Tandem Hypnotherapy†

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

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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

By “tandem” we mean several things: 1. a multi-seated bicycle; 2. an acronym for Touch of Ancient and New Generations with a Dialogue Experiencing Oneness of Minds (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 hypnotist’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

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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 (Türky, 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 hypnодrama (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 transfers 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 gets 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 (Balint, 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 boundaries 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 attainment 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 nutriments 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 killed in her womb. 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.

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
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 sky.” 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
muses; 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 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

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”.

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

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