

## Tandem Hypnotherapy<sup>1</sup>

### P. József Vas, MD, ECP and Noémi Császár, PhD, ECP

Submitted 3 November 2013; received in revised form 21 February 2013; accepted March 2013

#### Abstract

Tandem hypnotherapy (THT) has recently been developed by the authors. It is a group hypnotherapeutic method for resolving psychic and psychosomatic pathology originating from pre/perinatal traumas. While multi-person touching happens, the patient and the co-therapist go into hypnosis together. Meanwhile, the therapist keeps a distance. A mutual attunement evolves during THT. By using THT the symptoms of pre/perinatal traumas can be replaced with an associative mode of prenatal experiencing which includes acceptance and love. The essence of THT is viewed as an integration of touch, trance, and transference. Three case vignettes are presented to illustrate how THT works.

*Keywords:* touch, trance, transference, mutual attunement

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*  
Volume 12, Number 1, 2013 pp 74-86 Printing ISSN Number 2169-4745 Online ISSN 2168-1279  
© Author and USABP/EABP. Reprints and permissions secretariat@eabp.org

By “tandem” we mean several things: 1. a multi-seated bicycle; 2. an acronym for **T**ouch of **A**ncient and **N**ew Generations with a **D**ialogue **E**xperiencing **O**neeness of **M**inds (**TANDEM**). Tandem hypnotherapy (THT) as a new form of group hypnotherapy—a method for resolving psychopathology of inter-generationally mediated pre- and perinatal traumas. It was developed by the authors a few years ago (Vas & Császár, 2011a). THT involves the participation of more than two persons: the client, the co-therapist and the hypnotherapist. During THT, there is a possibility for the co-therapist to go either into a superficial or a deeper trance together with the client in the tandem situation. The clients are usually in a deeper state of trance than the co-therapist. The aim of THT is to elicit a positive, corrective experience with the potential of resolving the client’s trauma.

According to the number of participants, we can distinguish between two settings of THT. In case of a three-person setting the participants are the client, the co-therapist and the therapist. The co-therapist can be the client’s natural mother, father or sibling, or may even be the patient’s individual therapist (in which case the hypnosis is done by a supervisor hypnotherapist) or another professional person (a nurse, an occupational therapist, etc.). While the hypnotherapist keeps a distance from both the client and the co-therapist, the co-therapist makes body contact with the client, e.g. by touching his/her arm or having him/her sit on his/her lap. The professional co-therapist assumes a symbolic mother/father/sibling role (if the relative is not available or doesn’t want to participate). The co-therapist can also assume the role of the patient’s imagined twin brother or sister when twin-type THT is used. In the case involving a professional co-

therapist, he/she may be of the same or the opposite sex as the patient. When a female or a male patient has suffered serious physical or sexual abuse as a child the framework of the therapy must be very carefully set because of ethical reasons. It should be arranged in a way that allows only the slightest amount of touch to be realized between the patient and the co-therapist of the opposite sex, i.e. touching of the hands. If we want to conduct the THT with a setting of more than three persons, there may be more than one client and co-therapist (Vas & Császár, 2011b).

The triad containing the patient, the therapist and the co-therapist forms a psychological healing team that functions cooperatively for the patient’s benefit. The co-therapist’s mediating role seems to be a significant component of THT because s/he supports and helps the patient cope with his/her trauma. As the therapist does not touch the patient, the co-therapist must then mediate the therapist’s acceptance and love towards the patient. One may be reminded of the work of Michael Balint whose psychoanalytic technique was used to serve as a means of expressing primary love (Balint, 1965/2001).

#### Brief History of Touch in Psychotherapy

According to ethno-psychology, there are two types of therapies regarding spatial settings: first, proximate types which are characterized by physical closeness; and secondly, types of distal or distancing therapies characterized by spatial distance between the patient and therapist (Hermann, 1934/1984). While even ancient shamanistic practice involved physical closeness between members of a tribe (Krippner, 1993), proximate types of therapy have changed with the emergence of modern psychotherapy. There has been a historically reluctant attitude regarding touching that can be traced back to Mesmer—about whom the French Academy expressed an ethical judgment in a secret report regarding his magnetic cures—and Freud, who introduced the rule of abstinence. This attitude still applies to today’s many practices and theories of psychotherapy. However, after Freud refused proximate hypnosis for the sake of distancing analysis, his follower, a Hungarian analyst Sándor Ferenczi (1933, 1988) applied the proximate method again and made the patient sit on his lap. Wilhelm Reich’s orgone therapy was based on bodily massage (Reich, 1976). Later, Frank Lake, Leonard Orr and Stanislav Grof practiced psychotherapies, dubbed “re-birthing therapies”, to relive the birthing process (Grof, 2008). At present, several proximate types exist such as body psychotherapy, movement- and dance therapies, bio-energetic methods, haptonomy, etc (Meyer, 2010; Veldman, 1994; Young, 2007). Non-contact touch is also employed as an energy healing method in treating somatic illnesses (Krieger, 1975).

Distal therapies dominated the psychotherapeutic mindset throughout the whole 20th century regarding spatial setting, while proximity psychotherapies were relegated to the background. The situation with touch in regard to hypnotherapy seems to be the same. Touch is generally used as the hypnotherapist’s ideomotor signaling technique to communicate with the patient’s unconscious mind without words (Cheek, 1980, 1986, 1993). However, touch in tandem hypnotherapy has a different role. There have been several sessions throughout the history of hypnosis, which were called tandem hypnosis, when trance was employed with more than one persons, for instance with couples and family members, in order to reveal lost objects or vanished memories, or to improve

<sup>1</sup> We would like to thank Prof. Éva I. Bányai, former president of the International Society of Hypnosis, and the Hungarian Association of Hypnosis Hungary, Prof. Em ke Bagdy Prof. Ontapadó Jegy, Hungarian Society of Relaxation and Symbol therapy, Prof. Ferenc Túry, former president of the Hungarian Association of Hypnosis, and Tom Ormay, former editor of the International Journal of Psychotherapy, for their efforts clarifying certain ideas in our study.

relations among relatives (Kluft, 1987). However, touch and physical closeness never played an essential role in this type of tandem hypnosis. Recently, tandem hypnosis has successfully been used with identical female bulimic twins without touch (Túry, Wildmann & Szentes, 2011). Because of its emphasis on touch, THT is viewed as an original therapeutic approach both in the theoretical and the methodological senses, despite its similarities with the methods mentioned earlier as well as the following sources which serve as its theoretical and methodological roots: ancient shamanistic practice (Jilek, 1988), Jungian archetypal therapy (Jung, 1978), hypnotherapy (Bányai, 1998), psychodrama and hypnodrama (Moreno, 1987), contextual family therapy (Böszörményi-Nagy & Krasner, 1986), rebuilding therapy (Gass, 1997), evolutionary psychology (Cosmides, Tooby, 2001), ethno-psychology (Hermann, 1934/1984), developmental neuropsychology (Schore, 2003), prenatal and perinatal medicine & psychology (Janus, 1997), and transpersonal psychology (Wilber, 1986).

The authors suggest that the essence of THT is the integration of touch with trance and the multiple transferences that evolve among participants (which will later be described). This integration is viewed as a guiding principle along with the different approaches that are to be introduced in therapy.

### Ethics of Touch in Psychotherapy

All psychotherapists know how careful they must be regarding touching their patients. In the 1980s, Patrick Casement's case drew attention to touch as a non-erotic challenge (Phelan, 2009). Touch is viewed as a normal act among people for expressing friendship, closeness and intimacy. However, the ethics of touch in therapy are essentially different and boundaries are found to be fundamental. Clinical studies of touch have come to the conclusion, regarding the conditions that patient's set for effective touch in therapy, that touch is therapeutically effective only if the patient wants to touch or wants to be touched; s/he gives permission to the therapist; s/he is able to say no; and s/he has an adequate diagnosis (no paranoid hostility, homophobia, or unbearable aggressive or sexual urges). The therapist's touch is effective in therapy if s/he possesses a strong foundation of knowledge and self-experience before using touch; is able to handle transference securely; has the opportunity for professional supervision; does not view therapy as a resource of his or her biological needs; and if s/he feels touching to be a natural thing (Bálint, 2005).

Zur and Nordmarken (2011) have recently compiled a list of clinical, ethical and legal considerations for touch within psychotherapy. They draw attention to the fact that Western cultures seem to exhibit an aversion to touch even in parents' attitude towards their children, which may easily explain why the relating rules of psychotherapy are so stringent. This is why the emphasis on touch in psychotherapy is for it not to be exciting, unpleasant, confining, aggressive, possessing or erotic. Before induction of THT, we always ask our patients to tell us how they feel about being touched by the co-therapist, and if desired, the necessary modification is done for the sake of the patient's comfort.

### Pre/Perinatal Traumas and the Developmental Levels of Approach in Psychotherapy

Prenatal trauma occurs when an expectant mother and her fetus have distress in the form of either of the following: intrauterine infection (i.e. flu), intoxications like smoking, alcohol and drug addiction, the mother's severe somatic illness and/or surgical

intervention, starvation or physical exhaustion (Bergh, 2002), Blighted Twin Syndrome (Robertson, 2010), the mother's insufficient mourning of previous or current loss, the mother's negative emotional attitude toward or neglect of the baby, death or dire life situations of family members (Austermann & Austermann, 2008), attempted artificial abortion (Janus, 1997), or prenatal medical interventions like amniocentesis, etc. (Hugo, 2009). We can speak of perinatal trauma when some form of complicated delivery occurs such as a Caesarean section, intensive perinatal care, etc. (Emerson, 1996).

The patterns of coping with peri/prenatal traumas are built into the bio-psychological regulation of the developing personality, and when facing new stress situations, the coping strategies repeat the patterns of over- or down-regulation previously secured, having become incorporated into the personality as an implicit somatic memory (Turner & Turner-Groot, 1999; Verny, 1996). This implicit somatic memory will be repeated at the original sensorimotor level against new forms of stress, which can lead to somatic, psychosomatic and psychological dysregulation and in the worst cases, disorders.

How can this type of pathology caused by prenatal trauma be treated? According to developmental neuropsychology, touch appears to be the "mother" of perception and the first language of developing babies (Montagu, 1986). In the fetal period of life, touch is absolutely necessary to establish the frontiers of the body, and to evolve the boundaries of the ego and non-ego that is the basis for attachment and relationships. The experience of touch is processed in the right hemisphere, which represents relations and contexts (Siegel, 1999). Thus, touch is responsible for reliving spatial regression, which is an attunement with partners via mirror neurons (Bauer, 2010); in other words, touch is essential for experiencing protection, security, warmth and love. The neurochemistry of social support emphasizes the role of oxytocin excreted when people get close in order to touch one another. Touch is said to have stress-relieving, calming and love-inducing effects (Varga, 2009).

The earliest phase in the child's cognitive development was described by Piaget (1937/1954) as the sensorimotor period. We believe that the sensorimotor period of development starts as early as fetal life. We suggest that several psychic, psychosomatic and somatic disorders can originate from a deficit in the sensorimotor and visceral information processing at the prenatal period of life. This is why these disorders need to be treated by a therapeutic approach that functions on the same sensorimotor level on which the trauma occurred. This approach will be illustrated by the following cases.

Since the development of THT was based on inferences drawn from the authors' clinical experience, we describe first how the method works, and then the relevant theory for interpretation of its applications in clinical practice. The participants described below made reports based on their own experiences and gave their written consent for publication. The client names mentioned in this paper are fictional and non-identifiable.

### Case Vignettes

#### Treating a Borderline Patient with THT (therapist: Dr. Vas, co-therapist: Dr. Császár)

The authors have been working with a broken family whose father, Sebastian, divorced his previous wife because of her massive alcoholism. They had three children, the youngest of whom, 17-year-old Esther, experienced fetal alcoholic brain damage and now struggles with the consequences: dyslexia, borderline personality disorder, attention deficit and lack of impulse control. Esther's mother started to drink alcohol regularly when she was pregnant with her.

In this THT session, Dr. Vas served as the hypnotherapist and Dr. Császár the co-therapist in a virtual mother-daughter context as Esther did not want to engage in tandem trance with her biological mother. As the co-therapist, Dr. Császár gave Esther a holding environment via touching and caressing. The therapist made Esther imagine a meadow and asked her to select a flower. She looked at a red tulip, which the therapist asked her to transform herself into. While being a tulip, she can feel well and experiences having a big bulb under the ground. The therapist tells her that the tulip is healthy probably because the bulb is strong and can separate nutrients from poisons in the ground so poisons would not be absorbed; poisons would be stored in the bulb instead of causing harm to the flower. In that moment, Esther burst into tears. When the therapist suggested that she would develop into a beautiful red tulip, she shed tears again. Upon returning to human form, she expressed that her chest had become lighter, free from a heavy burden.

It is important that the suggested metaphor be properly articulated. When asking Esther to imagine herself changing into a tulip with a big bulb under the ground which is able to separate poisons, the therapist took care to paint Esther's fetal alcohol poisoning in such a way that Esther's symptoms (dyslexia, attention deficit, lack of impulse control) were treated as a mechanism of bio-psychological selection of harmful stimuli that probably protected her life in the fetal period. Within the therapy, however, these symptoms are viewed as harmful and needing to be switched for more adaptive techniques.

This session can be viewed as a form of transference as well. Within the vocabulary of transference, we can interpret the therapist as representing a good father who wants to eliminate the harmful impacts Esther suffered as a fetus as a result of her mother's alcoholism. After hypnosis, the co-therapist stated that while she was in deep trance, she was not able to say a word. It may have happened because her counter-transference role was to hold Esther, her fetus, in therapy, as Mother Earth might hold her plants, namely a lovely red tulip.

After this type of THT was practiced three times, Esther became more relaxed than she was before. Since then her therapy has continued in an individual framework. Esther's therapy is not yet finished.

#### **Treatment of Anorexia Nervosa With Mother-Daughter THT (therapist: Dr. Vas)**

Angie, age 18, has a diagnosis of anorexia nervosa and weighs 33 kg at a height of 170 cm. As her mother had had an intrauterine infection during pregnancy, Angie was born prematurely. It is an interesting parallel that when therapy began, she was just about to graduate from high school, so she was in a premature state regarding both her emotions and her physical appearance. She has always suspected she had a twin-sibling who was lost prenatally. As a child, she was overweight and was bullied by her schoolmates. She started a drastic slimming diet a few years ago after breaking up with her boyfriend. Recently, her grandmother died and her parents' enterprise went bankrupt. The family atmosphere has been very tense. Angie felt that she had to starve to save money for the family. She became 33 kilograms and all she was able to do was lie in bed.

Angie and her mother—who was almost as thin as Angie—agreed to come to THT. Since Angie seemed to have ego weakness, Dr. Vas decided to initiate guided affective imagery with nature symbols of a meadow, a stream, a tree, and a flower. In tandem trance, her mother's role was to serve as a holding environment because Angie's security was fragile as a fetus from the intrauterine infection. Angie enjoys being in a meadow and watching a stream. Then, in tandem trance she is instructed to transform herself into the

stream. As a stream she feels she is moving, continually flowing, she can feel her energy ever-reviving because the spring water would always feed her. This can be regarded both as a symbolic message of purification from prenatal infection and of gaining ancestral power. At the sensorimotor and visceral level she is able to overwrite the traumatic prenatal experience of infection by experiencing herself as a fluid—a clear amniotic fluid, which exhibits features of self-purification and ever-reviving energy. The following thoughts are cited from her diary:

“During the previous imagination I had an incredible experience when I was transformed into a stream. This little stream was capable of purifying itself because it had immense strength. It is capable of coping with cliffs and other obstacles and it is capable of reaching its goal. It is beautiful when the sun shines on its surface; it looks like gold and silver. I consider this stream to be my ideal that I am going to reach my goals in every field”.

In the next session Angie and her mother told us that after one year of lying in bed inactive Angie suddenly started to study so much every day that she slept only three hours a night. It seemed as if she had identified herself with a fast stream running down a valley. This hyperactivity and the previous period of inactivity raised the question whether she might have bipolar affective disorder. Dr. Vas then decided to change the course of the therapy and slow her down. Following the therapist's instructions, Angie and her mother imagine that as a stream, Angie reaches a little pool in which she is slowed and calmed down while deepening, in order to accumulate strength. As a consequence of this suggestion, her sleep gradually came to be a consistent six to eight hours a night. In a later session she imagined herself transforming into a tree with tropical flowers, which can be taken as a metaphor of her unsatisfied symbiotic fetal needs. She then started to exhibit feminine features in the eyes of others as well.

On a later occasion, they imagined Angie as a not-yet-born fetus. Angie says she feels joy being in the uterus and the therapist suggests that she sleep in the womb and have a dream in which she and her twin-sibling meet in the realm of unborn babies. She notices a nice girl, Wendy. Dr. Vas suggested that Wendy say that they love each other so much, she would like to be born at the same time, but that it is very hard to make it come true. Therefore Wendy emphasizes that one of them may fail to be born. If it had been the case, neither of them would feel sorrow or guilt because of the other having failed to be born. Instead one would have to keep in mind that either Wendy or Angie would love and guard the other twin during her life on earth. While this suggestion is given, Angie bursts into tears.

Later in real life, Angie performed excellently on her graduation exam. During the corresponding period of the therapy involving her mother in tandem, we were focusing on satisfying their symbiotic needs. In accordance with the fetal sensorimotor level of deficit, Angie had to symbolically assume the role of a fetus—this was her mother's unconscious symbiotic need. As a matter of fact, the mother's personality had gone through additional development as well via THT. Her main “transference” issue was to repeat her pregnancy with Angie in fantasy, to provide better mothering and expectancy (in a psychological sense) to her daughter and help develop her femininity. At the end of the four-month THT period Angie weighed forty-five kilograms and had no symptoms of bipolar affective disorder.

Angie's therapy is not yet finished as we plan to work on integrating feelings of separation into her personality in the framework of individual therapy.

### Treatment of Trichotillomania with Mother-Daughter THT (therapist: Dr. Vas)

Regina, 38, had a miscarriage during her first pregnancy but later gave birth to three children. On the night preceding her miscarriage she had a dream in which a black-hooded horseman was chasing her. She was running to escape him but the horseman caught her, pulled a sack out of her body and threw it into the sky. Regina's grandmother on her mother's side was physically and mentally abused during World War II by soldiers of the occupying forces. Her mother grew up in an emotionally frozen climate and gave birth to Regina after a prolonged labor. Regina was born in the caul and she has lived within a "caul" of anxiety ever since her childhood. During the weeks preceding hypnosis, she had been experiencing recurring panic-like states though it was her daughter and not herself for whom she originally sought help.

Her daughter, Cynthia, age 14, has been plucking her eyebrows and eyelashes for around a year, communicating gender identity problems this way. She is the oldest child and is gifted, with ambitions of becoming a musician. She showed interest in hypnosis and was keen on joining her mother in trying it. During a joint interview, Regina revealed something Cynthia had not known previously: when expecting Cynthia, Regina was hospitalized for two weeks prior to Cynthia's due date, as the ultrasound examination indicated a small cranial size. The obstetrician therefore ordered that the nervous system be strengthened with medication. As Cynthia hadn't assumed the correct position in the womb before birth, a difficult birth was expected and a Caesarian section was applied. While listening to this story, Cynthia fiddled nervously on the sofa. As the therapist, Dr. Vas thinks that Regina and Cynthia could jointly re-experience pregnancy and birth and this time involve more successful coping with the situation.

The therapist's intuition suggests that Cynthia is ready to go ahead and experience THT for the first time in her life. Turned on her side, she is lying comfortably on the lap of her mother who is embracing her, and from that moment it seems most natural for her to go to the fetal age, the earliest phase of her life, step-by-step in her imagination. Dr. Vas could observe her intense experience. Answering his question of how she feels, she whispers, "It is wonderful here." Following Dr. Vas' suggestions regarding healthy growing and the assuming of contact with the mother and her impending birth, Dr. Vas tells them, "The obstetrician is going to say something which will shock you. Don't worry about it; it's not true; he is worrying without reason. Believe me, you will not have any trouble, you are a healthy, beautiful and clever baby. You will soon be born and then you will show yourself to your parents and others and everybody will see that you are a healthy, clever and sweet baby." Cynthia's face turns a bit worried, so Dr. Vas continues, "You will signal to your mother the onset of your birth; you possess the knowledge. You know how to move, how to pass through the birth canal." At this point, Regina joins Dr. Vas in saying, "Thank you Cynthia that you have chosen me to be your mother, and thank you for the wonderful nine months I've had of you growing in my womb." Cynthia starts crying and turns toward her mother who gives her a loving hug. Dr. Vas speaks again, repeating how Cynthia knows when to start moving in order to be born. Cynthia slowly starts to move by making two rounds and a half with her body while Regina takes a position lying on her back. Cynthia is lying on her stomach facing her mother and lifts her head, bowed until now. At this point, Dr. Vas says, "Your head has emerged into the sunlight; Cynthia, you have been born. You will be put on your mother's chest and you will look into each other's eyes, and you will know how much your mother loves you and that you love her, too." Again, Cynthia starts sobbing and they give each other a close

hug. Regina is crying, too. In Cynthia's crying, the therapist senses a release of traumatic feelings. They are both deeply moved.

When asked, Cynthia explains that during the de-hypnosis experience of her coming back from infancy to the present, she entered her classroom and punched the boy who harassed her at school at that time. Cynthia's crying gradually comes to an end. The following week, Regina reported that the eyelash-plucking became less frequent; now it occurred during times of stress only. Moreover, Cynthia began to look more confident. The hypnosis took place on a Saturday and the following Monday, Cynthia told her mother that when the boy started teasing her at school, she sent him packing to everyone's surprise. Symbolically it was the "aggressive" obstetrician whom she "sent packing" as it was his ominous prediction that, because of Regina's worries, undermined Cynthia's sense of physical integrity and thereby her self-concept. Moreover, two weeks later, Cynthia, who was the only girl in her class who had not yet "become a woman", had her first menstrual period. Two months later, she fell in mutual love with a boy even though she had always kept romantic relationships at a distance. Six months after hypnosis, Regina revealed to the therapist that when Cynthia was born by Caesarian section she herself was under a general anesthetic and after the birth the baby was put on the chest of the father first, who took his shirt off to allow a skin to skin contact. Thus, Cynthia had first looked into her father's eyes, which might give a plausible explanation for their almost imprinted relationship. Cynthia followed her father everywhere, always sat next to him, and so on. In the birthing experience of the THT session, it was Regina and Cynthia who looked into each other's eyes. Cynthia sobbed while hugging her mother and resolved the heavy feelings, and it is possible that it was in this part of the therapy that the early imprinting with the father became overwritten. Two years after that single THT session Cynthia switched secondary schools in order to reach her original goal of becoming a musician. She now feels well and reports no symptoms. THT has enhanced her sense of identity as a woman by resolving her self-depreciation caused by prenatal trauma. This case serves as an example of how intergenerational traumas can be treated with THT, as Cynthia's matrilineal line, including her grandmother and mother, suffered serious traumas that have been inherited by successive generations (Vas & Császár, 2011b).

### The Theoretical integration of Touch, Trance and Transference

A cornerstone of our hypothesis is the wide experiential and meaning dimensions of touch. We suggest that merely imagining being intimately touched cannot be considered the same as being touched in actuality. Within the THT modality, touching is thought to function even before the central nervous system evolves in the embryo, which is the reason why representations of this touch cannot be made. The experience of imagining mother-fetus relationship in the context of individual psychotherapy can be considered a separate experience from THT. Participants in THT have regularly mentioned that in individual hypnotherapy they had never relived what they had experienced in a tandem situation, an experience that could hardly be expressed in words.

We propose that early nervous system functioning which is usually suppressed by ego processes to be preconscious or unconscious in the normal waking state can be relived via bodily contact in THT. The functioning of the fetal primordial nervous system may become conscious via the following: tactile and nociceptive information being processed through skin receptors; proprioceptive impulses being processed by receptors of skeletal

muscles; and emotional information being processed by the autonomous neural network of the heart and of other visceral organs (Chamberlain, 1993, pp. 9-31; Piontelli, 2010). It is likely that the embryonic nervous system works the same way as it works in adulthood.

It is proposed that the earliest sensorimotor level of functioning has an *associative mode of experiencing*. Every sensory moment is continuously associated with every other, and experiences and consciousness may be treated as one without any ego-reflection. As the central nervous system does not evolve before there is ego-consciousness, which is seen to be necessary for distinguishing and separating subject (inner reality) and object (outer reality), it is called “*primary oneness-experience*”. After the central nervous system develops, ego-consciousness occurs, which is viewed as being able to differentiate experiences from consciousness to create separation between outer and inner reality (Oakley, 2008). In the course of the therapy conducted by guided affective imagery methods, the therapist can ask the patient to imagine a stream. The stream is seen to be suitable for a dissociative mode of experiencing because the patient doesn't see him/herself as identical with the stream. On the contrary, if the therapist asks the patient to imagine transforming into this stream, the patient then experiences at a bodily level how it feels to be this stream, which means being at an associative mode of experiencing, recalling implicit sensorimotor somatic and visceral memories from the earliest embryonic period of life. However, this type of experience can only be conscious by virtue of the patient's ego-functioning. That is the reason why it is called “*secondary oneness-experience*”.

To be touched also seems to fall into the category of associative functioning in which all of sensorimotor and visceral experiences are collected. According to the bodymind theory (Pert & Marriott, 2007), all of our body cells, especially our skin receptors, preserve traumatic experiences that are processed at an associative level. So touch in THT can also influence those traumatic experiences preserved in skin receptors. The tandem-partner's touch that is felt by the patient during trance can be analogized with the caressing of the amniotic fluid that was once experienced. Thus THT can help patients relive on a sensorimotor level the positive experiences of once being in the womb prior to trauma. This positive sensorimotor associative experience can be regarded as replacing the prenatal or perinatal traumatic experience with a sense of acceptance, security and love.

While the client and the co-therapist are in physical contact touching each other, the therapist's next step is to create a trance state. During rapport, induction and trance, a mutual physiological, emotional and experiential attunement is established between the participants in tandem. The hypnotherapist prompts a specific division of attention, whereby the participants in trance, instead of focusing their attention on themselves, focus on the “meeting points” of their experiences. In this way, autonomous signals, involuntary behaviors, sometimes even the most minute of motions, mutually emphasize the development of a joint emotional and experiential focus, which can lead to a sensorimotor attunement between the tandem participants. The therapist builds upon the experiences that originated from joint bodily communication, creating calmness, warmth, and security. Moreover, a visceral level of attunement or a mother-infant kind of attachment may develop, which can regulate very early deficits of stress-coping functions.

Acceptance, security and love can be regarded as the essence of transference and counter-transference evolving among the participants in tandem and in therapeutic context, including the therapist. I, Dr. Vas, once asked Noémi Császár to go into trance as co-therapist with a relative of hers. Thus, she was the first person to ever gain self-

experience during THT. After the sessions, we discussed all the details in the frame of a collegial consultation. It is important to state that acceptance, security and spiritual or ontological love are viewed to be necessary conditions both between the therapist and the co-therapist, and in the context of the therapeutic dyad with the patient. As in family therapy, transference issues are to be handled with great tolerance, respect, and acceptance. To be practiced, this method requires highly qualified professionals who are capable of expressing their respect to all members involved in tandem hypnotherapy, as well as of maintaining psychological boundaries.

### Indications and Contraindications

Natural mother-child THT is indicated in the case of a negative evaluation of one's own motherhood (e.g. “I am a bad mother”); physical/mental trauma which affected the mother during pregnancy or birthing of the child under consideration; or the child exhibiting behavior disorders such as a phobia or tic.

The joint trance of natural and/or virtual twins is indicated if aiming at the resolution of the ontological splitting involving the dilemma as to one's right to exist which might result in several types of pathologies, such as anxiety disorder, dissociative disorder, bipolar affective disorder, personality disorder, drug addiction or criminality. THT may also be capitalized on for its potential for gaining a sense of unity and thus incurring spiritual and psychological strength.

THT is contra-indicated by any psychological state which involves severe weakness of self-boundaries which thereby pose the risk of losing the sense of reality and an outbreak of psychosis; grave aversion to physical closeness and touching, for example myso- or homophobia; manifest paranoid anxieties; hostility; and uncontrollable aggressive or sexual urges.

### Conclusion

From Freud's time on, there has been much debate about how catharsis works for healing (Gravitz & Gerton). We suggest that THT is a cathartic and catalytic method that aids patients who need to use their power to work through the intrapersonal and relational difficulties of their everyday life. For this reason, THT can be used when individual psychotherapy has come to an impasse because of pre/perinatal traumas and then the individual therapy can be continued after resolving them. The two case vignettes shown in the article are not closed, so the results we have are preliminary. To understand efficacy, more detailed research of THT is planned in the near future.

Finally, THT is a new method, which was developed by the authors, and belongs to transpersonal therapies. Instead of being symptom-oriented, it is characterized by a holistic, existential-ontological approach that focuses on the meaning of life and its marked events. The physical presence and mutual touches of those in the joint trance can facilitate the resolution of traumatic experiences from the past not only on an imaginary level but also in reality, with the possibility of eliminating entirely pathological consequences originating from relational traumas of the prenatal and perinatal periods. The aim of the method is to replace the repetition of traumatic experience with positive mutual attunement, which is called the “communication of ontological love”.

**BIOGRAPHY:**

P. József Vas, MD, ECP, is a former president of the Hungarian Association of Hypnosis (HAH), a supervisor hypnotherapist, and the Head of the Psychotherapy Department in Miskolc, Hungary. He is the author of the book titled *Hypnose bei Psychosen*, München, Quintessenz (1993), two other professional books edited in Hungary, and more than 100 articles.

Email: nyelvmuhely.bt@upcmail.hu

Noémi Császár, PhD, ECP, is the Head of the Education Board of the Hungarian Association of Hypnosis (HAH), a clinical psychologist, supervisor hypnotherapist, psychotherapist, Head of the Psychotherapy Department and the Psychosomatic Out-Patient Department of the National Centre for Spinal Disorders, Budapest, and Human Resources Director of Areus Kft. She has authored the special issue chapter *Psychosocial Issues In The Cancer Patient* in *Spine*, and the book chapter *“Hypnotherapy Treatment of Chronic Pain”* in *Vértess’ Hypnosis – Hypnotherapy* (2006).

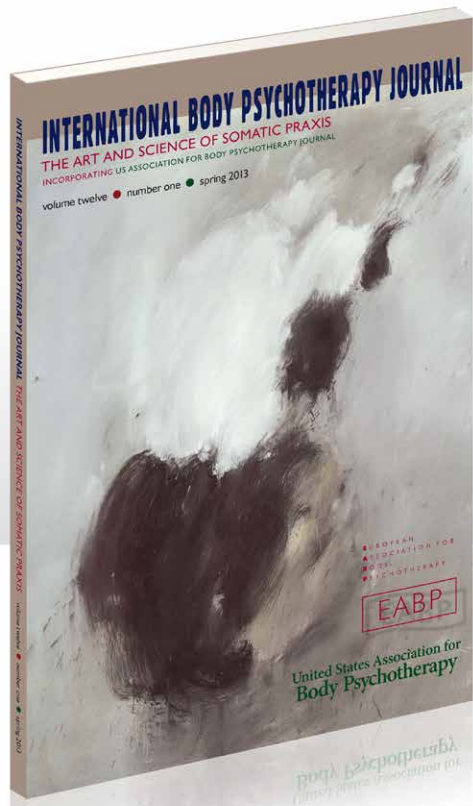
Email: noemi.csaszar@areus.hu Website: www.pszichoszamoca.hu; www.ogk.hu; www.bhc.hu

Presenters of Tandem Hypnotherapy at the 3rd International Congress of Clinical and Experimental Cardiology (website: Cardiology 2013, OMICS Group, Chicago, 15-17 April, 2013).

**REFERENCES**

- Austermann, R., & Austermann, B. (2008). *Dráma az anyaméhben (Drama in Womb – The Lost Twin)*. Budapest: Hellinger Institute
- Bauer, J. (2010). *Miért érzem azt, amit te? (Why can I feel the same as you can?)*. Budapest: Ursus Libris.
- Balint, M. (1965/2001). *Primary Love and Psycho-Analytic Technique*. London: Routledge.
- Bálint, K. (2005). *Érintés a pszichoterápiában. (Touch in Psychotherapy)*. Doctoral Thesis. Budapest: Library of Eötvös Lorand University.
- Bányai, É. I. (1998). The interactive nature of hypnosis: Research evidence for a social-psychobiological model. *Contemporary Hypnosis*, 15(1), 52–63.
- Bergh, Van der, B. (2002). The effect of maternal stress and anxiety in prenatal life on fetus and child. In L. Janus (Ed.), *The Significance of the Earliest Phases of Childhood for Later Life and for Society*. Heidelberg: ISPPM, 37-46.
- Böszörményi-Nagy, I. & Krasner, B. R. (1986). *Between Give and Take: A Clinical Guide to Contextual Therapy*. New York: Brunner/Mazel.
- Chamberlain, D. B. (1993). *Prenatal Intelligence*. In T. Blum (Ed.), *Prenatal Perception Learning and Bonding* (pp. 9–31). Berlin: Leonardo Publishers.
- Cheek, D. B. (1980). Ideomotor questioning: revealing an apparently valid traumatic experience prior birth. *Australian Journal of Clinical and Experimental Hypnosis*, 1(8), 65-70.
- Cheek, D. B. (1986). Prenatal and perinatal imprints: Apparent prenatal consciousness as revealed by hypnosis. *Pre-and Peri-Natal Psychology*, 1(2), 97-110.
- Cheek, D. B. (1993). On Telepathy, Clairvoyance and 'Hearing' in Utero. *The Journal of European Society of Hypnosis in Psychotherapy and Psychosomatic Medicine (HYPNOS)*, 20(2), 76-85.
- Cosmides, L. & Tooby, J. (2001). Evolutionary Psychology. In C. Pléh, V. Csányi, T. Bereczkei (Eds.), *Lélek és evolúció (Mind and Evolution)*, (pp.311-335). Budapest: Osiris.
- Emerson, W. R. (1996). The Vulnerable Prenate. *Journal of Pre- and Perinatal Psychology*, 10(3), 125–142.
- Ferenczi, S. (1933). Trauma in Psychoanalysis. In S. Ferenczi (Ed.), *Final Contributions to the Problems and Methods of Psychoanalysis*. New York: Brunner/Mazel.
- Ferenczi, S. (1988). *The Clinical Diary of Sándor Ferenczi* (Ed. by J. Dupont). Cambridge, M. A.: Harvard University Press.
- Gass, M. A. (1997). *Rebuilding Therapy Overcoming the Past for a more effective Future*. Westport (Conn.): Praeger.
- Gravitz, M. A., Gerton, M. I. (1984). Hypnosis in the Historical Development of Psychoanalytic Psychotherapy. In W. C. Wester & A. H. Jr. Smith (Eds.), *Clinical Hypnosis—a multidisciplinary approach*, (pp. 1-17). Philadelphia: Lippincott.
- Grof, S. (2000). *Psychology of the Future*. New York: State University of New York.
- Hermann, I. (1934/1984). *Az ember ősi ösztönei (Primordial Instincts of Man)*. Budapest: Magvető.
- Hugo, S. (2009). *The Fertile Body Method. The applications of hypnosis and other mind-body approaches for fertility*. Carmarthen, Wales: Crown House Publ.
- Janus, L. (1997). *The Enduring Effects of Prenatal Experience*. London: Jason Aronson.
- Jilek, W. G. (1988). *Indian Healing*. Surrey: Hancock.
- Jung, C. G. (1978). *Man and his Symbols*. London: Picador.
- Kluft, R. P. (1987). On the use of hypnosis to find lost objects: A case report of a tandem hypnotic technique. *American Journal of Clinical Hypnosis*, 29, 242–248.
- Krieger, D. (1975). Therapeutic Touch: The Imprimatur of Nursing. *The American Journal of Nursing (Lippincott Williams & #38) 75(5)*: 784–787.
- Krippner, S. (1993). Cross-cultural perspectives on hypnotic-like procedures used by native healing practitioners. In J. W. Rhue, S. J. Lynn & I. Kirsch, (Eds.), *Handbook of clinical hypnosis*. (pp. 691-717). Washington D.C.: APA.
- Meyer, R. (2010). *A szomato-pszichoterápia (La Somato-psychothérapie, dans la mouvance de Ferenczi)*. Budapest: Oriold és Társai.
- Montagu, A. (1986). *Touching. The Human Significance of the Skin*. New York: Harper & Row.
- Moreno, Z. T. (1987). Psychodrama, Role Theory and the Concept of the Social Atom. In J. K. Zeig (Ed.), *The Evolution of Psychotherapy*, (pp. 341-366) New York: Brunner/Mazel.
- Oakley, D. A. (2008). Hypnosis, trance and suggestion: evidence from neuroimaging. In M.R. Nash, A.J. Barnier (Eds.), *The Oxford Handbook of Hypnosis. Theory, Research and Practice*. (pp. 365-392) Oxford: Oxford University Press.
- Pert, C. B. & Marriott, N. (2007). *Érezd magad istenien! (Everything You Need to Know to Feel Go(o)d)*. Budapest: Édesvíz Kiadó.
- Phelan, J. E. (2009). Exploring the use of touch in the psychotherapeutic setting: A phenomenological review. *Psychotherapy: Theory, Practice, Research, Training*, 46(1), 97–111.
- Piaget, J. (1954) *The construction of the reality in the child*. New York: Basic Books.
- Piontelli, A. (2009). *Development of Normal Fetal Movements: The First 25 Weeks of Gestation*. München: Springer.

- Reich, W. (1976). *Character Analysis*. Buenos Aires: Paidós.
- Robertson, T. (2010) Fertility and The Mind–Body Connection. Retrieved from <http://www.birthpsychology.com/lifebefore/concept11.html>
- Schore, A. N. (2003). *Affect Dysregulation & Disorders of the Self*. New York: Norton.
- Siegel, D. J. (1999.) *The Developing Mind. Toward a Neurobiology of Interpersonal Experience*. New York: The Guilford Press.
- Turner, J. & Turner–Groot, T. (1999). Prebirth Memory Discovery in Psychotraumatology. *The International Journal of Pre- and Perinatal Psychology and Medicine*, 11(4), 469–485.
- Túry, F., Wildmann, M. & Szentes, (2011). Tandem hypnosis with identical bulimic twins. Case report. *American Journal of Clinical Hypnosis*, 53(4), 271–281.
- Varga, K. (2009). Szexualitás, szülés, kötődés: az oxitocin pszichoemotív hatásai. (Sexuality, delivery, and attachment: psychoemotive effects of oxytocin). In E. Bagdy, Z. Demetrovics & J. Pilling (Eds.), *Polihistória – köszöntők és tanulmányok Buda Béla 70. születésnapja alkalmából*. (pp. 449–476). Budapest: Akadémiai Kiadó.
- Vas, J. P. & Császár, N. (2011a). Trans-natal Tandem Hypnotherapy (TTH): A New Method for Resolving Prenatal Traumas. *International Journal of Psychotherapy*, 15(1), 55–64.
- Vas, J. P. & Császár, N. (2011b). Multipersonal Tandem Hypnotherapy (MTH): A New Method for Resolving Intergenerational Traumas. *International Journal of Psychotherapy*, 16(3), 38–48.
- Veldman, F. (1999). Confirming Affectivity, the Dawn of Human Life. *The International Journal of Prenatal and Perinatal Psychology and Medicine*, 6(11), 11–26.
- Verny, T. R. (1996). Isolation, Rejection and Communication in the Womb. *The International Journal of Pre- and Perinatal Psychology and Medicine*, 8(3), 287–294.
- Wilber, K. (1996). *A Brief History of Everything*. Boston: Shambala.
- Young, C. (2007). The Power of Touch in Psychotherapy. *International Journal of Psychotherapy*, 11 (3), 15–24.
- Zur, O. & Nordmarken, N. (2011). To Touch Or Not To Touch: Exploring the Myth of Prohibition On Touch In Psychotherapy And Counseling. Clinical, Ethical & Legal Considerations. Retrieved from <http://www.zurinstitute.com/touchintherapy.html>



# INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS  
(formerly US Association for Body Psychotherapy Journal)

Online issues are available free of charge  
[www.eabp.org](http://www.eabp.org)      [www.usabp.org](http://www.usabp.org)

Print subscriptions are also available:  
 Printed single issue: Members €17.50, Non-members €20  
 Yearly subscription: Members €30, Non-members €35  
 Two-year subscription: Members €55.00, Non-members €60.

Payment through bank transfer, American Express or PayPal.  
<http://www.eabp.org/ibpj-subscribe.php>

**Somatic Psychotherapy Today**

Free Online [www.usabp.org](http://www.usabp.org) and [www.eabp.org](http://www.eabp.org)  
[www.issuu.com/SomaticPsychotherapyToday](http://www.issuu.com/SomaticPsychotherapyToday)

Clinically relevant topics from preconception on.  
 Cutting-edge research and resources reviewed. **Vibrant**

**Fresh** In-depth articles and interviews by and for people immersed in the field of body psychotherapy.

Summer Conferences      The Self in Psychotherapy

**Alive**      **Embodied**

Collaboration      **Published quarterly**

**Innovative**      **Theme based**

Embodiment      **Honoring everyone's voice and story**

We are now available for subscription in hardcopy.  
 Check us out at [www.usabp.org](http://www.usabp.org)

Multicultural Impact on Psychotherapy



# INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

volume twelve ● number one ● spring 2013

## TABLE OF CONTENTS:

### 4 Editorial

Jacqueline A. Carleton, PhD

## ARTICLES

### 8 Sense and Sensibility in Supervision

Sibylle Huerta Kreffit, MA, ECP

(Translated from the German by Elizabeth Marshall)

### 15 Bridging the Split: Integrating Psychodynamic and Body-Centered Therapies.

Claire Haiman, PsyD.

### 27 A spacious life

Salita S. Bryant, PhD., MFA.

### 28 Broken Boundaries, Invaded Territories - The Challenges of Containment in Trauma Work

Morit Heitzler, MSc

### 42 Yoga Based Body Psychotherapy: A Yoga Based and Body Centered Approach to Counseling

Livia Shapiro

### 56 Expanding the Dialogue: Exploring Contributions from Energy Medicine

Debra Greene, PhD

### 74 Tandem Hypnotherapy

P. József Vas, MD, ECP and Noémi Császár, PhD, ECP

EUROPEAN  
ASSOCIATION FOR  
BODY-  
PSYCHOTHERAPY



United States Association for  
Body Psychotherapy