

Exploration of the integration of hypnosis and
psychodynamic psychotherapy

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Introduction

Integration plays a major role in psychodynamic psychotherapy. (Jacobs, 2012) The approach itself encompasses various schools of the dynamic psychological theories such as Freudian, Kleinian, Jungian, Object Relations, Attachment theories, Transactional Analysis and in some extent the Narrative approach. (McLeod, 2009). Also, the process of integration of the personality is one of the core concerns of psychodynamic psychotherapy. The word “dynamic” describes the psyche’s active relationship with the outside world (people, objects or part-objects) and with the internal aspects of the psyche itself (“selves”, ego-states or internalised external objects). The aim of dynamic therapy is to take disowned, split and repressed feelings, thoughts or aspects of the self and make them part of the conscious psyche while facilitating the person to gain awareness and understanding into his or her psychological forces. It is a basic premise that childhood experiences are especially powerful in the making of the adult personality and thus therapy focuses on the exploration of the client early development and its possible linkage to current experiences and difficulties. Making sense of the person’s experiences helps promote healing. According to psychodynamic theories “psychopathology is understood as a product of repression and dissociation and therapy is designed both to identify the repressed dynamics and to allow clients to gain insight into formative experiences at physiological, affective and cognitive levels.” (J.Hawkins, 2006, p. 61).

The explorative journey into one’s psyche or in other words the “process” is central to the psychodynamic therapy and it is the therapeutic alliance between the client and therapist that provides a safe background for the work to take place and change to happen.

Integration of hypnosis and psychodynamic psychotherapy is surrounded by scepticism for they believed to have irreconcilable differences (Karle, 1987). The reason behind this is that hypnosis is still widely associated with authoritarian hypnosis (direct suggestions focusing on symptom removal) rather than its modern application, the “permissive hypnosis” where the therapist acts as a “benign guide” (Fromm, 1987, p. 2). It is the inappropriate use of hypnosis, in worst cases the manipulation, intimidation and psychological seduction of clients (I. Lief, 1999) that feeds these concerns and beliefs that lack a scientific openness and cause hypnotic techniques to be dismissed altogether (Fromm, 1987; Karle, 1987). While suggestion would superimpose something new upon the client, the aim of permissive hypnotic techniques is similar to that of the psychodynamic interventions, namely to uncover the aetiology and source of the client’s psychological problems (Bernstein, 2001).

The phenomenon of hypnotic trance is more common than one would think and it can enhance the in-depth exploration of the psyche (Mackey, 2009).

Hlywa and Dolan defined hypnosis as “the inherent, enhanced potentiality of human beings, which spontaneously appears in human life and which is also tapped by certain procedures known as hypnotic induction” (Hlywa & Dolan, 2011, p. 125). It is inherent because - usually unaware - from

deep sleep to normal waking state people reach various psychological states every day producing different brain waves each time they tap into the various mind states. The brain produces Beta wave patterns in the ordinary state, Alpha waves under relaxation, Theta waves in deep meditation and Delta waves while one is sleeping (Hartman & Zimberoff, 2013; Howell, n.d.).

The mind state that we call hypnotic trance is the Theta state. It is also known as the hypnagogic state or deep mind, an altered brain state that is often referred to as the gateway to the lower unconscious and also the higher unconscious or superconscious mind (Whitmore, 2013). It is associated not only with an increased level of suggestibility but also intuition, higher aspirations and insight that lie beyond the border of normal awareness. (Al Rubaie, 2004; G. Jones, Ed.S., 2009; Hartman & Zimberoff, 2013; Hlywa & Dolan, 2011; Karle, 1987; Knight, 1995; McKay, Davis, Eshelman, & Fanning, 2008; Whitmore, 2013, 2013)

This paper aims to explore the dimensions of hypnosis other than direct suggestions and review techniques which employ the Theta state and can enhance the explorative journey into the psychodynamics. Although Freud abandoned hypnosis as a means of suggestion (1904), others like Carl Jung continued to work with this psychological state using it as a vehicle to retrieve forgotten psychic wounds and access unconscious repressed material of the client (Hartman & Zimberoff, 2013). As previously mentioned, in this type of hypnosis the focus rests on communication and the therapist stance remains that of the client - centred therapist, namely a facilitator of the client's self-exploratory processes. Helmut W.A Karle (1987) highlights the commonalities between modern hypnosis and dynamic therapy in the sense that the modern understanding of hypnosis involves a therapist "who is doing nothing other than assisting the patient to take or recover control of functions that have become disordered, or to assume control in areas in which it had been lost or where control had never been known"(Karle, 1987, p. 59).

This paper will explore ways which can take the previously mentioned explorative journey to another level. The overall aim is to widen the discussion around the integration of hypnosis into the contemporary psychodynamic treatment. In the material accessed reference is frequently made to "hypno-psychotherapy", "hypno-analysis" and "hypno-counselling" to describe this type of integration which claimed to be of a great benefit to the client (Frederick & McNeal, 2013; Fromm, 1987; J.Hawkins, 2006; V. Sunnen, n.d.) when administered in an appropriate and professional manner.

Emotional catharsis is considered one of the major curative factors in psychotherapy (Frank, 2006; J.Hawkins, 2006; Kosmicki & Glickauf-Hughes, 1997; Von Glahn, 2011). However catharsis alone cannot effectuate a permanent therapeutic change, it is highly associated with "re-experiencing" in the hypnotic trance (Jorgensen, 2004) thus makes it highly relevant to the subject matter. The researcher is also interested in the exploration of methods applied to avoid an exposure to premature revivification of traumatic experiences and to provide the client with resources with which they can cope with and resolve painful memories and reinterpret the situation with new information and insight.

Abreaction and catharsis, their historical account and mechanisms will be explored in Chapter 1 with hypnoanalytic techniques used for therapeutic interventions being assessed in Chapter 2. Discussions and arguments will be embedded in the text and along with the data on the various research areas. Chapter 3 will enumerate and discuss contraindications which will be followed by the Evaluation.

1. Chapter: Abreaction and Catharsis

1.1 Definitions

Abreaction: It can be defined as a discharge of “pent-up” emotions or “strangled affect” (Bernstein, 2001, p. 3) that is “consistent with a traumatic memory, experienced when an individual relives that trauma.” (Jemmer, 2006, p. 30).

Catharsis: The English term derived from the ancient Greek and it refers to the process of purging and cleansing through a release of emotional tension. It results in purification which is often associated with psychological healing. (Hartman & Zimberoff, 2013; Jackson, 1994; Jemmer, 2006; Kosmicki & Glickauf-Hughes, 1997)

1.2 Historical account

Jemmer (2006) in his paper “Stirring Dull Roots with Spring Rain” provides a thorough historical account on the origins of abreaction and catharsis. Rituals and ceremonies of purification and cleansing have always been part of the human life. Impurity and uncleanness stem from the innate repugnance felt in relation to one’s bodily fluids which were always seen as signs of human profanity and were associated with unworthiness of the connection with the deities. This sense of impurity and inferiority translated into the religious notion of sin. While purifying rites continue to be in place in the various religious practices bathing and changing clothes on a daily basis in people’s everyday life also suggest the basic need to be clean physically and with that, psychically.

Jemmer, citing Barbour, points out that the rituals of the ancients who “danced, chanted, sang, and pounded drums...” (2006, p. 27) can be learned from in terms of their holistic healing methods in which they treated the person as an integrated whole; physically, emotionally and spiritually. They employed abreaction and catharsis to achieve the “extreme feeling of serenity” centuries before any scientific framework has been laid down.

The term catharsis in its application as a metaphor first emerged in relation to the Greek tragedies. Aristotle claimed that when the protagonist’s downfall induces pity and fear in the audience, the outpouring of such intense emotions would help them restore their emotional balance. “The ecstatic individual would have an increased capacity in various modes of operation: whether emotional, physical, spiritual or intellectual, he or she might therefore attain a depth of feeling, spiritual revelation, intellectual insight, or physical prowess not accessible under mundane conditions.”(Jemmer, 2006, p. 28)

In psychotherapy, the cathartic –method developed by Breuer and Freud considered to be the prelude of modern emotive therapy. (Bernstein, 2001; Kosmicki & Glickauf-Hughes, 1997). The technique they used was the so called hypnoanalysis (Hawkins, Fromm) which was a “clinical innovation of listening to patients talk freely while in hypnosis.” (Stross & Shevrin, 1969, p. 135). The phenomenon called abreaction was first reported by Breuer and Freud during hypnoanalytic works of hysterical patients who showed signs of recovery (Jemmer, 2006) after vividly remembering and relieving repressed traumatic experiences that have been deemed intolerable previously.

Freud (1896), although still believed that the root of hysteric symptoms are in the patient’s repressed unconscious pathogenic ideas, he found that working with transference (as a means of repeating) as opposed to remembering in hypnosis was more advisable (Freud, 1914)and controllable (Jemmer, 2006) . He then gave up the cathartic method for the favour of free association. Those who are familiar with both psychoanalysis and hypnosis (Fromm, 1987; Karle, 1987) highlighted commonalities between free association and hypnosis. They claim that once the patient propelled deeply into free association he or she shows signs of moving into a trance-like state called “reverie” (Hartman & Zimberoff, 2013, p. 6) which can also be described with a sense of disconnection from the outside world and the activation of primary process functioning in cognitive activity.

There is an inconsistency in the literature regarding the relationship between abreaction and catharsis, whether they are independent phenomenon or requisite conditions for each other. Jemmer (2006) uses the two together as “abreaction –catharsis” to indicate that catharsis is the subsequent therapeutic effect (the insight) of abreaction. However others (J.Hawkins, 2006; M West, 2012) remain apprehensive towards abreaction which they use in the sense of uncontrolled venting and acting-out that needs to be prevented in the therapy session while catharsis still regarded as of a therapeutic value.

Nevertheless it can be ascertained that writers (Hartman & Zimberoff, 2013; Jemmer, 2006; Karle, 1987; Kosmicki & Glickauf-Hughes, 1997; Mackey, 2009) who postulate that abreaction-catharsis is a curative agent are keen to underline that it is only so if it is accompanied by salient cognitive processing in the presence of an experienced therapist with whom the client has a trusting, in-depth relationship. They are all in agreement that abreaction in itself is counterproductive at best when these criteria have not been met. Without objective cognitive awareness there is no learning and the client would only unproductively repeat the original emotional responses. Kosmicki and Glickauf-Hughes (1997) in their paper refer to Scheff (1979) who believed that the effectiveness of the catharsis lies in “distancing” where “one is both participant in, and observer of, one’s own distress, so that one can go in and out freely”. (1997, p.157)

1.3 Mechanisms

Therapeutic catharsis occurs when the client in discussing an event becomes emotionally aroused and at the peak of their emotion they re experience the psychological hurt caused. They then immediately feel a sense of relief and describe how the event interfered with their life, usually delivered with a profound insight (Von Glahn, 2011, p. 132). Neurobiologist, Michael Holden in the 1970s elucidated that this clinical scenario can be explained by the stimulation of the Sympathetic – Parasympathetic divisions of the Autonomic Nervous System. The S-phase becomes activated when the client breaks through the traumatic amnesia. The stress and anxiety that build up through the recollection of the hurtful memory result in sympathetic physiological responses such as the elevation of heart rate, metabolism, blood pressure and breathing. Cathartic reactions that have a healing effect are crying - to express grief and deep hurt - and anger, for injustice or maltreatment. This is when the trained professional's supportive and empathetic role becomes the most important. The therapist capacity of holding and guiding the client through the psychological pain assist the S-phase to transform into P-phase. Now, that the situation appears to be manageable, the ability to cope with the stressor becomes magnified and brings powerful instinctual forces into action. The hurt having been lessened or eliminated, the Parasympathetic Nervous System takes over and down-regulates the SNS arousal, thereby returning the body to normal functioning. The P-phase is associated with release and resolution. According to Von Glahn (2011) it is a common sight to see clients, when moving out of this frozen, shock induced state, usually shake or tremble in the aftermath, this is a natural response and it is the body's way of releasing the energy that built up in the body when the trauma occurred.

The sequence of S-phase and P-phase when cognitively mediated, provides a transformational experience (Kosmicki & Glickauf-Hughes, 1997; Levine, 1997; Mackey, 2009; Ogden, Minton, Pain, Siegel, & Kolk, 2006; Von Glahn, 2011).

Holden's trauma theory is one of the stored trauma approaches which recognise trauma as a physical registration in the nervous system. Body - centred psychotherapies such as the Somatic Experiencing and the Sensorimotor approach (Levine, 1997; Ogden et al., 2006) postulate that trauma is stored in the body as a neurobiological imprint (Von Glahn, 2011). Levine (1997) also suggests that the key to understand trauma resides in what happens after the freezing state. The freezing response is brought on when someone is literally paralysed with fear. He proposes that humans' highly evolved neo-cortex (rational brain) overwrites the subtle instinctual and emotional impulses and interferes with the energy dynamics; leaving the natural energy unfinished. Immense energies are bound in the freeze and unless they are allowed to become mobilized again, they can and will get stored in the body resulting in the development of various traumatic symptoms.

The Somatic Experiencing approach however disapproves the cathartic methods. Levine (1997) argues that "some cathartic methods that encourage intense emotional reliving of trauma may

be harmful “ and “ because of the nature of trauma, there is a good chance that the cathartic reliving of an experience can be traumatising rather than healing.”(Levine, 1997, p. 10)

In contrast, Von Glahn states that “ the anxiety in the S - phase is caused by the activation of the imprint, and it has, unfortunately, been mistakenly viewed as the client being “re-hurt” (“The Four Incorrect Assumptions of Primal Therapy,” n.d.). According to his views, the stressful stimuli is not a new hurtful event therefore the person cannot be re-hurt or re-traumatized. Von Glahn (2011) highlights however the importance of a *gradual* activation of the ANS as a therapeutic factor which requires the practitioner to be highly perceptive to allow memories and their integral emotional component to come forth in a natural and unforced way.

2. Chapter: Hypnoanalysis

2.1 Hypnoanalysis

“In hypnoanalysis, hypnosis and psychodynamic therapy are systematically integrated into a comprehensive and holistic way of working. The clinician utilizes hypnosis both to assist clients in uncovering the origins of their problems in their unconscious and to help them deal with their behavioural, emotional, cognitive and somatic experiences.” (J.Hawkins, 2006, p. 62)

The basic premise of dynamic theories is that an individual has all the answers to solve his or her own problems but there is usually an amnesia that prevents the person from remembering intolerable experiences and emotions (Frederick & McNeal, 2013; J.Hawkins, 2006). As Freud famously put it, “you know it; you just don’t know that you know it”. No memory and feeling will ever disappear completely, only some of them might be forgotten and stored in the unconscious part of the mind. A number of theorists (Al Rubaie, 2004; Crabtree, 2012; Freud, 1914; Fromm, 1987; Grossman & Pressley, 1994; J.Hawkins, 2006; Jackson, 1994; Jemmer, 2006; Karle, 1987; Mackey, 2009) suggest that healing is correlated with the insight gained into these repressed or suppressed materials that have previously been denied from consciousness. The reintegration of the significant events and the associated affect, while avoiding intense abreaction, can allow psychosomatic reframing. The hypnotic state is a mind state where the barriers between the conscious awareness and the unconscious behavioural, emotional, perceptual and somatosensory memory are lowered and thus such memories become increasingly accessible (Fromm, 1987; Hartman & Zimberoff, 2013). Many writers (Fromm, 1987; Karle, 1987; M West, 2012; Mackey, 2009; Yates, 1961) argue that it is necessary that the therapist, in collaboration with the client, create some sense of distance between the client and the experience that is being uncovered. On the other hand, Hartman and Zimberoff state that in hypnosis “a neutral point of view available to the hypnotic ego, relative to the waking ego. There is a natural fluidity to moving into and out of various complexes, and to recognizing the relationship between them. The phenomenon of self-hypnosis brings into focus this fluidity, where there is an active ego and a recipient or passive ego engaging one another” (2013, p. 4). Karle (1987) explains that since the adult’s dissociated adult self continues to function throughout, he is able to monitor the hypnotic experience and can therefore intervene or stop the process when feel uncomfortable. With this tool, however vivid and realistic the hypnotic experience, the monitoring self or observer remains firmly rooted in the here and now.

It seems as if there is a sense of multidimensionality in a deeper mind state creating a sense of simultaneous distance and connection which can be utilised in therapeutic interventions.

Another area of concern lies in the suspension of many ego functions in the hypnotic state which may result in premature revivification of traumatic experiences. Fromm (1987) in her paper challenges the work of earlier researchers which states that “hypnosis is a regression in the service of the ego” (1987, p. 2). She claims that studies conducted in her laboratory in the 1960s didn’t find that defences decrease in a “statistically measurable way”. She found however that the hypnotic trance state is characterised by ego receptivity and an openness to experiencing where “critical judgement, reality orientation, and active goal directed thinking is held to a minimum and the individual allows himself freely to let unconscious and preconscious material float into his mind” (1987, p. 3).

According to Hawkins (2006) the following need to be covered before the sessions. The client need to assume responsibility for the problem, set goals and make hypothesis in relation to the cause of the problem ie. the “story”. It is also essential to deal with concerns and the client’s understanding of therapy in hypnosis.

The literature accessed brought forward the following standard exploratory and uncovering hypnoanalytic techniques that thought to be correspondent with the aims of the psychodynamic psychotherapy. (J.Hawkins, 2006; Karle, 1987; Stross & Shevrin, 1969)

2.2 Ideodynamic Questioning

Ideodynamic questioning is the hypnotherapeutic application of the ideomotor effect (Carpenter, 1852), a common phenomenon in which automatic physiological responses in the body are produced by an idea and its mental representation in the mind. These responses are generated at an unconscious level to an external or internal stimulus and are common events. In 1855, James Braid assimilated the phenomenon with hypnotism and it became the central theory of hypnotic suggestion (“Ideomotor phenomenon,” 2014). Beside the fact that spontaneous ideodynamic behaviour (dynamic refers to the dynamic between body and mind) in hypnotic trance increases (Frederick & McNeal, 2013) it provides with an opportunity to access the wisdom of the deeper mind and get in touch with the person’s own creative inner resources (Cheek & Rossi, 1994; Frederick & McNeal, 2013; Mackey, 2009). By pre-suggesting the positive and negative responses and attaching them to finger or hand signals enables clients to access state-bound information and reframe their problem psychosomatically. Since the Ericksonian studies on ideodynamic signalling in the 1920s, it is considered to be the primary tool in hypnoanalysis (Frederick & McNeal, 2013; Mackey, 2009).

Cheek and Rossi (1994) remind us that there are three levels at which mind –body information can be encoded: the physiological, the ideodynamic, and the verbal levels. They point out that state-bound memories would be difficult to access by verbally oriented psychotherapy since these memories are “synchronously encoded in the limbic system with the emotions and behaviour becoming inseparable” (“state-bound,” n.d.). These memories are not accessible to normal memory but can be encoded by ideodynamic signalling which enable a deeper level of communication and mediation between body and mind. (1994, p. 20) Implicit memory is also activated in hypnotic trance

and otherwise silent physiological realities such as felt experience in the past can be translated into psychological realities in the present. According to Hartman and Zimberoff (2013, pp. 6–7) “hypnosis is well documented as a vehicle for accessing and focusing on the somatic unconscious”.

In order to uncover psychobiological sources of specific problems a careful series of questions need to be asked of which the very first should be the following that puts immediate control in the client’s hand and also creates expectations on both conscious and unconscious level to find inner solutions to the client’s problem.

“Would it be alright for (here the patient is named) to go within so that her inner mind can focus on the problem of why she is having (the presenting problem)? And resolve that problem?” (Frederick & McNeal, 2013)

Ideodynamic finger signalling is used as rituals for analysis and questioning and as part of the management of the dissociation in order to prevent intense emotional abreaction. It is a useful device to monitor the progress of therapy (Cheek & Rossi, 1994; J.Hawkins, 2006; Karle, 1987; Mackey, 2009). The task of the therapist is to facilitate the client to find inner resources to problem solving and to achieve insight.

2.3 Hypnotic Age Regression

Pivotal experiences in early childhood development allegedly become increasingly accessible in hypnotic trance and offer an opportunity to discover and reframe psychic damages from the past (Fromm, 1987; Hartman & Zimberoff, 2013; J.Hawkins, 2006; Karle, 1987; Mackey, 2009).

The technique of age regression guides the individual back in time to earlier life stages that may be linked to the presenting problem. The client may then report that he is 5 years old and recall an event for the first time since it occurred and give voice to the attached feelings and sensations.

This technique requires an experienced therapist since the process of identification of the sensitising events can be extremely overwhelming for the client. The therapist need to be very skilled in order to introduce distancing and ego-strengthening techniques to prevent re-traumatisation (J.Hawkins, 2006; Kosmicki & Glickauf-Hughes, 1997; Mackey, 2009). In order for the repressed material to unfold at the client’s own speed the material that comes up need to be handled more symbolically. Imagery, hypnotic drawings and anagrams, working through screen memories (A false recollection constructed as a compromise between complete repression and full awareness of an unacceptable wish. Generally, the psychological significance of an important event is maintained, but displaced onto another, more mundane memory(“» Screen Memory - Encyclopedia of Psychology,” n.d.)) and the building of delays can promote gradual uncovering of the sensitising event (Fromm, 1987; Hartman & Zimberoff, 2013).

“Ego strength of the client is more important than the brilliance of the therapist” (Frederick & McNeal, 2013). Many papers consulted in the topic place great emphasis on ego-strengthening support of the client (Frederick & McNeal, 2013; Fromm, 1987; Hartman & Zimberoff, 2013; J.Hawkins, 2006; Jemmer, 2006; Karle, 1987; Kosmicki & Glickauf-Hughes, 1997; Mackey, 2009) such as therapeutic alliance, empathy, respect and care. Ego strength is then manifested in a capacity of self-care and to know “safe space”, the ability to trust one’s self and others, self-soothe.

In hypnosis, it can be suggested to the unconscious mind that it has all the inner resources to face the source of the problem and that only when it is appropriate (ideodynamic finger signalling can be useful to monitor the process). The following script allows the unconscious to protect the person from experiencing premature abreaction and cause re-traumatisation:

“Just stay with whatever comes into mind knowing that you only need to allow those memories that are appropriate to come into your conscious mind... and all other memories, emotional, somatic, and cognitive, can stay in your unconscious.... and maybe you can find some important conscious or unconscious learnings from this experience that you can utilize in the future to solve the current problems ..” (J.Hawkins, 2006, pp. 68–69):

Asking the client to see him or herself on a television screen can also facilitate a positive dissociation or a sense of distance (J.Hawkins, 2006) which can be further increased by turning down the sound or suggesting that the picture is black and white or even “blurred”.

Regression techniques:

- *Theatre-of-the-mind technique*: the therapist invites the client to an imaginary theatre to see a play. This technique is similar to psychodrama but it is played out in fantasy.
- *Affect bridge technique*: an emotional bridge to the past following appropriate ego-strengthening techniques where the client retains an “anchor” to his or her positive resources. The client is then asked to experience a situation with negative emotions and then asked to recall the first time when he or she felt the same way.
- *Ego-state therapy*: A technique where the therapist helps the client’s repressed or upset ego states to give voice to their needs. The dissociative nature of the hypnosis offers an opportunity for the therapist to communicate with fragmented ego states or personality segments and help them with re-integration. Also, the client’s adult ego state can provide reassurance and comfort to the child ego-state to cope and resolve the memory that caused the problem.

In discussions of age regression, there is an ongoing debate and concern (Karle, 1987) whether hypnotically age-regressed individuals exhibit developmentally previous modes of mental functioning. According to Nash (1987) the answer is no. His review of the empirical research of 25 years concludes that although there is a dramatic “shift from sequential, logical thinking to a more

visual, holistic thinking” in hypnosis, there is no evidence to a literal reinstatement of childhood functioning. This means that clients who undergo age-regression do not go back in time but “experience a shift toward a more prelogical, primary process modes of thinking” (Nash, 1987, p. 50). This view is supported by the various papers written by practicing hypno-psychotherapists (Cheek & Rossi, 1994; Fromm, 1987; Hartman & Zimberoff, 2013; Mackey, 2009).

The implication of this finding can be that the re-experiencing of past events is rather the re-visiting of the scenes from another, higher perspective, with the adult ego providing containment to the inner child and bring about another ways of looking at certain situations.

Research was extended to the False Memory Syndrome. FMS is based on the principle that “memories can be altered by outside influences” (“False memory syndrome,” 2014). An individual suffering from FMS believes in a pseudo memory or confabulation that factually has never happened and may become obsessed with it. There are multiple lawsuits (I. Lief, 1999) against hypnotherapists who out of misconduct and malpractice created memories iatrogenically in their clients mind. FMS can be destructive to both the delusional client and to the family who he or she may accuse of abusive behaviour and cause unalterable ruptures in the relationship. (Grossman & Pressley, 1994; I. Lief, 1999).

To conclude, those who are contemplating utilising hypnosis in their psychotherapeutic practice must adhere to code of ethics and code of conduct and undergo a relevant professional training and accreditation.

3. Chapter: Contraindications

The review of various materials ("Contraindications To Hypnosis?," n.d., "Hypnotherapy - irishhealth.com," n.d., "Hypnotherapy contraindications information - the Therapy Partnership," n.d., "Therapeutic Hypnosis," 2012) in the topic shows that utilisation of hypnosis is contraindicated in the following cases:

- Schizophrenia or signs of psychotic disorders: there is a risk that hypnosis could exacerbate a pre-existing psychosis
- Pathological personalities (borderline or dependent) : further arousal of an anxious or emotional state would be undesirable and also there is a risk that the individual "will want to form intense or inappropriate relationship
- Alcohol and drug psychosis: client is lacking ego –strength
- Senility or dementia: inability to properly interact and establish effective rapport
- Epilepsy and narcolepsy
- Bi-polar conditions including severe depressive illnesses and suicidal tendencies
- Serious heart conditions
- Brain trauma: individuals with organic symptomatology should not be treated without recommendation from a doctor ("ICHHP," n.d.)

It has to be noted that more detailed medical or psychotherapeutic research materials in the area of contraindications with respect to hypnosis were unavailable to the researcher of this paper.

Evaluation

The aim of this paper was to explore the integration of hypnosis and psychodynamic psychotherapy. It can be suggested that the pillars of this integration is the phenomenon of catharsis and the assumption that gaining an intuitive and creative understanding into one's inner processes promotes growth and healing.

The papers consulted show that permissive hypnosis or hypnoanalysis can be explained as psychodynamic psychotherapy conducted in hypnosis. The hypnotic trance state reportedly (Frederick & McNeal, 2013; Hartman & Zimberoff, 2013; J.Hawkins, 2006; Karle, 1987; Mackey, 2009; Wallace, 1978; Whitmore, 2013; Yates, 1961) provides more access to the unconscious mind and thus can be viewed as an extension of the frontiers of deeper exploration for psychodynamic theory. In permissive hypnosis the client does not lose control or censorship, only goes beyond the surface of ordinary awareness. (Fromm, 1987; Karle, 1987)The therapist is merely a guide, listening to what the client has to say. The client can experience moments of intuition, wisdom and creativity when unconscious processes flash into their conscious awareness putting aside logic, space and time and transmit creative solutions to the presenting problem.

The literature indicates that there are concerns in relation to emotional processing as in the hypnotic state of mind abreaction can increase in intensity and frequency. In hypnosis, the original psychological hurt becomes more accessible as a result of lowered barriers between conscious, preconscious and unconscious material and therefore its use becomes problematic if used imprudently. Authors in the topic suggest that the explorative work is to be made gradually at the pace that the client can tolerate. This gradual work can be facilitated by distancing techniques which will enable the client to safely mediate between ego and primary sensory experiences.

Contraindications suggest that clients with weakened ego capacities, such as sufferers of psychosis or severe personality disorders and those under the influence of any substances are not suitable for hypnoanalysis before a relatively strong, cooperating ego is not established.

The importance of ego-strengthening interventions is highlighted in most of the papers that presented on the topic along with the appropriate and timely probing of the ego-defences. The purpose of ego-strengthening is the empowerment of the client. The therapist's task is to facilitate the client to acquire inner resources such as the ability of self-nurturing and self-containment ahead of the working through of distressing life events and furthering the process of understanding. Professional counselling skills and the establishment of the therapeutic alliance are therefore not in any sense less important in hypnoanalytic work than in psychotherapy provided in the ordinary state of consciousness. Hypnosis is a means of delivering psychotherapeutic treatment; it is not a system of therapy. (Karle, 1987) Without a psychotherapeutically trained professional the positive therapeutic

outcome is jeopardized and raises serious concerns over duty of care. It appears that in Ireland, the professional body that provides adequate training in hypno-psychotherapy is the Institute of Clinical Hypnotherapy and Psychotherapy (IChP) in Cork.

This paper wanted to emphasise the value of discussions around therapeutic integrations and the possible broadening of therapeutic repertoire of psychodynamic therapists. Professional development is not possible without openness to holism and willingness to explore other approaches or techniques that can bring more information and understanding into the realms of human body and mind.

Hypnosis is a field that still lacks a rigorous scientific research and as such remains controversial. Nevertheless, there are practitioners who claim that there are safe techniques for the exploration of consciousness and that it holds great potential for emotional healing (Crabtree, 2012; Fromm, 1987; Hartman & Zimberoff, 2013; Hlywa & Dolan, 2011; J.Hawkins, 2006; Karle, 1987; Weiss, 1993) when administered properly by a trained professional.

Bibliography

- » Screen Memory - Encyclopedia of Psychology. (n.d.). *Psych Central.com*. Retrieved May 3, 2014, from <http://psychcentral.com/encyclopedia/2008/screen-memory/>
- Al Rubaie, T. (2004). The Use of Hypnotic Dreaming in Psychotherapy. *European Journal of Clinical Hypnosis*, 5(3), 2–8.
- Bernstein, A. (2001). The Classical Parameters of Psychoanalytic Technique: A Review. *Modern Psychoanalysis*, 26(2), 125–181.
- Cheek, D. B., & Rossi, E. L. (1994). *Mind-Body Therapy: Methods of Ideodynamic Healing in Hypnosis* (Reprint edition.). New York: W. W. Norton & Company.
- Contraindications To Hypnosis? | Adam Eason School of Hypnosis and Hypnotherapy. (n.d.). Retrieved from <http://www.adam-eason.com/2007/11/28/contraindications-to-hypnosis/>
- Crabtree, A. (2012). Hypnosis Reconsidered, Resituated, and Redefined. *Journal of Scientific Exploration*, 26(2), 297–327.
- False memory syndrome. (2014, May 4). In *Wikipedia, the free encyclopedia*. Retrieved from http://en.wikipedia.org/w/index.php?title=False_memory_syndrome&oldid=606880818
- Frank, J. D. (2006). Therapeutic Factors in Psychotherapy. *FOCUS: The Journal of Lifelong Learning in Psychiatry*, 4(2), 306–311.
- Frederick, C., & McNeal, S. A. (2013). *Inner Strengths: Contemporary Psychotherapy and Hypnosis for Ego-strengthening*. Routledge.
- Freud, S. (1914). *Remembering, Repeating and Working-Through (Further Recommendations on the Technique of Psycho-Analysis II)* (Vol. 12). Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pph&AN=SE.012.0145A&authtype=cookie,custuid&custid=s6175963&site=ehost-live>
- Fromm, E. (1987). Psychoanalysis and Hypnoanalysis: A Professional History and a Challenge. *Psychoanalytic Psychology*, 4(3), 207–218.
- G. Jones, Ed.S., S. (2009). Hypnosis Leads to Heightened Brain Waves and Levels of Consciousness. *NaturalNews*. Retrieved from http://www.naturalnews.com/026844_hypnosis_brain_consciousness.html

- Grossman, L. R., & Pressley, M. (1994). Introduction to the Special Issue on Recovery of Memories of Childhood Sexual Abuse. *Applied Cognitive Psychology*, 8(4), 277–280.
- Hartman, D., & Zimberoff, D. (2013). Jung and Hypnotherapy. *Journal of Heart-Centered Therapies*, 16(1). Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=15205495&AN=90595247&h=a7cxHOIpuFQ1eqMihugq0sQiAT3hLTM6%2BpHpnhPqqWMWEax45ROIZTVIBEujDEfM%2Bv5leACcgvOrwwNa3g%2FzKA%3D%3D&crl=c>
- Hlywa, E., & Dolan, L. (2011). SPIRITUALITY, HYPNOSIS AND PSYCHOTHERAPY: A NEW PERSPECTIVE. *Australian Journal of Clinical & Experimental Hypnosis*, 39(1). Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=01560417&AN=71142054&h=o5ZHEzLiFRO70q%2FS67xs1FJnU3JECbHQi4cZ0uOZlaw%2Fd3ZTx%2FU8lqFhKmlIF93wjV8aAsefceldN5TXOfHuyQ%3D%3D&crl=c>
- Howell, K. (n.d.). Brainwave Chart. Retrieved March 2, 2014, from <http://www.brainsync.com/brainlab/brain-wave-chart-.html>
- Hypnotherapy - irishhealth.com. (n.d.). Retrieved May 5, 2014, from <http://www.irishhealth.com/article.html?con=432>
- Hypnotherapy contraindications information - the Therapy Partnership. (n.d.). Retrieved May 5, 2014, from <http://www.therapypartnership.com/contra.htm>
- I. Lief, H. (1999). Patients Versus Therapists: Legal Actions Over Recovered Memory Therapy | Psychiatric Times. Retrieved April 26, 2014, from <http://www.psychiatrictimes.com/articles/patients-versus-therapists-legal-actions-over-recovered-memory-therapy>
- ICHP. (n.d.). Retrieved from <http://www.hypnosiseire.com/>
- Ideomotor phenomenon. (2014, April 18). In *Wikipedia, the free encyclopedia*. Retrieved from http://en.wikipedia.org/w/index.php?title=Ideomotor_phenomenon&oldid=601591575
- J.Hawkins, P. (2006). Hypnoanalysis - An integration of clinical hypnosis and psychodynamic therapy. In *New approaches to integration in psychotherapy* (pp. 62–73). London; New York: Routledge.

- Jackson, S. W. (1994). Catharsis and abreaction in the history of psychological healing. *The Psychiatric Clinics of North America*, 17(3), 471–491.
- Jacobs, M. M. (2012). *Psychodynamic Counselling in Action* (Fourth Edition edition.). SAGE Publications Ltd.
- Jemmer, P. (2006). Abreaction-Catharsis: Stirring Dull Roots with Spring Rain. *European Journal of Clinical Hypnosis*, 7(1). Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=13511297&AN=24402818&h=9y6kZ5ztwzCHldVo98y2lsg%2FhU0AnOkTb4FBrEAb93QfdhKUR2T23Oofkucd5oVodRRCYcjJF7xRV4%2Fy0EAa1Q%3D%3D&cr=c>
- Jorgensen, C. R. (2004). Active Ingredients in Individual Psychotherapy: Searching for Common Factors. *Psychoanalytic Psychology*, 21(4), 516–540. doi:10.1037/0736-9735.21.4.516
- Karle, H., W. A. (1987). Hypnosis in psychotherapy in the 1980s. *Free Associations*, 1(8), 58–80.
- Knight, Z. (1995). The healing power of the unconscious: How can we understand past life experiences in psychotherapy? *South African Journal of Psychology*, 25(2), 90–98. doi:10.1177/008124639502500204
- Kosmicki, F. X., & Glickauf-Hughes, C. (1997). Catharsis in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 34(2), 154.
- Levine, P. (1997). *Waking the Tiger: Healing Trauma - The Innate Capacity to Transform Overwhelming Experiences*. North Atlantic Books, U.S.
- M West, J. (2012). Therapeutic Hypnosis. Retrieved from <http://emedicine.medscape.com/article/1948365-overview>
- Mackey, E. F. (2009). Age Regression: A Case Study. *Annals of the American Psychotherapy Association*, 12(4), 46–49.
- McKay, M., Davis, M., Eshelman, E. R., & Fanning, P. (2008). *The Relaxation and Stress Reduction Workbook* (6 edition.). New Harbinger Publications.
- McLeod, J. (2009). *An introduction to counselling*. Maidenhead, Berkshire, England; New York, NY: McGraw Hill/Open University Press.
- Nash, M. (1987). What, if anything, is regressed about hypnotic age regression? A review of the empirical literature. *Psychological Bulletin*, 102(1), 42.

- Ogden, P., Minton, K., Pain, C., Siegel, D. J., & Kolk, B. van der. (2006). *Trauma and the Body: A Sensorimotor Approach to Psychotherapy* (1 edition.). New York: W. W. Norton & Company.
- state-bound. (n.d.). *TheFreeDictionary.com*. Retrieved May 2, 2014, from <http://medical-dictionary.thefreedictionary.com/state-bound>
- Stross, L., & Shevrin, H. (1969). Hypnosis as a Method for Investigating Unconscious Thought Processes—A Review of Research. *Journal of the American Psychoanalytic Association*, 17, 100–135.
- The Four Incorrect Assumptions of Primal Therapy. (n.d.). *Debunking Primal Therapy*. Retrieved from <http://debunkingprimaltherapy.com/four-assumption/>
- Therapeutic Hypnosis. (2012). Retrieved from <http://emedicine.medscape.com/article/1948365-overview>
- V. Sunnen, G. (n.d.). Hypnosis in Psychotherapy. Retrieved May 1, 2014, from <http://www.triroc.com/sunnen/topics/hypn&psychoth.htm>
- Von Glahn, J. (2011). Proposed necessary and sufficient conditions for optimal psychotherapeutic change. *Person-Centered & Experiential Psychotherapies*, 10(2), 129–143.
doi:10.1080/14779757.2011.576562
- Wallace, B. (1978). Restoration of eidetic imagery via hypnotic age regression: More evidence. *Journal of Abnormal Psychology*, 87(6), 673.
- Weiss, B. L. (1993). *Through Time Into Healing: Discovering the Power of Regression Therapy to Erase Trauma and Transform Mind, Body and Relationships* (Reprint edition.). New York: Touchstone.
- Whitmore, D. (2013). *Psychosynthesis counselling in action*.
- Yates, A. J. (1961). Hypnotic age regression. *Psychological Bulletin*, 58(5), 429.