or a self-sabotaging trait belongs to mother, father, or some other influential caregiver in childhood. "Oh, my God. It wasn't really me that cringed in fear of everything. It was my mom all along! I just took it on." One of the best ways to help clients realize what they introjected from another is to have them identify what they want to give back. After cathartic release in the age regression, often the individual is ready to "give back" his father's violence or depression, or his mother's guilt trips or anger. "What do you want to give back to [the traumatizing caregiver]? Tell them that it was never yours in the first place, that it's not yours, and that you won't carry it anymore." Have the client identify each behavior or trait that isn't really part of them, and encourage them to give it back forcefully, somatically. For example, it helps to provide a powerful visceral experience when the client throws a pillow each time they give something back.

A concept closely related to this is "clarity of self-concept," which connotes certainty about self-defining attributes, or certainty about one's identity. In the example above, the individual who realized that "It wasn't

really me that cringed in fear of everything" was engaged in the process of increasing his clarity of self-concept. Becoming more clear about who he *isn't* brings more clarity about who he *is*. This is very relevant to analyzing his corrective experience, because clarity of self-concept is correlated positively with self-esteem (Campbell, 1990). Put another way, people with low self-esteem tend to have less clearly defined and less certain identities than people with high self-esteem (Baumgardner, 1990; Campbell, 1990). As a person becomes more clear about who he is, about his qualities and capabilities, his self-esteem grows. In the words of Baumgardner (1990, p. 1062), "To know oneself is to like oneself." Setterlund and Niedenthal's research (1993) verifies that enhancing the client's stability of self-concept in turn enhances his self-esteem.

Jerry was a successful and intelligent man of forty who had difficulty in relationships with women. He would find himself attracted to a particular woman, but seemed to lose his nerve when he tried to approach her. In fact, the closer he got to introducing himself or initiating a conversation with a woman, the more he experienced an overwhelming sense of intimidation and fear. This seemed to happen no matter who the woman was, what she looked like, or what kind of person she was. In a hypnotherapy session, Jerry regressed to several incidents in his childhood which fit the pattern, one with a high school classmate, one with his fifth grade teacher, and then at birth with his mother as she reached out to take him from the doctor. In each case, Jerry felt scared without knowing why. He described the woman each time as "devouring." Jerry regressed once more from his birth, and experienced himself as his father's sperm approaching his mother's egg. The egg was huge, towering above him, and was slowly rolling toward him as if to swallow him up. He felt panic, but he also felt a deep longing to merge. He was able to stay with these contradictory urges long enough to come to a startling realization: the fear and intimidation was his father's reaction to his mother, carried in the sperm that he had entered and immediately identified with, causing great confusion. Once he separated himself from the fear and intimidation, which were not truly his feelings, Jerry experienced a warm rush of attraction and unambivalently surrendered to merge with the egg. Ecstacy! What a profound experience that session provided, recognizing how he had assumed those feelings were his feelings, and beginning the intuitive process of sorting out what is "truly me." Jerry was eager to put his new insight into practice, and found that he was no longer conflicted about approaching women.

Giving meaning to past events that were experienced as bewildering

We know that bringing a chaotic and confusing experience into the focus of its meaning is an essential component of healing trauma that the person originally dissociated from.

The meanings people attach to traumatic events are critical to understanding the events' impact on the person's capacity to be able to count on himself (van der Kolk & McFarlane, 1996). Traumatic events "attack" people's sense of the world as a predictable, safe place and imperil their perception of themselves (McFarlane & de Girolamo, 1996).

Davis et al. (1998) point out that there are two basic ways people find meaning following a traumatic loss. One is the *benefit-finding* construal of meaning, looking for the "silver lining" to adversity. Here the focus is on the individual's appraisal of the significance of the event for his or her sense of life goals and life purpose, and meaning is found in one's ability to develop new goals and a new, perhaps wiser sense of self. The "silver lining" might take the form of a new appreciation for life, a greater value on relationships, enhanced life skills, etc.

A second focus is on the person's ability to develop a relatively benign explanation for the loss, or to make sense of it within their existing fundamental schemas or worldviews, what Davis calls meaning as *sense making*. For instance, people sometimes report making sense of loss or trauma by attributing it to God's will, by assuming a degree of personal responsibility for the event's occurrence, or by seeing it as a just consequence of previous actions.

The need to find meaning has been documented as psychologically important within the context of bereavement and a wide range of other traumatic life events (Affleck & Tennen, 1996; Bulman & Wortman, 1977; Silver et al., 1983; Thompson, 1985).

Jonathon's twelve-year marriage had been chaotic and tumultuous, and finally his wife left him. He was despondent over having "failed" at his marriage, even though he knew that his only hope for creating a fulfilling relationship was in finding someone new. Jonathon and his ex-wife shared custody of a two-year-old son, so they were forced to interact several times each week as they picked him up and dropped him off. They both seemed to be unable to let go of the bitterness, rancor, and fault-finding with each other. Jonathon knew on a deep level that he would not be able to move on to a new relationship until he could let go of the old one. Yet he seemed to be unable to extricate himself emotionally, and the intensity of their

fighting continued unabated over the next two years. He was not motivated to heal the relationship.

It was at this time that Jonathon entered hypnotherapy. In his first session, he regressed to a past life experience, and described being a merchant, living in a house near the Mediterranean in Biblical times. He was annoyed to realize that his wife was the same woman as his ex-wife in this life, and their relationship was the same as well. Jonathon knew with crystal clarity in that moment that he had created another opportunity in this life to heal the relationship, and that if he failed to do so, he would create another and another in a never-ending sequence of opportunities until he finally did. The prospect of reliving this marriage again and again was all he needed to become motivated to do the personal therapy to heal his relationship, and resolve it once and for all. There was an element of *benefit-finding* as well as *sense making* in Jonathon's epiphany.

Reconnecting memories and emotions to events

Bucci (2003) states the case succinctly: "One may be aware of the physiological activation, the painful physical arousal, associated with the activated schema of anger or fear, and also aware of aspects of one's history, including the trauma and abuse, *but without connecting the two*. We see patients telling the stories of their history without emotion, feeling the physiological activation without recognizing its emotional connections" (p. 548, italics added). This is dissociation. The individual has an experience in the present that is sufficiently dangerous (or perceived to be dangerous) to lead to a central nervous system arousal – butterflies in the stomach, or a gnawing dread sensation in the chest, or painful stimulation in the sexual areas. These are body memories, triggered by the intensity of the arousal. Or the arousal may be cognitive – a sense of familiarity, or of the "other shoe about to drop." The individual is unable to consciously acknowledge the true source (distant past trauma), instead mistakenly attributing the arousal to the current triggering circumstance. That the activating trigger can as easily be in fantasy as in an actual life event makes it no less arousing, and the consequences set in motion no less devastating.

The physiological or cognitive activation is not connected in memory to the source of the trauma because they were not connected at the highly stressful time of originally laying down the memory (LeDoux, 1999).

When one reconnects viscerally to early events, the body is activated. "The True Self comes from the aliveness of the body-functions, including

the heart's action and breathing. . . . the experience of aliveness" (Winnicott, 1965, p. 148). Thus is dissociation repaired. From the poet Rumi (1250-1310):

Broken Open
Dance when you're broken open,
Dance, if you've torn the bandage off.
Dance in the middle of the fighting.
Dance in your blood.
Dance when you're perfectly free.

One of the specific corrective experience mechanisms that facilitates the reconnecting of current emotional experience with its source is redirecting the person from disconnected emotion to connected motor circuits. We do this through cathartic energy release methods such as yelling, throwing a pillow, or hitting a punching bag. LeDoux and Gorman (2001) have shown that the fear response of freezing (withdrawal, avoidance, emotional paralysis and despondency) is incompatible with the motor response of taking action. The flow of information into the amygdala within the brain is redirected from the central nucleus (which engages the passive fear response of defensive freezing through autonomic and endocrine reactions) to the basal nucleus, which projects motor circuits. "Taking action" literally terminates the physiological reactions (freezing) of conditioned fear. The "action" can be taken in a way that is avoidant rather than cathartic, however, and the individual simply develops workaholism or a need for overachievement. This person has traded physiological paralysis for emotional numbing.

Being connected to body sensation also allows one to become aware of pleasure resistance, physical sensations of discomfort or anxiety that arise during pleasurable experiences. Resnick et al. (2001, p. 90) state the case succinctly:

Anyone punished as a child for being too exuberant, too playful, or too sexual may put an automatic ceiling on how good he or she will allow things to be (Liedloff, 1977; Miller, 1983; Reich, 1961). For people with pleasure resistance, vague dissatisfaction is a familiar feeling and a hidden saboteur of happiness. If they feel too good, they may look for things to worry about. . . . What did they learn from their parents about their right to pleasure, and are they repeating their parents' prejudices in their own lives (Resnick, 1994, 1997)?

Practicing being in the "here and now"

The revivification experience in the trance state brings the client a sense of presence that may be generally lacking in his/her life. It can be a

"wake up call" to be more present for oneself in everyday experiencing. One of the most basic premises in Gestalt therapy is to make everything very immediate, emphasizing the here and now, what Fritz Perls called *presentness* (Perls, 1969a, 1969b, 1970). It is also a basic component of the age regression experience in hypnotherapy, of course, to experience the situation (whether it be yesterday, in childhood, the womb, the interlife, or past life) as here and now.

Most existential approaches view the present as the *only* reality; that is, all forces are seen to be acting now, in this immediate moment. The past exists here and now as memories, regrets, sources of shame or pride. The future exists here and now as anticipation, hope, rehearsing, dread. Effective therapy or healing involves seeing clearly how the past is alive in the present in the form of unfinished business and bleeding wounds. As the wounds heal and the business is finished, the person opens to the immediacy of the present moment. One of the reasons hypnotherapy is so powerful in helping people to change neurotic patterns is that the process involves experiencing the past (for example, age regression to a childhood trauma) or the future (for example, rehearsing an upcoming anxiety-provoking confrontation) *as an experience in the present.*

Experiencing meaning and purpose in life *in the here and now* is associated with satisfactory life experiences and positive future expectations, in other words, hope (Debats, 1999; Reker & Cousins, 1979). Passionately living today, "engagement in life" (Yalom, 1980), is the answer to meaninglessness, and is a reflection of perceiving the future as open or calling with opportunity, and that one's experience in the future will predictably be a reflection of one's choices today. This is a common outcome of the corrective experience in hypnotherapy of experiencing life fully in the present moment.

Increasing the capacity to be self-reflective
In the course of age regression therapy, an individual experiences an "observer self" simultaneously with experiencing the age-regressed ego state. This provides safety, insures an enduring memory of the insights gained, and gives a glimpse of the spiritually necessary experience of a transpersonal self, a witness, the hidden observer.

The experience of regression hypnotherapy inevitably brings opportunities to observe oneself, i.e., one ego state observing another. In other words, the individual is separating the observing self from experiencing self. Increased capacity for self-observation allows people to

think more broadly and openly (Tellegen & Atkinson, 1974), and thus strongly influences a person's current sense of identity (Horowitz, 1998). One primary reason for this is that the self-observation in age regression corrects the dissociation that occurred at the time of the trauma, and that diminished later levels of self-observational skills (Horowitz, 2002).

In the age regression experience, one can see oneself as if "from the outside" as an age-regressed ego state. It is "interesting to note that studies in human development (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Main et al., 1985) have found that the capacity to be self-reflective plays a crucial role in breaking habitual dysfunctional modes of relating" (O'Brien, 2004, p. 34).

The experience of observing oneself in a regression to the womb or to a pastlife, in finding and retrieving one's soul, or while participating in a dialogue between two parts of oneself (e.g., nurturing parent and wounded inner child) brings a degree of nonattachment to the biographical details of one's life. This benign detachment leads to the experience of an "ego-transcending, self-forgetful, egoless" self (Maslow, 1968, p. 79).

Acting with awareness of the action may be called *mindfulness*. Langer (1989) has shown that mindfulness can be induced in experimental subjects by means of drawing attention away from habitual schemas. When we are cognitively and emotionally experiencing an unfamiliar situation, we tend to be more consciously present. Increasing mindfulness equates with decreasing the effects of social pressure, egocentrism, and attentional automatism (Langer et al., 1990).

We facilitate the enhancement of self-reflection in numerous ways in Heart-Centered therapy sessions. For example, we bring attention to the client's emotions, identifying them and labeling them. We bring the client's attention to the somatic sensations at various points along the path of exploration: "Where do you experience that (sadness, fear, shame, etc.) in your body? What is the feeling?" We bring attention to the client's state of mind, including the unconscious pattern of beliefs that underlie it. We bring attention to the pattern of sequence of states, e.g., "So you can see how the feeling of emptiness and loneliness leads to compulsively eating cookies." In this way, the individual can learn what triggers an unwanted state, and how to avoid the triggering. We bring attention to the person's degree of control of his/her state, his reactivity: it may be inhibited, suppressed or denied; it may be impulsive and uncontrolled. We bring attention to the attribution of responsibility in past events, e.g., "He abused you. You are not to blame. The shame for that event belongs to him, not

you." We bring attention to situations in which the client identified with another, confusing his/her self-concept: "You can see how bullying the dog reflected your need to have some power in your life, just like your father did when he bullied you."

Horowitz (2002) summarizes the importance of this aspect of corrective experience well: "Self-observational capacity can be enhanced by using a focus on multiple states of mind. . . . Increased self-observation of thought and feeling can lead to more mindfulness in emotional behavior" (p. 126).

Self-remembering is another term for mindfulness. Ouspensky, speaking about Gurdjieff's "Fourth Way," defined self-remembering as the practice of bringing a sense of one's presence or existence into the moment; being aware of oneself as well as of what one is doing or experiencing.

Self-remembering begins by developing the capacity for *divided attention*, i.e., an intentional effort to be aware of two or more things simultaneously, in contrast with *identification*, in which attention is focused on only one thing. *Self-observation* is the practice of being aware of one's internal functions at the same time as one is aware of one's actions and environment. We can develop this capacity by bringing the attention to the sounds or smells in the environment, or looking at objects, as a means of being present and dividing attention. We can deliberately not use a specific word in the speech as an aid to being present, or deliberately change a habitual sequence of behaviors, such as shaving or putting on makeup.

Separation is the practice of maintaining a sense of self separate from one's actions, environment or experience, withdrawing a part of one's attention from one's experiences and using it to be aware of that within one which registers, or is aware of, those experiences. The emphasis is on the fact that the part which registers the experience is not directly involved in or affected by the experience.

Separation involves *being present*, the practice of paying attention to one's immediate environment, both externally and internally, without *imagination* or *identification*. Imagination is the state in which a person's attention is devoted to things which are not actually now present, often to the complete exclusion of awareness of the immediate environment, which leads to believing something to be true which is not true. Identification is the state in which all of a person's attention is focused on a single thing or

a single way of being to the exclusion of anything else, including being present.

The frequent experience in age regression hypnotherapy of self-reflection is corrective in helping to break habitual dysfunctional modes of relating. It is also corrective in bringing the individual closer to a mindfulness approach to life.

Reframing the early erroneous conclusions/ decisions

People generalize their experience into belief systems (also called schemas, internal working models, or conclusions) from the very earliest time of life. In the preverbal stage, traumas remain in the unconscious as diffuse feeling states, carried unconsciously, viscerally, somatically. Near the age of three, with the onset of language, these states are encoded linguistically, although they remain unconscious. Emerson (2002a) provides the example of a baby who gets stuck in stage one of birth, where immense pressures force it towards the cervix before dilation. The preverbal baby reacts experientially, either by remaining in the pushing state (hypertonic) or by giving up and going flaccid (hypotonic). In the verbal phase, though still at the level of the unconscious, what develops is one of two decisive encoded messages: "Under pressure, I struggle through" or "Under pressure, I give up."

These newly articulated decisions become well entrenched as habitual and unquestioned personal laws of the world, within the transpersonal domain of non-cognitive and unarticulated "knowings," i.e., of semantic memories. Semantic memory handles knowledge about the world; it underlies the acquisition of general knowledge that is not tied to any one specific personal experience. Semantic memory stores generalizations or summaries of the meanings of recurring memories, for example, "My father always ridiculed the kids in the family during mealtimes" or "It's not safe to be alone with men." Episodic retrieval (recall of specific events) involves autonoetic awareness and the mental re-experience of a previous moment in the past. Semantic memory, by contrast, is characterized by noetic (knowing) awareness only. There is no feeling of reliving a previous episode. The process of creating semantic memories is referred to as "deep" encoding (Demb et al., 1995; Fletcher et al., 1995; Kapur et al., 1994).

These deeply encoded semantic memories remain unconscious and highly influential throughout the lifespan, or until they are brought to consciousness and changed. Once deeply encoded early beliefs are ferreted

out, they can be kept intact, revised to reflect the individual's current level of understanding, or rejected as erroneous. Age regression therapy provides the means to follow the consequences in today's life experience back to the source of the underlying beliefs. Reliving those crucial moments is vitally important to reassessing the core beliefs and potentially changing them. Changing core beliefs is directly related to the experience of the self (Safran & Wallner, 1991). Changing core beliefs usually causes one to reassess priorities, e.g., the soul-searching that, for most people, follows a near-death experience (NDE).

What facilitates people changing their core beliefs? The research into the technology of how people change their beliefs and make behavioral choices documents an effective method called the "disrupt-then-reframe technique" (Price-Davis & Knowles, 1999). Before a currently accepted behavioral pattern can be replaced by a new one, the equilibrium of the current one must be disrupted. The disruption causes the person to move to a lower or more archaic pattern in order to recapture a sense of control of the action or situation. With this attention to the details of the situation, a sense of mastery is regained. The regained control over the action or situation then allows the person to substitute a new choice for the old entrenched one. When an individual's normal behavior has been disrupted, he/she is much more susceptible to any reframe offered, and much more likely to adopt the new, reframed behavior. In the age-regression experience, the corrective experience "disrupts" the old pattern. For example, a client regresses to a four-year-old state, operating with a belief and behavior pattern that he cannot be assertive with his father for fear of being punished. In the session, he is encouraged by the therapist to express the indignation he feels, and to yell out his anger at his father, which disrupts the old pattern. When he does so, he moves to a more archaic behavior (expression rather than inhibition), and he feels more of a sense of control and less helpless. He is opened up to adopting a new belief pattern: I am the most safe when I assert myself by expressing my feelings.

An important corrective experience in the therapeutic process is reframing erroneous beliefs into new healthy ones. The concept was developed extensively within the Transactional Analysis (TA) field regarding child *conclusions*, and has been extended in the attachment theory field regarding *internal working models*. Zimberoff and Hartman (2002) studied the formation of these conclusions as early as prenatally, and their persistent influence throughout the lifespan.

The TA model of conclusions (English, 1977) is that they are arrived at nonverbally during early childhood, between birth and about age four to five. Conclusions are unconscious observations about the way the world is, generally related to the child's security and identity: "expressing feelings is dangerous," or "I am not good enough," or "I can only count on myself," or "I am only lovable when I am sick," or "others know who I am better than I do." Some conclusions result from generalizing direct experience, real or imagined. If I am hit or yelled at every time I express my feelings to Dad, I very soon conclude that it is dangerous to express myself (to anybody, not just to Dad). If I repeatedly experience being laughed at by others, even though their behavior is in fact not aimed at me, I am likely to conclude that there is something wrong with me, that I am shameful.

Some conclusions result from introjecting beliefs directly from caregivers, whether the message is conveyed verbally, behaviorally, or intuitively. If Mom tells me, "I wish you were never born" often enough, I soon develop ambivalence about being alive. In fact, if Mom holds that sentiment in her heart, whether she acknowledges it to me or even to herself, I am intuitively aware of it and am affected by it just as surely as if she says the words verbally. The message that I am unwelcome and rejected can be conveyed by a mother to the fetus in her womb.

Conclusions are experienced viscerally and are carried in procedural memory. They become unchallenged foundational assumptions about life, and seldom come into conscious awareness. One of the most important elements of correction in therapy is bringing early conclusions to conscious awareness where they can be evaluated and discarded or modified. Remember the findings of Lyons-Ruth and colleagues that what makes for personality growth is change in *procedural* memory (2001).

Conclusions are formed by the child differently at different ages. As a child grows, he creates conclusions in response to experiences at that particular age. A conclusion about not trusting strangers formed in infancy as a response to a specific incident becomes accepted as a truth about the world. Years later this child at age five encounters a different more positive incident with a stranger, and forms a new conclusion that strangers can be trusted without reconciling it with the previous conclusion. Many conclusions, regardless of consistency, may be generated and retained by a given child that continue to affect his feelings and behavior. When an experience triggers the infant experience, and its conclusion, the person reacts based on the conclusion that strangers cannot be trusted. Another time, when an experience triggers the five-year-old experience, and its

conclusion, the person reacts based on the conclusion that strangers can be trusted. An adult's tendency to indecisiveness and ambivalence may result from the stalemate of contradictory early conclusions competing for dominance in choice-making moments. Similarly, compulsive behavior and addictions may be seen as an attempt to find refuge, to quiet those competing "voices."

There are four fundamental states of awareness, distinguished by the frequency of electromagnetic activity in the brain, and each of the states acquire predominance sequentially in a child's development (Laibow, 1999). The predominant state of awareness of the individual at the time of establishing an early conclusion is fundamentally related to the nature of that conclusion and to how deeply encoded it is. The earlier the trauma, the more deeply encoded is the generalization of that experience in semantic memory, and the more tenaciously is it embedded. The good news is that the earlier the experience, the more direct is the access to potential transpersonal, transformational, spiritual energies.

- *Delta* waves (0.5 – 4 Hz), the lowest level of activity, are the principal waves expressed by the brain developing in the womb and through two years of age. An adult in delta is in an unconscious, sleep-like state or in hypnotic trance states and other portals to transpersonal experience, such as meditation.
- *Theta* frequency (4 – 8 Hz) is experienced primarily in children from age two to six. An adult just awakening, half asleep and half awake, is in this very imaginative theta-rich state. Theta activity is associated with emotional processes and also occurs during a state of maximal non-cognitive awareness, a stage at which the mind is capable of deep insights and intuition.
- *Alpha* frequency (8 – 12 Hz) becomes predominant around the age of six, bringing an awareness of self that is the hallmark of consciousness. This state in adults is a quiet calm state, a state of relaxed wakefulness, also described as relaxed vigilance, and is most conducive to creativity and to the assimilation of new concepts.
- *Beta* state (12 – 35 Hz) develops around the age of twelve as predominant. This is the customary active or focused state of normal adult waking consciousness.

EEG activity at the midfrontal region was recorded during live hypnotic sessions, which included an induction, progressive relaxation

deepening technique, and therapeutic ego-enhancing suggestions. Results indicated significant increases in *theta* EEGs across the hypnosis process with a peak at the deepening technique, and with peak *theta* and *beta* power occurring during ego-enhancing suggestions (Stevens et al., 2004).

In going back to the source of dysfunctional patterns, an individual may encounter multiple conclusions, dating to different ages or different circumstances. These need to be disentangled from each other so that they can be assessed individually. This actually happens sometimes in one regression session, with one conclusion being clarified in the first age regression to age seven, and another uncovered in a subsequent regression to infancy. Usually the earliest conclusions, the most primitive ones, are the most deeply embedded.

> Just as the gradual development of the Adult does not erase the *separate* phenomenological existence and function of the Child ego state (and this was one of Berne's great discoveries), so does the advent of age six not erase the fact that a distinct two-year-old Johnny *Child* continues to exist within the six-year-old Johnny. When six-year-old Johnny later operates as a Child ego state within 30-year-old Mr. Jones, there sit within him several other Johnnys representing the several distinctly *different* systems of thought and feeling that Johnny used in his past.
>
> Anyone who knows children will confirm that a six year old can switch between different "systems of thought and feeling" from moment to moment, just the way you and I might switch ego states from one moment to another. Six-year-old Johnny might transact as a two year old one minute, then again as a six year old, then as a one-month-old infant, and then back as a six year old. These switches do not operate in an orderly regressive or progressive fashion, any more than do the ego-state switches of a grownup (English, 1977, pp. 301-302).

In the course of treatment in regression therapy, a particular primitive conclusion is identified and its continued existence threatened through therapeutic intervention. If the individual is not ready to release it and let it go, he may spontaneously switch to the ego state of another age, to another subsystem of the Child, usually to an earlier, more primitive one.

These early erroneous conclusions can be traced back to the circumstances surrounding conception into earthly life and through the prenatal womb-time. Next we review these stages of development based on Bourne (1975), Emerson (2002b), Seifert et al. (2000), and Upledger (1996), and the typical conclusions arrived at in each. These are broad generalizations, but they may be useful to the regression therapist in understanding likely conclusions being deeply encoded and imprinted at various milestone ages of development.

Pre-conception. Emerson (2002b) suggests, from many narrative accounts of regressions, that at the time of saying the "Final Goodbye" to spirit world before conception, many people feel angry, sad or ambivalent. The ambivalence is about uncertainty regarding whether one wants to be in this earthly life, made the right decision to come here, wants to go back, or hesitates to go forward. Alternatively, some people feel ecstasy and exhilaration. Emerson has catalogued a number of common experiences at this momentous time:

  a. *Divine homesickness*, in which the soul experiences loss, rejection, inadequacy and shame at leaving the spirit world, and longs to return.
  b. *Divine exile*, in which the soul experiences being expelled from or forced to leave Heaven, with resulting feelings of rejection, inadequacy, anger, guilt, shame and confusion.
  c. *Regretful choice*, in which the soul feels it made a choice to come here, but judges it to have been a bad choice.
  d. *Foreboding*, in which the soul feels a pervading but undefined sense of foreboding, not knowing what to expect but expecting it to be bad, whatever it is.
  e. *Clinical depression and anxiety*, in which the soul experiences the loss of spirit world and a dread about earthly life. There is a general sense of impotence to impact the life to come, fear of not being adequate to the challenge, and ambivalence to engage life.

Conception. At the time of fusion of the sperm with the egg to form a fertilized cell the prenate may experience an eagerness to move forward with the journey into human life, or dread, or ambivalence, depending largely on the attitudes of the mother (carried in her egg) and father (carried in his sperm). The egg may experience being penetrated as ecstatic union or as violation. The sperm may experience entering the egg as ecstatic union or as engulfment. Traumas that can influence the conceptus' experience include, for example, forced sex, substance abuse, physical abuse, poverty, war, or personal or cultural shame, such as when children are conceived out of wedlock or the child is the product of rape. If an individual feels unwelcomed or threatened by one or both of the parents, or ambivalence by either one, then surely he/she will have decidedly mixed feelings (anxiety and ambivalence) toward the unfolding journey.

The child's parents' feelings about becoming pregnant with him/her at the time of conception has a profound impact. Feder (1980) discusses the

parents' fears, ambivalence and contradictory conflicts, usually unconscious, regarding pregnancy. He used the term "preconceptive ambivalence." He suggests that the consequences of those fears and conflicts will greatly impact the future child, "whose destiny is significantly determined by both the manifest and the latent portions of the initial parental ambivalence surrounding his psychological and biological conception" (p. 164). Feder considers that, of all these preconceptive beliefs, the most damaging of all is the narcissistic hurt of realizing one is unwanted. He asserts that the initial ambivalent conflicts embedded in the child even at conception continue to manifest throughout the lifespan through repetition compulsion and recapitulation.

Individuals aware of being an "unwelcome child," e.g., parental rejection in the form of contemplated or actual adoption or contemplated or attempted abortion, react with shame and overpowering anxiety regarding their very right to exist. They may act to fulfill their perception of their parents' desire for their death. The existential angst and death urge become deep, unconscious forces at work throughout the individual's life. Research by Southgate and others suggests that many child accidents are in fact unconscious attempts at suicide (Southgate & Whiting, 1987).

Implantation. The new life descends through the fallopian tube to the uterus, a journey of about four inches. The experience of being in the fallopian tube is usually snug and "swaddled," but leaving it to enter the vast cavity of the uterus can feel like tumbling or falling. This occurs about one week (six to nine days) after conception, and the new life is impelled to stop its fall by grabbing ahold of something solid. Implantation is the process by which the fertilized egg attaches itself to the wall of the uterus, embedding into the uterine lining and becoming enveloped by it. The individual conceptus begins questing for a suitable site to implant, one that offers fertility, nurturing and welcome. Typically, the uterus at first reacts to this invasion of the new life (now called a blastocyst) as it would to the presence of an intruder. The lining tissues actively swell outward to engulf the embryo, and flood the area with thousands of white blood cells to deal with the invasion. Then, ideally, resistance turns to welcome. The blood vessels of the uterus become greatly engorged with blood, the lining glands secrete their fluids more actively, and the uterine tissues seem to make a place for the embryo (Bourne, 1975).

Depending on the father's and mother's attitudes, the individual may instead experience the uterine wall as barren, toxic, or engulfing. Examples are (Emerson, 2002b): a "narcissistic uterine wall" (quicksand that sucks

one into satisfying the mother's needs); an "entrapping uterine wall" (engulfing, full of rigid conditions and demanding expectations); or a "rejecting uterine wall" (unwelcoming, carrying the message that "I don't really want you" or "You are a burden"). Any of these compromised sites for implantation could result in a feeling of not belonging, of confusion and ambivalence about "being here" in this life, and could activate defenses of avoidance, control or preoccupation.

Themes of the implantation experience are creation, survival, and the life-death struggle. It is also during this phase of development that some individuals encounter the spirits or energies of previously conceived lives that have passed through this womb; particularly siblings that have been miscarried or aborted. Many people experience twin loss as well. Up to 80% of all conceptions are multiple, while only 10% of births are twins, leaving many twins lost within days of their multiple conception. Most of the deaths of a twin occur in the implantation time period.

Individuation. After 5 to 7 days of being completely absorbed by the mother in the uterine wall (in implantation), i.e., about two weeks after conception, the conceptus begins to grow back out of the uterine wall, separating from the mother's flesh. The separation can bring relief and a sense of freedom and accomplishment, but it can also initiate a profound sense of alienation, rejection and loneliness.

Because 60% of fertilized eggs die during implantation, and another 40% of embryos die during or after individuation, the struggle for the conceptus is one of life-or-death. In a hostile or ambivalent uterine environment, the conceptus may experience a sense of impending death, carrying a "death imprint" that contaminates the life-oriented impulse to move forward in life.

We will observe that several elements persist in subsequent stages of development: feelings of rejection, confusion, foreboding, engulfment, and a sense of impending death. We find these recapitulated in later stages of prenatal life, in birth experience, and in the struggle for balance on the continuum of security/ exploration, of attachment/ individuation for infants, toddlers, children, adolescents, and adults. And there is a special connection between the conceptus' experience of individuation and that person's eventual experience of death, both monumental times of separating from the mother's (or Mother Earth's) flesh.

Pre-Discovery. During the time from conception until the mother knows she is pregnant, the new life may experience a number of things. If there is fear of not being accepted, the prenate may experience existential

despair ("No one knows or cares that I exist"), or shame and anxiety ("I must hide and be still so they don't know I am here"). The defenses of withdrawal, hiding, and dissociation can then become imprinted as lifelong patterns.

Discovery. Once the mother knows with certainty that she is pregnant, the embryo experiences unconditional welcoming or varying degrees of rejection. Rejection may take the form of ambivalence, anxiety, shame, or even abortion thoughts or attempts. Or the rejection may take the form of realizing that the parents, rather than wanting *me*, actually want me to be a surrogate for their own unfulfilled dreams, or a replacement for a lost child. The embryo feels terror or despair at the threat to its existence, concludes that "I am in danger of annihilation," and defends by hiding its very existence, adaptively becoming "no bother," or raging at the disappointment of rejection.

At some point, often at discovery, this newly embodied life comes to realize that "I am not in control of my world." My assumption of the freedom of omnipotence is contradicted, and my total identification with myself is split, leaving me with the shattering conclusion that "I am wrong, bad, or unworthy," or that "I am totally powerless," or that "I am nothing, there is no real me, no unique identity." Ultimately what is called into question is that "I do not deserve to live." Faced with annihilation, the individual finds the defense of splitting. I turn against myself, distance and disown my original self-concept as perfect and whole. In its place I adopt a new identity, aligned with the apparent source of power, and this split results in the beginnings of identification with parental or other external introjects.

The embryo. At three weeks gestation, the head, brain and circulatory system begin to develop, and the heart has begun beating. At four weeks, and about an inch in length, the embryo begins to develop a spinal cord, arms, legs, and a digestive system. During week five, hands and lungs begin to form. During week six, the head grows larger, and the hands, legs and feet become more fully formed. During week seven, muscles form and the cerebral cortex part of the brain begins to develop. The new life's focus during the first trimester of gestation is on embodiment in this new physical form, on growth and expansion in the physical realm, and on how the environment either promotes or obstructs that growth.

The fetus. At about eight weeks, the eyes really begin to develop, along with fingers, fingernails, and eyebrows. Physical features become more adult looking. By twelve weeks the fetus responds to touch. By

sixteen weeks the fetus has a grasp reflex when its palm is touched and a Babinski reflex when the sole of its foot is touched. Between the fourth and fifth months, eyes can open and close, hearing is present, and lungs become capable of breathing in and out. The primary emphasis for the fetus during the second trimester is bringing spirit into the body.

During the third trimester, the fetus' primary focus is on its ego-oriented approach to earthly life. By the beginning of the seventh month, it has attained viability and could survive if born. The fetus may now be experiencing its environment (its mother) as suffocating, toxic, disconnected, or nurturing, and may be feeling impatience to get out, starved, lonely, or content.

Birth. The birth experience itself, elaborated by Grof (1985) as basic perinatal matrixes (BPM), can be fertile ground for observation of the early traumas, conclusions, and behavioral defenses. These four stages of birth are very real when re-experienced by an individual in age regression. Each stage offers a new challenge to the baby, and learning to navigate the nuances of the birthing experience will add immeasurably to the therapist's helpfulness in facilitating it for the client.

Obstetrical interventions in the birth process often recapitulate the neonate's previous conclusions about life. These include:

1. anesthesia, with control taken away through dissociation and thus resulting in bonding deficiencies and a desire for stimulation and contact;
2. induced labor, with control taken away through being overpowered and thus resulting in bonding deficiencies and a desire for less stimulation and contact;
3. forceps delivery, with control taken away forcibly, resulting in authority issues, rescue expectations, and bonding deficiencies;
4. cesarean delivery, with mutuality in the task taken away arbitrarily, resulting in bonding deficiencies, interruption and invasion complexes, and rescue expectations.
5. The separation of baby from mother immediately upon birth is perhaps the most damaging of interventions, as well as the most common, resulting in abandonment fears, control issues, and uncertainty about being welcome here.

Following is a summary of the erroneous beliefs that are common to each stage of birth (Table 2).

BPM I: Intrauterine Experience Before the Onset of Delivery

This matrix is related to the original condition of the intrauterine existence during which the child and his mother form a symbiotic unity. This symbiotic unity can be disturbed (in a toxic womb) or secure, protected and nurturing (in an optimal womb).

Erroneous beliefs: Resistance vs. acceptance, separation anxiety, longing for peace or stability, anxiety vs. safety, trusting vs. mistrusting oneself (intuition)
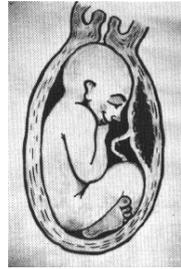
BPM II: Contractions in a Closed Uterine System

This episode can be one of "no exit," especially if there is interrupted or induced labor, or ambivalence on the mother's part. The fetus is alienated from the mother with no possibility of immediate escape which may be later manifested as feelings of being trapped and hopelessly overwhelmed.

Erroneous beliefs: Engulfment vs. clear direction, overwhelm, trust (reaching out or withdrawing), personal power vs. the Victim Triangle

BPM III: Propulsion through the Birth Canal

The uterine contractions continue, the cervix is wide open and the gradual and difficult propulsion through the birth canal begins. There is an enormous struggle for survival, crushing pressures and suffocation. The system is not closed any more, however, and an end is in sight.

Erroneous beliefs: Identity confusion, struggle vs. ease (spontaneity vs. regimentation)

BPM IV: Separation from Mother and Formation of a New Relationship

In this phase the agonizing experiences of labor culminate, the propulsion through the birth canal is completed and the ultimate intensification of tension and suffering is followed by a sudden relief and relaxation. Now the process of balancing attachment and individuation begins.

Erroneous beliefs: Unworthiness, separation vs. inclusion, fear of needs not being met

Table 2. Grof's Four Stages of Birth (1985)

Childhood. Next we review stages of development from birth to adulthood based on Barrett (1996), English (1977), Erikson (1963), and Spitz (1965), and the typical conclusions arrived at in each.

(1)   infant **(0-3 months)** is devoted to one of two alternative global messages: "Come into the world, you are welcome here" or "Go back where you came from." Conclusions center around the leading anxiety of this stage: fear of annihilation of the self and fears of needs not being met. The main defense employed against the terror of dissolution is splitting. Hated or feared aspects of the self are split off and kept separate and distinct from idealized parts. Healing requires that the split off parts, i.e., inner resources, need to be retrieved.

(2)   baby **(3-8 months)** deals with conclusions about being omnipotent (cosmic grandiosity) or impotent (despair and hopelessness): "My needs are automatically fulfilled – I control others by my wishes" or "Nothing is okay." The leading anxiety of this stage is fear that one's potency will result in being abandoned or that one's impotency will result in engulfment.

(3)   toddler **(8-14 months)** conclusions have to do with either confidence about or fear of excitement, curiosity, and experimentation, depending on the pleasurable and painful consequences, on the encouragement for or injunctions against exploration. The leading anxiety of this stage is shame, and safety lies in controlling and constricting. Basic beliefs about the world in general are formed here.

(4)   toddler **(14-24 months)** conclusions revolve around imitation of the caregivers, centering on more or less willingness to accept authority and on powerlessness. Beginning at about fourteen months of age, a conflict emerges between the child's grandiose aspirations and his/ her limitations and dependency. The leading anxiety of this stage is fear of rejection (insignificance), and the need for approval. Persecutor and rescuer stances often result from conclusions established in this stage, as well as conclusions about successful or failing results from taking initiative.

(5)   controller child **(2-3 years)** conclusions center around power struggles, manipulation of power to challenge parents, e.g., wanting just the opposite of what they want for or from him. The leading anxiety of this stage is fear of weakness. Shame is often

used to control the child of this age, and conclusions regarding shame abound. Children learn which emotions are acceptable and which must be repressed.

(6)   existential child **(3-4 years)** creates global conclusions about self-worth and other-trustworthiness, about social inclusion vs. exclusion, creating the existential positions identified by Berne (1962) as "I'm okay, you're okay" or "I'm okay, you're not-okay" or "I'm not-okay, you're okay" or "I'm not-okay, you're not-okay." The first leads to conclusions of security, the second to self-reliance and mistrust of others, the third to self-doubt, feeling overpowered and dependent on others, and the fourth to despairing impotence.

(7)   pre-schooler **(4-7 years)** conclusions revolve around charting his existence in the context of past and future, newly evolved concepts. The leading anxiety is fear of not belonging and not being accepted. Non-resolution of these anxieties creates a feeling of being stuck and trapped, since today's experience is now being extrapolated out into the indefinite future. Identity is based on inclusion, and so non-acceptance results in identity confusion.

(8)   latency (**7-12 years**) conclusions revolve around esteem and adequacy, discovering and expressing one's true self, and rules and authority. Dysfunctional beliefs center on perfectionism; procrastination; inability to negotiate, either giving in completely or insisting on having one's own way; inflexible values; discounting one's own feelings; or living in the past or future, not in the present.

(9)   adolescence (**12-13 years**) when the central concern is belonging, driven by the need for acceptance. The leading anxiety is narcissistic self-doubt and self-judgment (fear of vulnerability), and defenses tend toward psychological games to avoid real intimacy, needing to be one-up on others, and abandoning self to avoid separation or completion. Conclusions center around desperately seeking companionship to fill the emptiness one perceives in oneself

(10)   adolescence (**14-16 years**) when the central concern is uniqueness, driven by the need to separate or individuate. The leading anxiety is fear of intimacy, fueled by self-absorption. Conclusions center around either forming codependent

symbiotic relationships in which one loses a sense of separate identity, or isolating.

(11)   adolescence (**17-18 years**) when the central concern is worthiness, driven by rigorous demands to live up to internal standards and expectations. The leading anxiety is lack of clarity regarding one's purpose in life. Conclusions center around projection and identity confusion.

(12)   **adulthood** is the time to create meaning in life through appropriate decision-making and life-building. The leading anxieties are unworthiness, the struggle between alienation and connection, spiritual struggles over the "loss of soul." One struggles to create authenticity in life, overcoming fear of the unknown and resistance to change. Ultimately, one must prepare to face one's death anxiety.

These early primitive conclusions are not accessible through conscious verbal memory. TA group work combined with Gestalt therapy work has attempted to notice the activation of an early conclusion in the present moment through changes in the client's autonomic nervous system, such as blushing, tensing, twitching, blinking, laughter, sighing, and subtle changes in breathing. We suggest that a much more direct and accelerated method of accessing and identifying these primitive conclusions is age regression in hypnotherapy, or in trance-state psychodrama.

Reclaiming "lost" parts of the self
Furman and Furman (1984) discuss the phenomenon of "the lost child." Some parents or caregivers are unable to invest their psychical energy in their children. They are so preoccupied and distracted with their own unmet needs that there is just not enough attention left for the children. This is different from the parent who selectively attends to the child, offering conditional acceptance for certain aspects of the child and rejecting others. The parent of a lost child is not energetically connected with the child at all.

This child is ignored, neglected, and overlooked. Frequently, these children may be literally lost, having wandered off from a non-attending caregiver. The child learns to be vigilant for non-attention, and at the same time to have no expectation of getting attended to. Two primary ways such children attempt to protect themselves are (1) confrontationally demanding attention, and (2) precocious reversal of roles, i.e., mothering in order to be

mothered. The residue of such an experience in early development results in the adult's inability to invest emotionally in relationships, including in the relationship with himself. As the Furmans (1984, p. 432) summarize: "We invest in others, in things outside ourselves, as we invest in ourselves and we invest in ourselves as our parents initially invested in us."

It is immensely corrective when the client experiences regressing back to the "lost child" that they were (and that has continued lost ever since), and investing attention and compassion in that child ego state within. That child has been waiting, lost and disconnected and feeling forgotten, since the original experience, waiting for someone to come find and retrieve him/her. Now the client has the opportunity to correct the original experience of being parented, providing the safety and nurturing and attention that every child needs for healthy development. Correcting the deficit in the way our parents invested in us repairs the deficit in the way we invest in ourselves. And that in turn repairs the disconnect in the way we invest in our relationships.

Another form of going back, finding and retrieving in the age regression is to identify the child's strengths that were jettisoned and subsequently lost in the effort to cope with and survive trauma. The child may have lost her innocence, courage, trust, playfulness, etc. And it is wonderfully healing for the adult to experience retrieving those lost qualities on behalf of the child, and returning them to the rightful owner – the child now grown to adulthood.

Ultimately, of course, we assist the client in retrieving lost, i.e., disconnected, parts of his/her soul. It is no more of a theoretical or methodological stretch for the client to retrieve her disconnected soul than it is for her to retrieve lost trust or innocence.

We have discovered during the course of doing trauma work that traumatized individuals often have a splitting or fragmentation of the soul. Just as the personality can split off when trauma occurs, so too does the soul. It appears that pieces of the soul may split off or fragment (Modi, 1997) during different experiences. If the trauma is extreme enough, the entire soul may actually separate from the body. This fragmentation produces an individual who seems disconnected, dissociated and spaced out. There are many terms in our language that indicate this condition, such as referring to someone as "a lost soul," or "a space cadet." When someone has a traumatic experience, we may refer to it as "the dark night of the soul."

Jung refers to the diminution of the personality known in primitive psychology as "loss of soul" (1959, p. 119). He states that we label the similar experience in our civilized culture as an "abaissement du niveau mental," and describes it as "a slackening of the tensity of consciousness, which might be compared to a low barometric reading, presaging bad weather. The tonus has given way, and this is felt subjectively as listlessness, moroseness, and depression" (p. 119). The condition can go so far that the individual parts of the personality become independent and thus escape from the control of the conscious mind, a phenomena known as hysterical loss of function. The condition results from physical and mental fatigue, bodily illness, violent emotions, traumatic shock (p. 120), and dissociation and suppression of consciousness (p. 281).

We strengthen and consolidate the soul by retrieving any fragments that were separated at moments of trauma or unbearable pain (in this life or past lives). Jung said his task was the "cure of souls" (1961, p. 124). This surpasses the healing of pathology and aims at the fulfillment of individual wholeness. Within that Jungian context, we have learned from shamanic sources how to retrieve and integrate the "lost soul."

We say metaphorically that the person, or aspects of the person, were *lost* when what we mean is that they were *disconnected from*. In reality, however, these parts of the child have more literally been withdrawn inward for protection and safety. Within us all there exists a "sacred zone of safety," "an ultimate zone of safe retreat" (Eigen, 1973) that we can move away from threats of impingement from the outside world as needed. It is the "silent self" that Winnicott (1965) speaks of, a true, silent, inviolable self. The disconnection occurs for traumatized children because the person is eventually forced to make a terrible choice. Either she becomes schizoid, detached and depersonalized, withdrawn and contracted into this zone of safe retreat deep within, disconnected from others, or she sacrifices connection with the self in retreat, in order to maintain connection with others. Either choice leaves the child paralyzed with psychic deadness and a loss of meaning, alienated, estranged, facing the annihilation of identity with aliveness (Eigen, 1992). The true self is protected in its zone of safe retreat, but it is shell-shocked, made into an object (Spiegel, 1997), unreal even to herself.

Incidentally, there is a gender difference in making that terrible choice. In general, female responses to stress are to "tend and befriend," whereas male responses are to "fight or flight" (Taylor et al., 2000). Traumatized girls tend to sacrifice themselves in return for the connection with others

that is so vitally important. Traumatized boys tend to prefer avoidance and emotional distance, sacrificing the connection with others in return for the illusion of autonomy.

The concept of a "zone of safe retreat" provides an intrapsychic context for retrieval, whether retrieval of attributes, or ego states, or of the soul. We are, perhaps, retrieving "lost" aspects of the self from that place deep within where they were originally put for safekeeping.

Expanding into the transpersonal realm

The various types of corrective experience contained in this section share in common the reclaiming of one's identity, and, indeed, the expansion of the boundaries of that identity. This goes beyond increasing ego resiliency, and may be envisioned as "self-expansiveness" (Friedman, 1983, p. 39): an expansion of "the amount of the true self, or the universe of possibilities, which is contained within the boundary demarcating self from non-self." The self-concept expands as old dysfunctional imprints about oneself are shed, as erroneous identifications with introjects are let go of, and as new beliefs about oneself are embraced. As the individual incorporates shadows that were repressed as well as aspects that were dismissed as "unattainable," the scope of one's identity grows.

One's identity grows on the personal level in relation to self-acceptance, self-esteem, personal meaning, and presence in the here and now of one's life. That expansion requires permissiveness on the part of the ego, a willingness of the ego to relinquish "some of its power to allow the actualization of the potentialities of the preconscious and unconscious aspects of the personality" (Taft, 1969, p. 36), to allow peak experiences, acceptance of fantasy, and belief in the supernatural. Exploration of the realms of the preconscious and unconscious invites expansion into the realms of the transpersonal. One's self-concept grows on the transpersonal level, then, in extending beyond the here and now, such that the sense of existential isolation and limitation to the present time transforms into a sense of radical connectedness, i.e., the self-concept is *un*boundaried by time and physicality (Mayer, 2002).

In a hypnotherapy session, the individual usually encounters one or more of the following non-ordinary states of consciousness: (1) pre-conception; (2) prenatal; (3) birth; (4) dreams; (5) dissociation; (6) anesthesia; (7) meditation; (8) near-death or out-of-body; or (9) death itself. It can be very corrective to have these experiences

within the context of a supportive and therapeutic container, and the hypnotic trance milieu helps to normalize them.

Grof (1993) discusses the term *transpersonal* as referring to the transcendence of *conscious* and *individual unconscious* experience. This could include transcending the barriers of conventional time, space, or 'objective reality' limitations. Transpersonal consciousness could transcend the 'normal' ego boundaries, beyond the everyday distinction between ego and everything else.

Transpersonal consciousness exhibits in three ways: (1) as the psychic state, beyond the scope of the five senses and related to the body and personality; (2) as the mystical state, beyond the scope of the five senses and related to the soul; and (3) as the hypnotic state, a "wide angle lens" capable of surveying and finding patterns in a broad range of information related to the body, personality, *and* soul.

Psychic phenomena encompass out-of-body and life-after-death experiences, telepathy, precognition, clairvoyance, and extrasensory perception. Psychic states are transpersonal, and utilize the higher chakras to gain access to the superconscious and collective unconscious. People in hypnotherapy often experience, for example, an intuitive "knowing" about what others are feeling, including those who are deceased. Or they may experience seeing themselves in traumatic situations from outside themselves, out-of-their-body, witnessing an event rather than reliving it. When participating in the rehearsal of a future event, the hypnotherapy client may experience an extraordinary sense of certainty about what will happen.

The mystical state reveals spiritual knowledge in a direct internal experience, relating to the human soul as contrasted with the human personality. The basic ingredient of the mystical state is direct experience of the self as Soul, greater than the sum of one's body and personality, a sacred or holy experience. These experiences sometimes take the form of out-of-body and near-death. Jung referred to these mystical experiences as *numinous* to avoid any religious connotation. People in hypnotherapy often experience, for example, an all-enveloping sense of well-being after completing the catharsis and re-uniting with a lost or misplaced part of themselves. This may be viewed as reclaiming one's lost innocence or courage, or sometimes as literally retrieving one's lost soul. Another example of mystical experience is past life regression, in which one

experiences himself as Soul, even though it is in another body, personality, and time.

The hypnotic state is a "wide angle lens" consciousness capable of surveying and finding patterns in a broad range of information related to the body, personality, and soul. The hypnotic state allows access to the personality (conscious and individual unconscious) and to the soul (transpersonal).

Access to these transpersonal realms of energy, spirit, birth and death is available through transpersonal portals such as hypnosis, breathwork, near-death experiences (NDE), shamanic states, and the lucid dreaming state. Each of these states generates an increase in primary process thinking, a feeling of acute increased awareness, and a lowering of perceptual boundaries.

Cathartic therapy challenges old patterns of identifications and self-concepts, resulting in self-expansiveness, which in turn brings us as close as we can get to Self, or Soul. "The deeper the catharsis, the more likely that core aspects of the psyche will be touched at the level of transformational and/or spiritual energies. By 'transformational energies' we refer to the essential energies that connect us to the Self, energies that we can access through meditation, or other spiritual disciplines" (Emerson, 2002a, p. 69).

"Soul, according to [James] Hillman, is most apt to emerge in those chaotic, 'pathological' moments when we experience the disintegration of our beliefs, values, and security. For it is in such moments that our imagery, emotions, desires, and values are heightened and we have the fullest awareness of the psyche in its essential form. Indeed, for Hillman, the very point of deconstructing our fixed ideas in psychology is paradoxically to provide us with the conditions for the revelation of psyche itself" (Drob, 1999, p. 58).

Eigen (1981) calls the experience of becoming open to what is most basic and authentic in human experience, quoting the biblical phrase, experiencing "with all one's soul and all one's might" (p. 413).

Following are several examples of the corrective nature of transpersonal experiences in Heart-Centered therapeutic sessions. When a person goes through the death experience in a past life regression, the deep unconscious death anxiety is assuaged. Once past the dying and into the death it is virtually always experienced as calm, peaceful, illuminating, and transcendent. Likewise, people will often encounter in a session a loved one who has died, and be able to interact with the individual's spirit. Such

an encounter almost always provides a heart-warming completion of the grieving process that has been unresolved up to this time. People regress back so far that they encounter the experience in the interlife before incarnating on earth with their conception. The objectivity from this perspective often allows the person to let go of the victim stance regarding their life circumstances, and to begin accepting a much higher order of personal responsibility: "I chose these parents and this family in order to learn valuable lessons."

It is highly corrective for clients to know that their therapist is comfortable with the unpredictability, disorder, and ambiguity of transpersonal states. "Therapists in general probably underemphasize how putting contradictions together helps the patient to transcend the problem . . . Transcendent knowledge reveals that, for example, regressed components of the personality can coexist with and even enhance more mature elements, one does not preclude the other. . . . With this approach, there is maintained an aliveness, immediacy, and an excitement with the question rather than a 'now it is finally solved, and I can go on to something else' attitude" (Twemlow, 2001, p. 14).

Summary

We might conceptualize successful therapy, modeled after normal development, as a corrective experience of the attachment-separation-individuation developmental process (Copeland, 1986). We build the therapeutic alliance, then work toward attachment without ambivalence, and separation without anxiety.

> The focus in this stage of hypnotherapy involves the therapist's alliance with the patient's highest level of ego organization (Smith, 1984) or the healthy, mature ego (Fromm, 1984); emphasis on the controllability of symptoms (Murray-Jöbsis, 1984); building up the patient's strengths, as opposed to analyzing weaknesses (Fromm, 1984); placing limits on the patient's idealization of the therapist (Murray-Jöbsis, 1984); and fostering the introjection of the therapist as a "good," stable, and enduring object (Baker, 1981) (Copeland, 1986, p. 162).

Through creating corrective experiences in therapy, the dysfunctional can be lovingly released and the lost functionality can be lovingly retrieved. This is truly a process of, in Welwood's terms, awakening the heart. We gratefully and humbly facilitate that process through the vehicle of Heart-Centered therapies.

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