

## ATTACHMENT-FOCUSED HYPNOSIS IN PSYCHOTHERAPY FOR COMPLEX TRAUMA: *Attunement, Representation, and Mentalization*

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**Abstract:** The relational and psychological functions of attunement, representation, and mentalization are essential components of a secure attachment experience. Psychotherapeutic approaches informed by attachment theory have gained significant empirical and clinical support, particularly in the area of complex trauma. Despite these advances, attachment-informed trauma treatment could benefit greatly from the experiential wealth that clinical hypnosis has to offer. In its utilization of shared attention, tone of voice, pacing, representational imagery, and hypnotic language, clinical hypnosis as a state, relationship, and technique offers psychotherapists a way of introducing a healthy attachment experience and renewing appropriate developmental functioning in patients who are survivors of complex trauma. In this article, attunement, representation, and mentalization are reviewed from a hypnotherapeutic perspective.

Clinical hypnosis, the clinical utilization of hypnosis in treatment by health care professionals (Sugarman, 2013), has a great deal to offer practitioners interested in attachment and development (Baker, 1981; Brown, 2009a, 2009b; Zelinka, Cojan, & Desseilles, 2014). Aspects of hypnosis, including the state itself and the procedure through which it is elicited, closely resemble features of attachment and will be further explicated in this article. Moreover, the therapeutic relationship is a central factor as the therapist and patient are in a delicate balance of responsiveness to one another as the hypnotic process unfolds (Baker, 1981, 2000; Banyai, 1998; Diamond, 1984, 1987; Spiegel & Greenleaf, 2005; Yapko, 2005). Factors such as alliance, trust, and reciprocity in the therapeutic relationship all play a role in the hypnotic experience. Further, hypnotherapeutic techniques embedded in the relationship and its process, such as tone of voice, pacing, and utilization emulate

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qualities of the healthy primary attachment relationship (Brown, 2009a, 2009b; Zelinka et al., 2014).

This article proposes hypnotherapeutic applications from an attachment perspective within the treatment area of complex trauma. There is strong empirical evidence linking early complex trauma (abuse/neglect), the development of insecure attachment schemas (particularly disorganized), and the subsequent development of borderline personality disorder (BPD) (Bateman & Fonagy, 2012; Brown, 2009b; Carlson, 1998; Carlson, Egeland, & Sroufe, 2009; Choi-Kain, Fitzmaurice, Zanarini, Laverdiere, & Gunderson, 2009; Widom, Czaja, & Paris, 2009). A relational psychotherapeutic approach to treating trauma is understood to be a critical means for experientially rewiring unhealthy attachment schemas and re-engaging stalled developmental processes connected to the original traumatic attachment relationship (Courtois, 2004; Courtois & Ford, 2013; Pearlman & Courtois, 2005; Peebles, 2008; Peebles-Kleiger, 2002). As this article will illustrate, attachment-focused hypnosis integrated into such a treatment has the potential to significantly enhance and expedite this psychotherapeutic healing process. I propose and describe a hypnotherapeutic approach based on the attachment principles of attunement, representation, and mentalization.

### ATTACHMENT THEORY: THE RELATIONSHIP AS A MIRROR IN THE DEVELOPMENT OF THE SELF

Attachment theory is the theoretical and empirical study of intimate relationships and their impact on the development of the self. According to Bowlby (1979), our lives center around intimate attachment relationships “from the cradle to the grave” (p. 129). Bowlby (1973) also postulated that secure attachment develops in the period of infant development occurring after object permanence. He emphasized that secure attachment provides two essential qualities to infants: (a) a safe haven, or place where infants can go to for emotional safety and security, and (b) a secure base for exploration, or a launching pad for outreach into the world with the knowledge that the attachment figure is located near enough to provide a safe haven if necessary.

Winnicott writes (1971) “the precursor of the mirror is the mother’s face. . .” (p. 1) “. . . [the mother is] giving back to the baby the baby’s own self” (p. 5). Appropriate mirroring contains two essential attachment-related functions, contingency and marking, and serves to facilitate secure attachment (Allen, Fonagy, & Bateman, 2008; Bateman & Fonagy, 2012; Fonagy, Gergely, Jurist, & Target, 2002; Wallin, 2007).

With *contingent mirroring*, the attachment figure accurately matches the facial or vocal expressions of the infant, serving to recognize and validate the infant's preverbal emotional experience. Contingent mirroring is developmentally important because it allows the infant to discover and explore his or her feelings as mental states, first seen through the other (attachment figure) but over time internalized into the self (e.g., "If this is what my emotions look like in someone else, this is what they must be like inside of me"). On the other hand, *marked mirroring* involves the attachment figure inserting him- or herself into the attachment encounter in a way that contains the infant's distress and provides boundary demarcation. A central component of marking is signifying through the parental response that the infant feelings being contingently mirrored are not real. The parent is only pretending (and clearly has his or her own feelings that are different from the infant), soothing, and containing. For example, the parent might make a playful face after initially matching the infant's distress. This serves to communicate to the infant that his or her distress will not spill over into the world and contaminate the parent (Bateman & Fonagy, 2012; Fonagy et al., 2002). Because preverbal experience is the predominant mode in the sensitive period of attachment, the caregiver's facial expressions and tone of voice are more important than the actual words he or she is saying. As is the case with contingent mirroring, when the parent consistently marks the infant's affect, then over time the infant is understood to internalize this ability (Wallin, 2007).

### MENTALIZATION: HOW ATTACHMENT FACILITATES THE REPRESENTATIONAL DEVELOPMENT OF THE MIND

Developmental researchers have focused on the impact of parental mirroring and related attachment experiences in the maturation of adaptive internal representation and reflective functioning in the infant as he or she progresses into childhood and later adulthood. *Mentalization* is defined as "holding mind in mind" (Allen et al., 2008, p. 3). It is both a developmental milestone and an ongoing developmental capacity by which we become aware that our mental states mediate the way we experience the world (Fonagy et al., 2002). When we possess high levels of mentalization, we demonstrate this through effective reflective functioning. A person who mentalizes is aware of and attends to his or her own and others' mental states, as well as differentiates them from outwardly expressed behaviors (Allen et al., 2008; Bateman & Fonagy, 2006, 2012).

The construct of mentalization is relevant in that it expands upon attachment theory. Rather than viewing attachment solely as a means and end in and of itself (e.g., that the goal would be to develop secure attachment), mentalization researchers believe that the process of attachment also serves the purpose of creating a representational system that is useful for survival and adaptation (Bateman & Fonagy, 2006; Fonagy et al., 2002). Mentalization-based treatment (MBT) and other approaches informed by attachment theory emphasize improving reflective functioning and affect regulation through a relational stance and associated techniques that make patients more aware of and curious about their and others' mental states and processes (Allen et al., 2008; Bateman & Fonagy, 2006, 2012).

### COMPLEX TRAUMA: CONCEPTUALIZATION AND TREATMENT

The term *complex trauma* refers to a repetitive and escalating series of traumatic events occurring over a period of time, usually in a specific context, such as in an attachment relationship (Courtois, 2004). Although there can be variance in the precipitating context, complex trauma often stems from pervasive developmental abuse or neglect and involves significant psychological harm to a survivor's sense of personhood and associated psychological functions (Courtois, 2004; Courtois & Ford, 2013; Herman, 1992; Pearlman & Courtois, 2005).

Three central domains tend to be present in the presentation of adult survivors of complex trauma (Courtois & Ford, 2013). The first is emotional and/or somatic dysregulation. When the emotional and/or somatic response is overreactive, the survivor will feel physiologically flooded and have difficulty functioning. In the opposite "freeze" response, the survivor immobilizes and cannot marshal appropriate internal resources to resume normal functioning. Neuroception influences the quality and intensity of physiological and psychological reactions to cues in the environment. Traumatic attachment promotes faulty neuroception, leading to inaccurate "danger!" signals and a neurobiopsychosocial fight/flight/freeze response. Thus, traumatic dysregulation reduces the potential for further social engagement and internalization of healthy relational experiences (Courtois & Ford, 2013; Porges, 2011).

The second domain is dissociation, or a disruption in the experience of self-integrity. Potential expressions of dissociation could include experiences of loss of time, loss of consciousness, and loss of one's sense of self (Courtois & Ford, 2013). As Van der Hart and colleagues (2006) describe in their structural theory of dissociation, any kind

of dissociation involves a segregation of personal experience across aspects of personality and functioning. Expressions of traumatic experience can become separated from other aspects of personality and daily functioning. As a result, cues that trigger traumatic re-experiencing can often result in a profound disruption and can shift to the survivor's quality of self-integrity and self-experience.

The last domain of complex trauma is compromised interpersonal relationships. Because the traumatic harm is often inflicted by an attachment figure, complex trauma is strongly associated with insecure and disorganized attachment (Mikulincer & Shaver, 2007; Pearlman & Courtois, 2005). Significant attachment anxiety and avoidance match Herman's (1992) description of oscillating posttraumatic responses of intrusion and numbing. In this case, we can conceptualize the intrusion and numbing as being relationally based, in the form of attachment anxiety and attachment avoidance, since the *relationship itself* (and anything that reminds the person of it) is associated with the trauma in the survivor's mind. One manifestation of the disruption to the attachment process caused by the complex trauma is the foreclosure of mentalization. Because reconciling the inherent contradiction of the attachment figure being the abuser and/or neglecter is too great of a psychological burden to bear, the child shuts down his or her inquisitiveness about underlying mental states as a survival tactic. Curiosity about internal mental states in oneself or others no longer feels safe, and the result is a tendency to see things in black-and-white, world equals mind, concrete terms. This tendency to think in such a nonmentalizing way is referred to as psychic equivalence (Allen et al., 2008; Bateman & Fonagy, 2006, 2012; Fonagy et al., 2002). For these reasons, a treatment addressing the developmental, relational, and representational aspects of an insecure attachment is understood to be vital in ameliorating the dysfunctions in self-regulation that are associated with complex trauma (Courtois, 2004; Mikulincer & Shaver, 2007; Pearlman & Courtois, 2005).

Therapeutic treatment for complex trauma is usually divided into three phases consisting of safety and stabilization, controlled reprocessing, and working-through/integration (Courtois, 2004; Courtois & Ford, 2013; Herman, 1992; Peebles, 2008; Peebles-Kleiger, 2002). The safety and stabilization phase focuses on building therapeutic alliance, enhancing the patient's sense of safety, and developing affect regulation, boundary management, and associated skills. Also emphasized in this phase is the strengthening of patients' capacities to restabilize after a disruption and self-soothe (Courtois, 2004; Courtois & Ford, 2013; Peebles, 2008). Once a consistent, safe and stable frame has been established, the treatment emphasis shifts to controlled reprocessing of traumatic memories in the safe holding environment. In this phase, the focus is on reprocessing traumatic material in such a way so as to facilitate resolution of posttraumatic symptoms (Courtois, 2004; Peebles,

2008). Finally, the working-through phase is an opportunity for collaboratively restructuring patients' understandings of themselves and the world. Consistent experiences of safety with the therapist and others engender the development of new neurobiological templates of how self, relationships, and the world work (Peebles, 2008). The therapeutic features of establishing a stable relational alliance, creating safety and security, and enhancing affect regulation are seen as core aspects of a trauma treatment (Courtois, 2004; Pearlman & Courtois, 2005; Peebles, 2008).

Clinical hypnosis is best understood as a component of an existing phased psychotherapeutic trauma treatment, rather than as its own separate treatment (Peebles, 2008; Phillips & Frederick, 1995). Hypnosis is particularly valuable because hypnotic interventions occur in a state that is comparable in many ways to that of a traumatized mind (Kluft, 2012; Peebles, 2008; Peebles-Kleiger, 2002). As covered earlier in this article (see Van der Hart et al., 2006), the traumatized mind can be focused on traumatic experience and dissociated from other aspects of experience or can be dissociated from traumatic experience and focused on other aspects of experience. We can properly infer, then, that such a person is already in a hypnotic state under such conditions. This is because hypnosis by definition is a state of narrowed, focused attention (absorption) that inevitably features dissociation (e.g., all phenomena outside of the cone of attention) (Brown & Fromm, 1986; Hammond, 1990; Kluft, 2012; Peebles, 2008; Sugarman, 2013). As a result, we can conceptualize hypnosis as a way of adaptively utilizing the traumatized mind in the service of positive therapeutic goals.

### ATTUNEMENT, REPRESENTATION, AND MENTALIZATION IN HYPNOSIS: HYPNOTICALLY UTILIZING QUALITIES OF ATTACHMENT TO RE-ENGAGE HEALTHY DEVELOPMENTAL FUNCTIONING IN TRAUMA PATIENTS

I believe that an attachment-focused hypnotherapeutic approach (a) introduces the mutative components of attachment into the trauma treatment in a more explicit and intentional manner than a traditional hypnotherapeutic treatment might and (b) provides the attachment-oriented psychotherapist with a focused and experiential means (hypnosis) for the patient to internalize and integrate the language, phenomenological experiences, and imagery of healthy attachment experiences. By first directing attention to the sensory and relational anchors inherent within the patient, therapeutic setting and therapeutic relationship ("attunement") and then subsequently developing the patient's capacity to mentally represent them

(“representation”), the hypnotherapist facilitates and strengthens the emergence of mentalization and the adaptive use of language for the purpose of reflective functioning.

When considering the use of hypnosis to facilitate the development of mentalization in this type of work, it can be helpful to think of mentalizing in an expanded sense. As described earlier in this article, mentalizing is typically operationalized in a lexical manner, requiring language, cognition, and secondary process functioning in order to “hold mind in mind.” Mentalizing has to do with thinking, and thinking requires symbolic processing. However, it is also possible to hold an imagery-based pictorial representational awareness that precedes but is related to reflective awareness of mental states. Images are both preverbal and linguistically evocative connectors to the sensory experience, and the sensory experience is derived from the immediate here-and-now moment (E. L. Baker, personal communication, March 27, 2013). Thus, when a hypnotherapist attunes to the patient and notices aloud an indisputable observable phenomenological process occurring externally (a form of utilization known as a “truism”; e.g., “your feet are on the floor . . . your hands are in your lap . . . you’re breathing in and out”; Patterson, 2012), they are constructing an internal mental representation for the patient of the immediate sensory experience at hand (Baker, 1981).

As a result, in working in a forward, developmentally sequenced manner, we utilize hypnotic attunement in the here-and-now to permissively guide the patient towards sensorimotor and phenomenological anchors in her<sup>1</sup> body. This is a method for developing positive body-based awareness of somatic anchors that can become the initial building blocks for developing subsequent internal resources. Through this therapeutic attunement, the patient begins to enhance her own capacity to be present with her body in a contained and grounding way. As the patient becomes more skilled in this type of self-directed sensory attunement in the space of the therapeutic relationship, attention turns to internal representation through hypnotic imagery. At first, the imagery begins with immediate sensorimotor phenomenological experiences (e.g., representing the immediate moment in the patient’s mind) and then later shifts to more fantasy-based representational imagery. The latter imagery takes advantage of the patient’s developing imagination to picture scenes emphasizing salient aspects of healthy attachment and affect expression, self-regulation, and identity development. Thus, we use pictures to enhance the patient’s capacity for describing her experiences with language. Pictures become the building blocks for

<sup>1</sup>For purposes of simplicity and differentiation, in this article I use the male gender in referring to the therapist and the female gender in referring to the patient.



words. As the patient's ability to describe her experiences with words improves, her self-reflective language becomes more sophisticated, which in turn informs her use of symbolic representational imagery. In the subsections below, each phase is described in greater detail.

### *Attunement*

Attunement is a term that is derived from the literature on the psychotherapy relationship. While there are variations in terminology (e.g., empathic attunement) and the focus of attunement (e.g., to affect, to content, etc.) by theoretical orientation, it generally refers to the ability of the therapist to accurately track, to understand, and to relate to the patient's experience *as if* he were that person (Kohut, 1977; Rogers, 1957). This simultaneously joined yet differentiated empathic attunement is a critical part of the bond, or attachment, between patient and therapist that constitutes a healthy "working alliance" in psychotherapy (Gelso & Hayes, 1998).

The particular power of hypnosis as a treatment tool is rooted in its facilitation of attunement and the joining together in trance of patient and therapist in ways that are not as easily achieved in waking therapy (Baker, 2000; Diamond, 1987). The bond that comes with a strong working alliance between therapist and patient in waking state therapy has been shown to yield therapeutic benefits for the patient (Gelso & Hayes, 1998). Conceptually related to the working alliance, yet also more extensive in its depth and intensity, the hypnotherapy term "symbiotic alliance" refers to an internalized, mental sense of togetherness in hypnosis that occurs as a result of hypnotic attunement and hypnotic phenomena. In this hypnotic joining, time becomes distorted, the hypnotic language of the therapist becomes co-mingled with the patient's associated sensory experience, and the external regulatory functions of the therapist are experienced by the patient as if they are coming from inside the patient (Baker, 2000; Diamond, 1987; Zelinka et al., 2014). Diamond posits that this symbiotic alliance meets Mahler's (1968) description of a "corrective symbiotic experience" in that the patient absorbs and experiences feelings of soothing, safety, and security by hypnotically fusing with the therapist. Like Mahler, Diamond compares this process to the infant's preverbal attachment experience with its mother. Longitudinal experimental research on the social psychobiological synchronization of patient and therapist in trance suggests (a) a measurable and significant attunement and synchronization between therapist and patient during hypnosis and (b) that hypnosis allows for the accumulation of more proprioceptive anchors in the patient, such as the capacity for being attached in a safe, secure, and tolerable way that feels good (Banyai, 1998; Varga, Jozsa, Banyai, & Gosi-Greguss, 2006).



Because boundary establishment, repair, and maintenance are essential and defining components of psychotherapeutic and hypnotherapeutic trauma treatments (Peebles, 2008; Phillips, 2013; Phillips & Frederick, 1995), it is important to always ratify the patient's sense of awareness, control, and mastery over these boundaries during the attunement process. Indeed, the hypnotic experience of attunement may feel terrifying to trauma patients who experience discomfort with closeness (Scagnelli, 1976), as is the case with high avoidant attachment (e.g., the avoidant dimension in fearful-avoidant/disorganized attachment styles). However, rather than attempting to *create* a state of merger or fusion in hypnosis, we are utilizing the natural attunement that is inherent in the hypnotic process to facilitate a number of developmentally appropriate goals for the patient. One of these goals is often utilizing the unfolding attunement to reaffirm her control over her boundaries. For example:

As you focus on the sound of my voice with each breath in and out . . . good, that's right . . . your unconscious mind can automatically notice and recognize whether it would like to imagine my voice as being close beside you like a soft lullaby or at a safe distance like an echo from far away . . . or perhaps somewhere in between that feels just right for you.

I believe that when we attune to our patients in hypnotherapy, we do so in ways that have contingent and marked qualities to the mirroring. We share in and affirm their experience (contingent mirroring; see earlier examples of truisms). At the same time, we pace slightly ahead of them in the hypnotic process and offer suggestions from our own vantage point about what they might expect to happen next that would serve to contain that experience in which we are sharing (marked mirroring). For example, a therapist incorporating contingent and marked mirroring into his hypnotic attunement might state:

And as you continue to listen to my voice, I wonder what you will notice first. Perhaps you will notice that your hands are becoming more and more comfortably warm, maybe first in the fingertips and then the palm, to just the right amount of warmth for you . . . or maybe you will notice that with each effortless, automatic, and natural breath out, your breathing becomes more rhythmic and relaxed . . . and it really doesn't matter what you notice first . . . whether it's your hands, or your breath, or some other pleasant, natural process unfolding in your body . . . because you can begin to have an experience . . . perhaps slowly or perhaps more quickly . . . of feeling more and more [relaxed, comfortable, secure, anchored, grounded, present, alert; word choice would describe the attachment and trauma treatment goal that we wanted to address in the moment].

In reviewing the above example, it is my view that a powerfully curative process begins to unfold when accurate and positive somatic

tracking (e.g., observing aloud a natural, automatic, and beneficial unfolding physiological process in the patient) is paired with the developmentally rich qualities of vocal prosody in the hypnotherapist's tone, pacing, and rhythm of voice. This synchronistic experience of having a relationship figure tune into the patient's phenomenological experience and do so in such a soothing and affirming manner is deeply satisfying and evokes the developmental rhythms of secure attachment.

In describing the affective neuroscience of attunement, Schore (2012) writes that right hemisphere communication is analogous to primary process functioning or day dreaming, which is how a hypnotic state can be described (Brown & Fromm, 1986; Hammond, 1990; Sugarman, 2013). In an attuned therapeutic encounter, Schore explains, right brain to right brain communication between therapist and patient is occurring. He summarizes this right brain interpersonal communication as "the music behind our words" (Schore, 2012, p. 38). As we know, musical instruments can convey great meaning in the way that they articulate a song. Notes of music can carry deep emotional and physiological resonance without a single word being uttered, as in the case of classical or electronic dance music. In this regard, then, the hypnotic "music"—the rhythmic manner in which the hypnotic language is delivered—can become even more significant than the hypnotic language itself in promoting healthy attachment.

Additional neurophysiological pathways of attunement exist in the hypnotic process. Mirror neurons, which are present in the prefrontal cortex, serve to help the patient and therapist emulate the motoric movements of one another. The gestures, expressions, and posture of the therapist stimulate mirror neurons in the patient, much in the same developmental vein as between a parent and infant. This motoric information encoded through observation of the interpersonal encounter allows the patient to imitate the therapist. It is through this imitation that internal emotional associations begin to develop in the patient (Cozolino, 2010). Milton Erickson referred to hypnotic ideomotor induction techniques and suggestions as "pantomime techniques," because they accentuate the automaticity, involuntary, and unconscious motoric processing that exists and can be activated in the patient (Erikson, 1964, as cited in Rossi & Rossi, 2006, p. 271). Rossi and Rossi utilize the term *rapport zone* to refer to the empathy about others' minds that develops in the patient. They hypothesize that this type of mental empathy begins with mirroring observations and repetition of movements and then transitions into mirroring of and curiosity about internal mental processes. Through its presentation of psychosocial cues in the therapeutic encounter, hypnosis thus stimulates patient rapport zones and generates brain neuroplasticity in the sensory-motor cortex and associated areas (Rossi & Rossi, 2006).

From the perspective of attachment researchers, it is the repetition of experiences of joint attention inherent in the attunement that leads to the development of self-directed attention, which in turn fosters internal mental representation and mentalization (Allen et al., 2008; Fonagy et al., 2002). Allen and colleagues (2008) define joint attention as a shared attentional space between caregiver and child that facilitates the development of self-directed attention. Relatedly, they describe mentalization as requiring “effortful control of attention” (Allen et al., 2008, p. 36). In an effortful way, we are harnessing the executive functions of our mind to focus in on mental states, whether our own or those of others.

Comparably, hypnosis by definition is focused attention (Brown & Fromm, 1986; Hammond, 1990) that happens in a joint therapeutic space. In a hypnotic induction, the therapist directs the patient’s attention to a particular object, sensation, or experience (Brown & Fromm, 1986; Hammond, 1990). As the patient focuses her attention on this reference point, the therapist focuses on the patient’s responses (nonverbal and verbal) to assess for hypnotic phenomena (e.g., depth of breathing, muscle tone, facial cues) and the patient’s subjective reactions to being hypnotized. The therapist will regulate his pacing, language, tone of voice, and actual content to appropriately mirror and guide the responses of the patient (Brown & Fromm, 1986). Furthermore, the therapist can utilize the joint attention present in the hypnotic therapeutic relationship to facilitate greater patient awareness of internal experiences. For example, the therapist might state, “You are fascinated by the thoughts and feelings that just seem to come up in your mind” (Brown & Fromm, 1986, p. 59). Hypnotic language is utilized to enhance patient curiosity about her inner world.

As an interesting parallel to the developmental transition from joint attention to self-directed attention, hetero-hypnosis is often a developmental antecedent to self-hypnosis because the patient is learning from the therapist how to apply her own innate hypnotic capabilities (Levitan, 1998). Ultimately, it is the transition from joint attention to self-directed attention that paves the way for the patient’s internal representation of here-and-now phenomenological experiences. This transition will be discussed in greater detail in the section “Representation.”

The process of attunement to positive somatosensory experiences can serve as a metaphor for boundary management and affect containment. As an example, eye closure and fractionation can function as methods for utilizing the body (in this case the eyelids) to regulate boundaries. In the initial induction, permissive motoric suggestions can be given to the patient with regard to controlling the degree to which she would like to have her eyes open or closed. Additional contingent suggestions can be given regarding the patient’s mastery of being able to regulate these somatic boundaries. Assuming it is appropriate, a

fractionation suggestion can then be given asking the patient to (briefly) open and then reclose her eyes. The suggestion to reclose her eyes is paired with another deepening suggestion emphasizing a clinically appropriate goal (e.g., safety, mastery, affect regulation, boundary management). Thus, the fractionation not only serves to deepen the trance but also demonstrates to the patient her burgeoning positive mastery over her body. Thus, in this regard, muscle control, boundary management and trance ratification become paired together in a way that is pleasing to the patient. An example of this and other attunement hypnosis interventions are provided in [Table 1](#).

Attunement in hypnosis can also serve to realert or refocus the patient on her immediate anchors during a dissociated state (e.g., blinking her eyes and reopening them; feeling the crisp air in her lungs as she takes a deep, refocusing breath in, feeling the ground beneath her by pressing the soles of her feet against the floor). It can also be incorporated as a cue in conjunction with a hypnotic suggestion for positive affect or cognition. For example:

When the word *refocus* pops up in your mind, it will be a signal to you to take a deep breath, count to three, blink and reopen your eyes slowly and clearly, and feel fully alert, present, and in control of your body.

Utilizing these types of sensorimotor anchoring and grounding interventions in the attunement phase allows the patient to establish, to maintain, and to appreciate a sense of “this is what it feels like to be in my body in a way that feels good.” She is developing a framework for being with herself in a positive way that she can reference and return to as she needs to. This foundation in turn allows her to better tolerate traumatic cues that would have previously triggered rapid hyperarousal or dissociation.

### *Representation*

When a patient can direct her own attention in a sustained way, she is better prepared to create a detailed representational picture in her mind of the phenomenon to which she is attending. Moving the patient from tactile sensory attention of her somatic experiences (e.g., “this is what my foot feels like [in a sock, shoe, barefoot, etc.]” to visual mental representation of those experiences [e.g., “this is what my foot looks like in a mirror as it feels \_\_\_”) strengthens representational capacities and object constancy (Baker, 1981). It also naturally follows that, as these internal working models of self-experience and self-constancy develop in hypnotherapy, the patient can begin to move from representing parts of her body and parts of herself to representing her whole body and whole being; from representing “it” to representing “I”; and from representing “me” to representing “we” (whomever the “we” may be; more on this in the subsections that follow). This movement facilitates a sense of self-integration.

Table 1  
*Hypnotic Attunement: Skills, Applications, and Examples*

Skill	Application	Example
Ideomotor induction techniques (e.g., arm levitation, reverse arm levitation, Chiasson technique)	Since attunement is bidirectional (the patient is also attuning to the therapist) and not restricted to verbal interactions, this type of nonverbal modeling is particularly helpful for patients who are responsive to motoric movement. In modeling the beginning of the ideomotor technique, the therapist activates mirror neurons in the patient.	"Now having fully reviewed how hypnosis works, I'm understanding that you feel ready to proceed. Is that correct? Good. Well you might be curious to learn that there are many ways of entering a hypnotic state. And if it's alright with you, I'd like to show you an interesting way of beginning. Why don't you (allow your arm to drift, lift up your arm and bend it at the elbow, etc.) <i>just like I am doing right now</i> . And although hypnosis may begin similarly for many people, each person experiences hypnosis uniquely, in their own special and helpful way. So in a moment, I'm going to [put my arm down, etc.] and you can focus your attention on your [arm, fingers] as [it/they] begin to . . ." (One can then use induction language such as that from Hammond [1990].)
Utilization	This is the most important and universal skill of attunement. One of the overarching aims of attunement is to increase patients' abilities to more consistently and safely observe and utilize their moment-to-moment experience. The therapist initially models it for them with the goal of increasing their ability to do it for themselves.	"And as you continue to listen to my voice, I wonder what you will notice first. Perhaps you will notice that your hands are becoming more and more comfortably warm, maybe first in the fingertips and then the palm, to just the right amount of warmth for you . . . or maybe you will notice that with each effortless, automatic, and natural breath out, your breathing becomes more rhythmic and relaxed . . . and it really doesn't matter what you notice first . . . whether it's your hands, or your breath, or some other pleasant, natural process unfolding in your body . . . because you can begin to have an experience . . . perhaps slowly or perhaps more quickly . . . of feeling more and more [relaxed, comfortable, secure, anchored, grounded, present, alert; word choice would describe the attachment and trauma treatment goal that we wanted to address in the moment]."

(Continued)

Table 1  
(Continued)

Skill	Application	Example
Truism	<p>A type of utilization. Here, we utilize a cue that we observe in the patient whose truth he or she cannot deny for the purpose of ascribing therapeutically significant meaning in a hypnotic suggestion that we link to the truism (contingent suggestion).</p>	<p>"As you notice yourself sitting on the beige couch, you can really feel your two feet on the floor. Two feet . . . just as there are two of us here in this room together . . . at just the right amount of space for you . . . as close or far as you need us to be. And your two feet are on the floor . . . whether you are sitting or standing . . . standing still or walking. And it is right, is it not, that your two feet . . . left and right . . . walked you into this office so that you could be right here and right now in just the way that you need? And it is also correct, is it not, that you have been walking . . . freely, easily, and effortlessly . . . on your own two feet . . . since you first learned how to walk, isn't that right? And have you ever imagined how you first learned to walk? It doesn't really matter if it comes to mind in this moment or not . . . because on a deep level that your unconscious mind can truly understand and appreciate . . . in whatever way and whatever time is right . . . you must know that you progressed from being immobile . . . to being able to roll up . . . roll down . . . and roll all around . . . then to crawling . . . at first slowly or unsurely . . . and then perhaps later more quickly and more confidently . . . to then taking your first steps . . . maybe at first tentatively, then later more assertively . . . and with every step that you took . . . you began to realize that you could take another . . . one step could turn into two steps . . . two steps into four steps . . . four could turn into more . . . But now I'd like to tell you something really interesting . . . would you like to know what that is? Before . . . there was two . . . and one . . . and although you may have previously thought that it was apparent that a parent taught you how to walk . . . you really took your first steps the moment they let go, isn't that</p>

right? And although it can feel good to have someone hold your hand and walk by your side . . . that can happen whenever and however you are ready . . . you will always be able to walk on your own two feet . . . just as you will always be able to hear what you need to hear with your own two ears.. or see what you need to see with your own two eyes . . . or smell what you want to smell with your own two nostrils. And each of these two belongs to the one that is you . . . and holding, walking, hearing, seeing, smelling . . . are just the beginning of all the wonderful things that you can do . . . and that do is also a be . . . And isn't nice to know that you can be with yourself in all these ways that feel good? And you can feel more and more comfortable being with yourself . . . whether it is by yourself or with someone else."

Imagine speaking the above example with particular attention to alternations of volume, pace, and enunciation of syllables.

Prosody & Synchrony:  
Pacing, rhythm and tone of voice

Meant to replicate early healthy, developmental rhythms of attachment. The key is to stay in step with the patient's moment-to-moment experience while slightly leading in directing what one observes next and the meaning one gives to the observation. The therapist's voice is in an instrument designed to evoke rhythm, tone, and effect.

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(Continued)



Table 1  
(Continued)

Skill	Application	Example
Eye closure / Fractionation	<ol style="list-style-type: none"> <li data-bbox="232 1118 314 1376">1. Emphasize control of boundaries (eyelids open/closed/degrees)</li> <li data-bbox="320 1118 431 1376">2. Foster curiosity in similarities/difference between internal and external states and experiences</li> <li data-bbox="437 1032 546 1376">3. Manage dissociation or abreaction through either re-alerting from or deepening trance</li> </ol>	<p>[At initial eye closure] "and isn't it nice to know that your eyelids can remain open or begin to close by themselves . . . sooner or later . . . just in time . . . watch as it happens . . . easily . . . automatically . . . in ways you couldn't have possibly known you would know. And maybe your eyelids would like to remain open . . . or maybe they'd like to close. . . . or perhaps they'd like to close a little . . . as they remain mostly open . . . or, on the other hand, they could remain open a little . . . as they close a lot . . . or you could keep one eye open and close the other . . . I don't know, and it really doesn't matter . . . but the 'I' that is you knows just what you need right now, isn't that right? Just as you can experience exactly the right degree of comfort that you'd like to feel in your body in this moment . . . whatever is right for you . . . you'll be able to feel it clearly . . . as easy as A-B-seeing clearly inside . . . even with your eyelids securely closed . . . and now you can see in your mind, can you not, that your eyelids are like your own personal door . . . and you can open and shut this door to go outside or inside exactly as you need. And just as you can use this door to let yourself go out and then in . . . or in and then out . . . you can keep others out while you remain securely on the inside . . . or you can let others join you and be with you as you need . . . and sometimes it is enjoyable to be with just yourself and other times you might enjoy the company of someone whom you can trust . . . and your unconscious mind knows just what is right for you in each moment. And would it be alright to briefly open your eyes for just a moment?" [At point in trance of fractionation.] "That's right . . . good. Take a moment to reorient yourself. And now, whenever you are ready . . . your eyes can close all by themselves again . . . more easily than they did before . . . and you can feel even more [comfortable, secure, anchored, etc.] than you were a moment ago."</p>

Arm catalepsy      In addition to ratifying the trance experience, this hypnosis technique becomes an immediate, sensory-based symbol of affect containment.

“Let’s observe something together that you may find helpful . . . would that be alright? I’m going to tell you something about one of your arms . . . pick one . . . good . . . that might surprise you. But you might find that you are pleased to discover how surprised you are . . . or surprised to discover how pleased you are . . . as you become aware of this.” [Note: therapist gives suggestion for positive anticipation in the event that catalepsy or immobilization has negative traumatic implications.] “As you focus your attention on this arm, you can imagine it becoming very strong . . . so very strong and thick and solid . . . and of course we can move solid objects when and as we need to . . . but for now I wonder whether you might imagine the arm as being stiff and rigid in its strength . . . that’s right, stiff and rigid and heavy . . . as stiff and rigid and heavy as an iron bar . . . because an iron bar is stiff and rigid and heavy and inert and unbreakable . . . good . . . and your arm is so stiff . . . and rigid . . . and heavy . . . just like an iron bar . . . that you wouldn’t even be able to move it if you tried. Go ahead and try.” [Upon ratification] “And isn’t it amazing to become aware of how strong that iron bar is? I wonder what it would be like to imagine a whole container made out of that same iron. Strong and solid and unbreakable . . . and able to hold just about anything securely inside . . . You can nod your head as it comes to mind. Good. Now . . . allow an unpleasant feeling or sensation to come to mind . . . and as it does, the ‘yes’ finger can rise to let me know when you are aware of it . . . and now imagine that this feeling or sensation is flowing out of you . . . all the way down through the arms . . . and hands . . . and out the fingertips . . . and into this iron container . . . that’s right . . . and you can be curious and interested . . . like a scientist conducting an experiment . . . to imagine how these feelings and sensations appear as

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(Continued)

Table 1  
(Continued)

Skill	Application	Example
		<p>they leave your body . . . maybe they look like a colored liquid . . . or some other unique image that comes to mind . . . you could share what you are noticing aloud if you wanted to . . . and then . . . whenever you are ready . . . you could close the top of the container and securely lock all of the contents inside the container . . . knowing that it is strong enough to hold them. And you can pay attention now to what your body feels like after it has released these sensations, this energy . . . What do you notice?" [After hypnotic exploration, consider offering a posthypnotic suggestion for the unconscious to secure the contained affect in the way that it needs to after the session is over]. [Note: A subgroup of patients will move their arms at the hypnotic suggestion for catalepsy. This could be an indication of poor hypnotic response. But just as likely, it could also be a sign of the patient's defensive/protective functioning. Should this occur, provide suggestions that reaffirm the patient's sense of control. For example, "that's right . . . good . . . isn't it nice to know that you could move your arm if you really wanted to?! You are discovering more and more all of the ways in which you are strong on the outside . . . and inside. And I wonder what your unconscious mind will do next to allow you to feel even more strong and secure and protected."]</p>

Posthypnotic suggestion	<p>Posthypnotic suggestions are important in affirming for the patient that it is possible for her to positively attune to and be with herself outside of the therapy session. These suggestions then become cues for transferring this attunement to external environments.</p>	<p>Daitch's (2007) "OK signal" technique is an excellent example in that it is a form of sensorimotor anchoring and also a cue for a posthypnotic suggestion. In this example, the therapist asks the patient in hypnosis to allow their thumb and forefinger to come together on their own and touch. The therapist directs the patient to notice the sensory aspects of the two fingers touching and then gives a contingent suggestion for a positive affective association with this sensory experience. The therapist observes aloud that the patient is making the "OK" sign with her fingers. Further, every time that her fingers touch, it can remind her of the positive feeling(s), sensation(s), and experience(s) that she had during the hypnosis session, as well as let her know that everything will be alright.</p>
Re-alerting	<p>This can be a hypnotic method for refocusing the patient on immediate sensory anchors during a dissociated state.</p>	<p>"... and when the word 're-focus' pops up in your mind, it will be a signal to you to take a deep breath, count to three, blink and reopen your eyes slowly and clearly, and feel fully alert, present, and in control of your body."</p>

Hypnotic representation also serves to further the previously incomplete formation of self and object constancy, which is a necessary component of boundary formation and self-integration (Baker, 1981; Phillips, 2013). This is particularly relevant and helpful for adult trauma patients who have Borderline spectrum personality organization (e.g., features of BPD) and will be described in greater detail below. In explicating her concept of object constancy, Mahler (1968) theorizes that in the third year of appropriate development, children achieve object constancy, in which they can internalize a positive, loving, and soothing image of their mother and integrate it into moments of distress in which they experience their mother as “bad,” due to misattunement to their needs. Thus, with this milestone, they are able to experience their mother as a constant and durable internal figure across varying external relational experiences. It is this stabilized, integrated, and nuanced internal archetype of mother that allows them to tolerate the inevitable and numerous moments of disappointments by the actual mother. This object constancy allows the child to understand that, even though “I may feel [scared, angry, withdrawn, etc.] because I sense that mother is [angry, sad, disappointed, etc.] with me right now, I know that she is still a good, caring person who loves me.” From this example, one can deduce how object constancy leads to the parallel quality of self-constancy.

Through its repeated representation of scenes evoking object constancy, hypnotherapy can be utilized to recapitulate this stalled developmental process in our adult patients with trauma histories. Hypnosis can be used to create varied and interesting image representations of a person while inherently suggesting that they retain some aspect of constancy, despite the moment-to-moment changes. This constancy can then be linked to constancy of self or other across changing affective and cognitive states (E. L. Baker, personal communication, August 17, 2011). Therefore, “I can feel sad and still be Eric,” rather than “I [Eric] am a sad person” with the implication being that Eric is himself no matter whether he is happy or sad.

I theorize that object constancy is a necessary precursor for consistent mentalization. As referenced earlier in the article, in a prementalized state of *psychic equivalence*, internal and external realities are merged and “world equals mind” (Allen et al., 2008; Bateman & Fonagy, 2006, 2012). In this concretized mode of thinking associated with BPD, there is a failure of symbolization and a suspending of “as if” for what appears to look, to feel, and to be real to the person in a given moment (Bateman & Fonagy, 2006). I understand psychic equivalence and a lack of object constancy to be overlapping concepts. In a mode of psychic equivalence, we cannot conceptually grasp the concept of mental states occurring outside of behaviors and external events (which is a lack of object constancy; e.g., if someone *does* something “bad,” they must “be

a jerk.”), nor can we grasp that a person possesses a varied collection of mental states and associated thoughts, feelings, and subjective experiences. Further, in this mode, we certainly would not be able to allow ourselves to be curious about those mental experiences, whether inside of ourselves or others. Therefore, we developmentally need to be able to possess a sense that every person has a core, identity-based selfhood that is inherently nuanced, integrated, and durable from moment-to-moment (e.g., self/object constancy) in order (a) to appreciate that they can have varying mental states across those moments and (b) to be curious about what those mental states might be (e.g., mentalization). It is from this foundation of self/object constancy, and the affective containment that it provides, that one can psychologically allow a reflective curiosity to develop about different mental states in a single person and the internal and external experiences that elicit them.

As representational capacities develop, the patient can move from imaginably representing immediate experiences to constructing fantasy-based representative experiences designed to serve a particular purpose in the trauma treatment, such as somatoaffective regulation, management of boundaries, internalization of adaptive relationship experiences, controlled reprocessing of traumatic memories, or integration of diffuse ego states. The hypnosis literature is robust with examples of utilizing representation in the treatment of trauma. Although the underlying principles are similar, I believe that these representational techniques are best organized into three general categories: representation of the therapeutic relationship, imagined parental figure representation, and ego state representation. Although they differ in their theoretical underpinnings and choices of relational healing symbols, all three forms of hypnotic representation serve to facilitate healthy internal working models that promote constancy and integration. Hypnotic imagery creatively intersperses fantasy with reality to create more flexible, nuanced, and exploratory mental attachment experiences involving self and other.

Postulating from a psychoanalytic object relations framework, Baker (1981, 2000, 2010) proposes representation of the therapeutic relationship because it accesses the immediate here-and-now experience of the therapeutic encounter. This representational process begins with imagining immediate relational cues in the here-and-now therapeutic milieu and then, as the patient is ready, eventually shifting to an interactive scene in which the therapist is a responsive, nurturing figure who can respond to the patient in ways that affirm, secure, and comfort her. As the patient's capacity to imagine this type of interaction and experience positive affect in response to it increases, the therapist can then begin to suggest representative imagery for the purpose of externalizing negative object representations associated with the patient's traumatic history. In the latter stages of Baker's object representational model, the

therapist focuses on the integration of “bad” and “good objects, affects, and self-states. Representations of relational figures from the patient’s life are introduced into the hypnosis, and suggestions are given to give “good” characteristics to the “bad” people and vice versa. Transference reactions to this process are explored in hypnosis and therapy with the goal of reducing splitting and dichotomous cognitive processes and the affective reactions that they engender. All of this promotes a more balanced, integrative representation of self and other (Baker, 1981, 2000, 2010).

A second type of representational approach is an imagined parental figure method, which utilizes representation to facilitate adaptive internal representation of self and other and to secure attachment functions (Brown, 2009a, 2009b; Murray-Jobis, 1990a, 1990b, 1993; Phillips, 2004). Initially created as a hypnotic renurturing technique used in addressing developmental arrests in patients with trauma histories exhibiting features on the borderline personality spectrum (Murray-Jobis, 1990a, 1990b), it has been modified in recent years to more explicitly address attachment themes, language, and imagery (Brown, 2009a, 2009b; Phillips, 2004). This hypnotic renurturing involves the therapist permissively directing the patient to imagine a series of attachment-based experiences with a real or imagined parent(s). The techniques initially create, enhance and strengthen the imagery of a secure base with all of its secure, safe, nurturing, and bonded functions. Based upon the patient’s response, the imagery subsequently shifts to accentuating exploratory and mastery functions associated with leaving (and returning to) the secure base (Brown, 2009a, 2009b; Murray-Jobis, 1990a, 1990b, 1993). The entire process from start to finish promotes greater internal representation, affect regulation, coherence of mind, and mentalization that are associated with secure attachment.

In explaining the need for an attachment-based hypnotherapeutic approach, Brown (2009a, 2009b) notes the numerous studies associating insecure attachment with complex trauma diagnoses and believes that we must shift our conceptualization of how complex trauma develops. He believes that early attachment disruptions are the core problem in the representational and self-regulatory deficits present in survivors of complex trauma, and that the subsequent trauma abuse only serves to exacerbate those deficits. As a result, Brown has shifted his emphasis from controlled reprocessing of traumatic memories to attachment-based developmental repair when working with patients who are survivors of complex trauma. According to Brown, hypnosis is a particularly effective treatment approach for attachment pathology, because it allows for the patient to have a method of visualizing and internally representing adaptive attachment relationships, such as the therapeutic relationship, through structured imagery (Brown, 2009a, 2009b).



Brown's (2009a, 2009b) method is designed with two attachment goals in mind: (a) to aid in the development of positive internal representations and (b) to teach and facilitate mastery of metacognitive abilities for the purpose of increasing self-reflective awareness. For the first goal, he believes that hypnosis helps to amplify cues for secure attachment across time until the patient can consistently represent positive affect and regulate negative affect. For the second goal, Brown defines metacognitive abilities similarly to Fonagy and others' definitions of mentalization and reflective functioning, namely as being aware of one's mental state. By creating metacognitive cues during imagined attachment experiences, the therapist helps patients organize their minds. Through an emphasis on metacognition during an imagined positive attachment experience, Brown believes that his model will help patients cognitively remap their mental states, leading to improved self-monitoring, mental organization, and regulation of affect related to mental states (Brown, 2009a, 2009b). Brown's model is also notable for its direct incorporation of the metacognitive aspect of mentalization in its imagery.

Finally, the third representational approach, ego state representation, is grounded in ego state therapy (EST), a specific approach within clinical hypnosis that focuses on pathological dissociation in survivors of complex trauma. Although numerous papers and books have been written about EST, a succinct description of the therapy is that it focuses on attuning to, stabilizing, and working through the traumatic experiences of and eventually integrating the dissociated and fragmented ego states of the self (and their respective somatic, affective, cognitive, and proprioceptive experiences) (Morton, 2009; Phillips & Frederick, 1995; Watkins & Watkins, 1997). Similarly to the object relations and parental renurturing approaches previously described, EST utilizes hypnotic representation for the purpose of developmental repair. However, rather than using the therapist or parent as a reparative relational representational symbol, EST enlists adaptive ego states of the patient (e.g., the wise elder, shaman, calm adult, etc.) to interact with the developmentally arrested ego states (e.g., the child, victim, etc.). EST representational techniques for treating trauma could include addressing ego strengthening, such as identifying, affirming and amplifying a more mature ego state or experience (Daitch, 2007; Watkins & Watkins, 1997), having an internal family support circle, where a mature ego state might transfer adaptive functioning to a wounded, child ego state, perhaps through soothing or comforting (Daitch, 2007; Morton, 2009), symbolizing the affect of a more malevolent ego state ("black gunpowder") and containing it (putting it in a chest and locking the chest) in a way that creates feelings of safety (Morton, 2009), or working with ego states in the past or future to work through traumatic experiences or to imagine integrated future experiences (Hammond,

1990; Torem, 1992). Overall, in an EST approach, representation is utilized with the goals of identifying and accessing the patient's positive internal resources, providing a series of corrective self-experiences, and facilitating integration of the patient's personality (Morton, 2009; Phillips, 2004, 2013).

### *Mentalization*

Mentalization has received far less attention in the hypnotic literature. Nonetheless, it should be understood as a natural progression from representation in the developmental process that occurs during an attachment-informed hypnotherapeutic treatment of complex trauma. As covered earlier, imagery-based representational awareness of sensory experience is a rudimentary building block of mentalization in that we first must represent our sensory and affective experiences through images in order to develop the thoughts and words necessary to describe their mental meaning and to organize them into a larger framework. As imagery representation fosters lexical representation, mentalization can begin to occur more explicitly in the hypnotherapeutic treatment process.

By representing a variety of figures and ego states in our patients' imagination, we have the opportunity to create scenarios that heighten their awareness and understanding of underlying mental states. As with attunement, this can be done explicitly or implicitly. For example, Murray-Jobsis's (1990b, 1993) creative self-mothering variation of her parental renurturing technique asks the patient to call to mind the mental experience of both parent and child in playing each role. But even in more "passive" parental renurturing scenes where the patient is imagining having something "done" to her by the parent (e.g., protecting, affirming, containing, etc.), it is the patient who is creating this imagery (with minimal permissive guidance from the therapist) and the mental associations that come with it, whether she realizes it or not.

Similarly, Daitch describes a variation of the internal parental figure model in which the patient imagines her actual parent as a child interacting with an imagined secure attachment figure. By imagining her parent as a child-like figure most likely in some kind of pain or distress and in need of a healthy parental relationship him or herself, the patient mentalizes about the mental life of her parent. Participating in this exercise allows the patient to imagine her parent in a different way than she has most likely historically remembered him or her (C. Daitch, personal communication, March 23, 2014).

Hypnotic suggestions for mentalization can either be directly incorporated into representational scenes or indirectly offered through stories or metaphors. For direct suggestions, Brown (2009b) suggests a framework (a) of "notice the effect of \_\_\_ on your state mind" or (b)

of “notice how \_\_ (e.g., organized) your mind feels right now.” These are but a few variations of direct hypnotic suggestions for mentalizing that a hypnotherapist could offer. Alternatively, because MBT often invokes the here-and-now experiences of the therapeutic relationship (Allen et al., 2008; Bateman & Fonagy, 2006), direct hypnotic suggestions could be given to explore the mental experiences and interactions between therapist and patient. In this regard, one can apply an explicit mentalizing focus to Baker’s (1981) object relations protocol utilizing the therapeutic relationship.

Indirect suggestions are a method for modeling mentalization without explicitly instructing the patient to do so. Indirect suggestions for mentalization can be beneficial when direct suggestions stimulate attachment anxiety or avoidance. I often tell hypnotic stories with mentalizing themes (e.g., “The Little Engine that Could—“I think I can, I think I can . . . I know I can, I know I can”—and the parallel imagery of scaling a mountain that comes with these progressing mental states).

An apt example of a mentalization metaphor is being able to “see the forest for the trees.” I find this metaphor useful because it’s very meaning—discerning a larger pattern from a mass of detail—describes a quality of mentalizing. I have devised an extended mentalizing technique and script based off of this metaphor. In this permissive approach, the patient is asked to symbolize an image of a tree that represents a particular mental (e.g., affective) or ego state that he or she is having difficulty with. Hypnotic suggestions tailored to the patient’s attachment dimensions and needs are given with the intention of positively modifying the patient’s experience of her “tree.” As mastery increases, suggestions shift to imagining, exploring, and articulating relatedness between this and other nearby trees. The hypnotic emphasis gradually moves from a single tree to a forest of trees. Hypnotic suggestions emphasize shifting sensory perspectives of the tree(s) and forest for the purpose of building greater reflective functioning. This approach is designed to help patients have a greater appreciation of the diversity of their mental experiences, feelings, and thoughts; and better be able to reflect on and to organize them into a cohesive, integrated mental experience.

## CONCLUSION

In this article, I drew upon the combined literatures of attachment theory and clinical hypnosis in proposing an attachment-based model of how hypnosis might be developmentally utilized in a psychotherapy treatment for complex trauma. Additionally, I was influenced by the literature documenting the central role of mentalizing in guiding

responses to traumatic cues and promoting overall secure attachment (Allen et al., 2008; Bateman & Fonagy, 2006, 2012; Fonagy et al., 2002). However, given the centrality of language in framing such mentalizing, I was curious about how such reflective language could be developed in the patients who need it the most. Thus, not only does this article explicate the elements of attachment inherent in hypnosis but it also considers how attunement and representation facilitate the emergence of mentalization and reflective language.

An underlying assumption of attunement is that the process of developing safety and security begins in the here-and-now interpersonal frame of the therapeutic relationship. As the therapist attunes, observes and shares with the patient in their joint space—through careful tracking, synchrony, pacing, vocal prosody, and language—the two work together to develop sensorimotor anchoring in the patient. Through their joint attention to positive phenomenological processes developing in the patient, the therapist begins to utilize these processes as contingent suggestions for affect regulation and boundary management. Thus, the patient learns how to “be” with her body in a containing, soothing, and grounding way.

Influenced by Baker’s work on the use of hypnosis in building structuralization (1981, 2010), I theorized that this sensory, “felt” experience also creates a concrete and tangible foundation for subsequent representation—first of the body and later of the self, other, and relationship(s). Thus, mastery of one’s immediate sensory experience influences the creation of images used to describe those experiences. It is in this respect then that representation expands from somatic to self-experience and from self- to relational experience. As the opportunities for representation increase, the therapist has more material to work with in framing and describing imaginative healthy attachment experiences.

Hypnotic mentalization utilizes these representational scenes towards the purpose of enhancing the patient’s reflective functioning. Through repeated use of varied representational imagery, the therapist augments the patient’s capacity to use reflective language to describe her and others’ mental experiences. With an expanded vocabulary of reflective language at her employ, the patient is now able to use her own language to assign meaning to the mental experiences highlighted in hypnotic representational imagery.

In conclusion, hypnosis is a beneficial addition to any psychotherapy for complex trauma. It experientially enhances the attachment processes of attunement, representation and mentalization in the treatment. Doing so promotes secure attachment and a recapitulation of stalled developmental processes, including the capacity for nuanced self-reflective language and associated mentalizing.

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### Anhangs-fokussierte Hypnose in der Psychotherapie komplexer Traumata : Anhaftung, Verkörperung und Mentalisierung

Eric B. Spiegel

**Abstrakt:** Die relationalen und psychologischen Funktionen von Anhaftung, Repräsentation und Mentalisierung sind essentielle Komponenten einer sicheren Anhaftungserfahrung. Psychotherapeutische Ansätze mit anhangstheoretischer Information haben vor allem auf dem Gebiet des komplexen Traumas signifikante empirische und klinische Unterstützung erfahren. Trotz dieser Vorstöße könnte eine anhangstheoretisch informierte Traumabehandlung in großem Maße von dem Erfahrungswert, die die klinische Hypnose zu bieten hat, profitieren. In der Utilisierung von geteilter Aufmerksamkeit, Stimmlage, Pacing, repräsentativer Imagination und hypnotischer Sprache, bietet klinische Hypnose Psychotherapeuten als Zustand, Beziehung und Technik einen Weg, um eine gesunde Bindungserfahrung einzuführen und angebrachtes entwicklungsgemäßes Funktionieren bei Patienten zu erneuern, die Überlebende komplexer Traumata sind. In diesem Paper werden Anhaftung, Verkörperung und Mentalisierung aus hypnotherapeutischer Sicht untersucht.

STEPHANIE REIGEL, MD



L'hypnose axée sur l'attachement en psychothérapie pour traumatismes complexes: harmonisation, représentation et mentalisation

Eric B. Spiegel

**Résumé:** Les fonctions relationnelles et psychologiques de l'harmonisation, de la représentation et de la mentalisation constituent les éléments essentiels de l'expérience d'un attachement sécurisant. Les approches psychothérapeutiques, alimentées par la théorie de l'attachement, ont acquis un soutien empirique et clinique important, notamment dans le domaine des traumatismes complexes. Malgré ces avancées, le traitement des traumatismes fondé sur l'attachement pourrait grandement bénéficier de la richesse expérientielle qu'offre l'hypnose clinique. Dans son utilisation de l'attention partagée, du ton de voix, du rythme, de l'imagerie figurative et du langage hypnotique, l'hypnose clinique en tant qu'état, relation et technique, offre aux psychothérapeutes un moyen d'introduire un attachement sain et de renouveler les bonnes capacités développementales fonctionnelles chez des patients qui ont survécu à des traumatismes complexes. Dans cet article, l'harmonisation, la représentation et la mentalisation sont examinées selon un point de vue hypnothérapeutique.

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La hipnosis enfocada al apego en psicoterapia para trauma complejos: Sintonía, representación y mentalización.

Eric B. Spiegel

**Resumen:** Las funciones relacionales y psicológicas de sintonía, representación y mentalización son componentes esenciales de una experiencia segura de apego. Los acercamientos psicoterapéuticos informados por la teoría del apego han ganado sustento empírico y clínico significativo, particularmente en el área de trauma complejo. A pesar de estos avances, el tratamiento al trauma, informado en el apego, podría beneficiarse en gran medida de la rica experiencia que la clínica hipnótica puede ofrecer. En su utilización de atención compartida, tono de voz, cadencia, visualizaciones representacionales, y lenguaje hipnótico, la hipnosis clínica, como estado, relación y técnica, ofrece a los psicoterapeutas una forma de introducir una experiencia de apego saludable y renovar un funcionamiento del desarrollo apropiado en pacientes sobrevivientes de un trauma complejo. En este artículo se revisan la sintonía, representación y mentalización desde una perspectiva hipnoterapéutica.

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