The Body’s Story:
A Case Report of Hypnosis and Physiological Narration of Trauma

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Adult Posttraumatic Stress Disorder secondary to childhood sexual abuse is clinically complicated by its increasingly noted deficient linguistic recording of the abuse, perhaps partially explaining consequent difficulties with verbalizing in therapy. A single case illustrates that hypnotically utilizing the body-emotion register of encrypted sexual abuse trauma may not only afford more naturalistic retrieval and purgation of the experience, but may also provide the very medium for the healing narrative required for recovery.

The patient’s original and continuing therapist was also present as support and observer for all but 1 of 25 hypnosis sessions. Treatment gains were robust at 3-year follow up. This case suggests that effective treatment for sexual abuse PTSD may in some instances reside in more nonverbally sensitive interventions not aiming to prove, probe, or process linguistic reconstructions of memory. This is the first published report of such a bodily narrative in hypnosis.

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Context

Adult Posttraumatic Stress Disorder (PTSD) secondary to childhood sexual abuse is well known for symptoms and registers in the physical and emotional systems of sufferers (Brewin, 2003; Gray & McNaughton, 2002; Lang, 1979; Yehuda, 2002). These may appear dramatically in specific bodily sites implicated in the abuse (van der Kolk, McFarlane, & Weisath, 1996)—what van der Kolk refers to as “motoric imprints” (van der Kolk, 2003, p. 17). Managing the physiological registers and attendant sympathetic nervous system hyperarousal is primary in PTSD therapy (Brewin, 2003; Foa & Rothbaum, 1998; Humphreys & Eagan, 1999; Porges, 1997), and hypnosis has been used to assist in such management (Brewin, 2003; Edmond, Rubin, & Wambach, 1999; Turner, McFarlane, & van der Kolk, 1996; Spiegel, 1996). Hypnosis has helped particularly with sexual abuse trauma when applied skillfully in the contexts of ego

Verbally constructing and articulating a “healing narrative” has been an accepted treatment for PTSD (Herman, 1992; van der Kolk, 2003, p. 17; van der Kolk & Fisler, 1995). These narratives afford a managed telling of the story so as to facilitate a disengagement from the very disturbing, lingering affect dysregulation so pronounced in PTSD symptoms. It is also currently believed within the developing, trauma-focused neurophysiological sciences, however, that left hemisphere regions\(^1\) responsible for linguistic narration constructions are compromised during trauma (Joseph, 1982; Schore, 2002; Tucker, 1992, van der Kolk, 2003), while the right hemisphere, amygdala and limbic systems are hyperaroused (Bechara, et al., 1995; Critchley, et al., 2000; Devinsky, 2000; Keenan, et al., 1999; Ledoux, 1998, 2000; McEwen & Seeman, 2003; McGaugh & Cahill, 2003; Ochsner & Schacter, 2003; Schore, 1994; Wittling, 1997). This hyperarousal is instrumental in encrypting these traumatic memories as episodic, emotionally charged, and not organized monosemantically (as seen in the left hemisphere; Rotenberg & Weinberg, 1999, p.11), a phenomenon partially explained by septo-hippocampal damage inflicted during trauma (Gray & McNaughton, 2002). This may elucidate why some PTSD patients have great difficulty in verbalizing memory and feelings. While the literature reveals that recognizing and managing nonverbal phenomena are an expanding focus of psychological trauma treatment (Brewin, 2003; Foa, Keane, & Friedman, 2000; Scaer, 2001; Schore, 2003) and sexual abuse treatment in particular (Rothschild, 2000; Simonds, 1994), no report exists of a physiological, nonverbal accessing, recounting, and relieving of the trauma itself. The hypnosis literature is rich in its treatment of an array of disorders in non-insight modalities, but this case, using hypnosis, focused only on the body’s consistent choreographical narrating of trauma events.

**Case Report**

**History and Referral**

The patient was a 31-year-old woman who at the time of referral for hypnosis had been in traditional insight-oriented therapy for approximately five years. The frequency of those sessions varied somewhat during that time, and the goal was alleviating anxiety, particularly manifest in starting and maintaining relationships with men. Initially in therapy the patient had presented as severely anxious, unable to sustain eye contact, and subject to long periods of silence while occasionally regressing to approximate fetal position posture.

Later in therapy the patient voiced awareness that “something [was] still not right,” describing this as gnawing at her, producing diffuse anxiety, vaguely preoccupying, and generally experienced as an abiding dysphoria. Concurrently she focused more pointedly on the problem of relationships and “pushing men away.” When the patient was in her mid-twenties a friend of a friend had broken a sexual boundary with her at an overnight gathering. Fully aware of it, she kept it private until late in the work. Discussing it with her therapist ushered in more intense anxiety. Nightmares ensued, and it aggravated her experience of “frozenness” in therapy.

\(^1\) These demarcations of left and right hemisphere reflect the parlance of authors cited and provide a workable frame in this discussion.
Eventually, after considering hypnosis for 9 months, she decided she would pursue it. Her therapist was supportive but did not advocate for hypnosis, electing to follow the patient’s lead. At that, it took another half year before she scheduled the first appointment.

She and her therapist considered hypnosis as a way to process those feelings hypothesized as unavailable for resolution in the verbal therapy modality, and her motivation was high. The goal from the outset, then, was not to uncover or probe memory but rather to use hypnosis as a vehicle suited to settling or reorganizing unconscious material putatively implicated in her discomfort. Thus hypnosis was seen as palliative and potentially helping to resolve the deeper non-specific discomfort.

**Hypnosis Sessions**

Because of the patient’s anxiety as described and because her work with her regular therapist would continue, the patient’s referring therapist was present initially for support and to have a context for the hypnosis work. That therapist and I had a good working relationship and had collaborated on cases before. The patient reported that her therapist’s presence was calming and reassuring, and in their meeting afterwards decided that the therapist’s remaining in the hypnosis sessions was useful. Consequently her therapist was present for all but one of the 25 sessions of hypnosis, missing that one session because of a scheduling conflict. These were spread over a year, and the individual therapy apart from hypnosis continued, though more sporadically. Sessions occurred every other week, a spacing preferred by the patient to prevent her other therapy from crowding into the same week and, importantly, to give her what she described as “time to absorb it all.”

In the first session we established the context and expectations for the presence of her therapist, elaborated on the information she had read and discussed with her therapist about hypnosis, and conducted the initial induction. The goals of hypnosis were specified again together as improving autonomic regulation within anxiety management, and allowing the unconscious mind-body system to explore and relieve whatever deeper conflicts might be relevant to the problem. No formal hypnotizability or susceptibility measure was used because the patient was eager to “get right to it” to allay nervousness. It was quickly evident that her absorption capacity was high, thereby establishing a credible baseline engagement. This is consonant with Smith’s (1996) capitalizing on such apparent involvement without formal assessment, and Telegen and Atkinson’s (1974) emphasizing absorption capacity as a valid marker of hypnotizability. Sessions averaged 35 minutes of hypnosis, followed by 15 minutes of debriefing, support, deriving meanings discerned by the patient, and ratification of safety and her control.

During the initial eye fixation (Crasilneck & Hall, 1985) transition into trance there was pronounced facial and some full-body twitching and energetic squinting, lasting only briefly, and this was the case for every hypnosis session. The first session

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2 “Unconscious” here is used in the sense described by Winson (1990), elaborated by Schore (2003), and amplified within a neurobiological perspective by Tassi and Muzet (2001). The construct is located within traditional analytical interpretations (mindful that for Freud the hypnotic state proved the existence of the unconscious (Freud, 1940/1964, and cited in Bachner-Melman & Lichtenberg, 2001), but, especially as Winson states, the “[unconscious] is a cohesive, continually active mental structure that takes note of life’s experiences and reacts according to its scheme of interpretation” (p.96).
taught controlled relaxation, hand warming to ratify the mind-body connection, techniques for safe place and emergency exit from trance (Dolan, 1991), and ideomotor signaling (Weitzenhoffer, 2002). The signaling was enthusiastic and at times fingers seemed to lift her arm off the chair. When this occurred the patient typically was able to smile and verbally acknowledge awareness of this new intriguing energy but did not judge how her body and unconscious were responding. It is interesting, therefore, that hypnosis afforded a relaxed posture regarding her experiences, as opposed to the rigidity described in the other modality. She remained an intrigued, involved follower and observer of what her mind and body appeared to be doing “on their own” during the course of treatment. Thus her presentation was strikingly redolent of van der Kolk’s assertion, “…when a traumatic memory is activated, the brain is ‘having’ its experience, rather than recollecting it” (2003, p. 26).

As therapy proceeded a sequence of physical gestures emerged that were consistent and cumulative from session to session. In each meeting the patient went into trance quickly and intensely as usual, and then her body briefly replayed, in summary fashion, the sequence up to and then through the most recent installments. For example, an early movement was her right hand’s ascending above and behind her head. Next, she appeared to struggle against the force or pressure exerted on the hand and arm. Finally, it became clear that the arm was either held or bound at the wrist into that elevated position. In the ensuing sessions, this sequence was rapidly replayed until she arrived at the next threshold of movements. By the tenth session it appeared that her body was reenacting a scene of oral rape. It was not necessary for her to texture and detail the events. Rather, she reported that while her physical experience was succinct she only needed it to be suggestive enough to validate that experience and provide a sensible scenario for what was happening. Typically in the middle of a scene in which her body was approaching more textured and graphic contact with the experience she would say: “I know what is happening and I will not go any further right now.” Then she would return to her safe place briefly and exit trance without incident. My suggestions collaborated with this approach, emphasizing, “your body will experience and communicate only what is useful for your understanding and your health now and in the future.” Each repetition of this protocol—physically/emotionally engaging an enacted fragment, attending to reactions and meaning, deciding about the degree of texture and specificity to experience, choosing to reconstitute in safe place, and exit trance—deepened and validated her ability to manage not only the physical story but the physiological and emotional discomforts associated with it.

Central throughout this work were reinforcing and utilizing the patient’s power to choose. For example, when a nuance or new piece of experience was becoming evident, there always was the inquiry: “It appears there is new energy now (in a hand, arm...). Would it be all right to pay attention to that? Would it be all right to do that now?” As always, the language is key to the art of hypnosis. “Pay attention” was preferred over “process,” “deal with,” or some other variant implying a verbal, semantically controlled sequence. Her ideomotor signaling was energetic and always clear in response. Interestingly, assertiveness and strength were available in this hypnotically abetted physical-unconscious domain, another stark contrast to her demeanor in the other more conventional therapy as described.

In that conventional ongoing therapy the ideomotor signaling continued in
sessions, but it was not sought. In those conversations her fingers would often jump and signal. When that happened she and the therapist noted the energy but did not make it a focus. Since her therapist was also present for the hypnosis work, he could read the different response intensities in her fingers, as they “with a mind of their own” were active during that therapy as well. Further, as we two therapists processed the hypnosis work in peer consultation it was clear that the original therapist benefited from having seen every step in the hypnosis interventions. The patient also reported that her fingers were busy during private ruminations, as when driving her car for example. From the start, however, she was taught how to manage her signals and experiences so that they did not suggest or evoke the out-of-control states associated with trauma. Thus throughout this hypnosis work she was able to exercise modulation skills important in her improving integration and understanding of emotional life outside the office. She found this surprising and encouraging, at times reporting that not only was she feeling more “balanced” socially and on the job but also others were giving her feedback indicative of such.

It appeared that the sexual abuse suggested by her body’s “memory” and “choreography” was powerfully encrypted in her physico-emotional experience. She reported that it was clear to her what all this suggested, often stating: “I am not sure what happened, or at least I can’t see what happened. But I know something happened. And, I am feeling stronger.” This strength was apparent also to her therapist; she was increasingly verbal and forthright in those sessions.

There was another benefit. In all of this sequence there was intense observable physical resistance as the attacker relentlessly forced compliance. It was like watching a fight with only one of the combatants visible. So often in trauma work the victim doubts in retrospect her/his will or effort to resist or escape. In this case she believed she had compelling evidence that her struggle was severe and maximal. More importantly, this is how she felt. That she experienced putting up such a fight as part of the physical story apparently was saliently relieving to her.

Eventually the patient felt she had completed what she needed to know and experience. This, as noted, was matched by her reports of increased strength and assertiveness in both relationships and professional and social life in general. She was better able to monitor her emotional and physical responses and demeanor. She felt more comfortable. Finally, there also were others’ remarks on changes in her, “looking better,” and “happier.” Hypnosis ended after the twenty-fifth session, and her other therapy shifted gradually to fewer appointments, terminating after three months post hypnosis.

Two years later the patient called for an appointment for hypnosis work on what turned out to be an emerging re-experience/memory of a date rape. In session she immediately used previous skills (absorption, ideomotor signaling, deepening regulation, and safe place) with the same level of proficiency. This experience was processed in two sessions, focusing on ego strengthening and ratifying previous gains. She also reported the two ensuing years after the initial hypnosis had been good and devoid of significant or unmanageable symptoms and discomforts.

One year after those two sessions, three years after the first hypnosis, she came in for one session to process a trigger event: a man accidentally had barged into her changing room in a clothing store. She did not freeze but rather reprimanded the
man, though she was shaken, and exited the store quickly. She used the hypnosis session again for strengthening and affirming her previous work and the action she took in the store. In both these follow-up events we used the familiar protocol of eye fixation induction, affirming her sense of control over her own bodily and emotional responses, affirming her read of the triggers and situations, and visiting of safe place coupled with future projections of successful management of self and situations.

Finally, in our last meeting a few months after that session, the patient sought a nonhypnosis consultation for a new surprising event: she had “met a man.” While she felt some apprehension and could acknowledge information and developmental gaps in pursuing a relationship, the flavor of terror was absent, replaced by what appeared to be both predictable nervousness and excitement at this new dimension of life for her. In the few, spread-out sessions subsequent to the initial hypnosis work the patient met solely with me since she had successfully terminated her other therapy, and she reported feeling strong enough to proceed on her own.

**Theoretical Support and Propositions**

This case may be understood within at least three theoretical domains involving brain and affective science studies for trauma and its register, thus presenting both a foundation and map for future research. First, that the right hemisphere is central—specifically the right parieto-temporal associative area—in altering consciousness as in hypnosis (Tassi & Muzet, 2001, p.186) and in accommodating trauma as noted above, suggests an affinity between these phenomena by virtue of their locus in brain (see Rainville, et al., 1999 for a comprehensive view). Beyond such speculation, however, some research has elaborated the collaboration between higher right brain regions and more fundamental ones. Hariri, Bookheimer, and Mazziotta (2000), for example, suggest a neural network exists for this collaboration, and while modulating mechanisms may be impaired in emotional disorders they also “may provide the basis for therapies to these same disorders” (p. 48).

Second, research has supported the right hemisphere’s role in accommodating and recording stark events like trauma and its connection with the limbic system in this regard (Joseph, 1982; Nadel & Moscovitch, 1997; Tranel & Hyman, 1990). Specifically, certain perceptual memories such as those incurred during trauma leave long-term residues or traces (Christianson, S. A., 1992; James, 1890; Janet, 1904; Pillemer, 1998; Terr, 1990; van der Hart & Horst, 1989; van der Kolk & van der Hart, 1991). Further, Damasio (1994) alleges that “dispositional representations” form during powerful events like trauma (p.102) and, in state-dependent fashion, may be activated later by triggers or cues to the trauma. While Damasio (1994, 1999) nowhere expounds specifically about abuse trauma, the relevance of his findings appears clear.

Finally, the case has been made for two memory systems (Bornstein, 1995; Hellawell & Brewin, 2002) in which “ordinary” memories of trauma fall within the common cognitive psychology formulations of memory as constructions and not literal video libraries. PTSD memories, and particularly flashback type, however, are quite literal in their right brain registers (Hellawell & Brewin, 2002, and cited in Brewin, 2003, p. 101). In particular Damasio notes that “knowledge which exists in memory under dispositional representation form … can be made accessible to consciousness in non-language versions” (p.166; emphasis added), and that these representations “can fire others if
linked strongly by circuit design (in the brain) or they can generate a movement by activating motor cortex” (p. 105; emphasis added).

**Discussion**

That two therapists could be present for all hypnosis sessions is unusual. Geographical location, a manageable financial arrangement for the patient and therapists, scheduling, and compatibility of personal styles and competence were all, perhaps anomalously, achievable. While this arrangement allowed for greater safety in the transition and subsequent complementarity between therapies, we speculate that the presence of the regular therapist in this case was a great benefit but not a necessary condition for responsiveness in the patient or effectiveness of hypnosis. This is not to minimize the effect of this combination, however. That both therapists were male, with the long-term therapist closer in age to the patient and the hypnotherapist about 10 years older, reasonably relied on the safety derived from the supportive attending of the original therapist in rapidly establishing the positive transference with the new therapist.

Second is the matter of comfort and propriety. There is inherently a significant qualitative difference in a person’s talking about what happened—even with very intense affect and even with reporting body reactions in site-specific trauma locations—and displaying what happened. It is vulnerability and visibility quite unusual in this work. We assert that for those patients who display an aptitude and energy for thus engaging the choreography of trauma, that the abbreviated emblematic movements described here are the protocol of choice. All that is necessary, at least from the perspective of this case, is enough to suggest a meaning in the activity. This perhaps allies with clinical and literature contentions that not every incident within a history of trauma needs to be accessed and processed for effective healing (Dolan, 1991). Further, it is especially important to consider the care, expertise, and consultation suitable to this problem and modality. For example, discussing with the patient particularly after the initial sessions how she felt about these experiences and the form they were taking cannot be overstressed. Such discussion and processing included attending to comfort level, felt sense of usefulness of the work, and especially that she experienced herself as in charge and a respected consultant as treatment proceeded. This debriefing and ratification of experience and utility occurred after each session.

Finally, concerning transference, Schore (2003; 1994) holds that trauma induces a type of transference distortion and that it is a right-brain phenomenon (2003, p. 28; see also Blonder, Bowers, & Heilman, 1991, and Cahill, 1996). He even goes so far as to proffer that “traumatic pain is stored in bodily based, implicit procedural memory in the right brain and therefore communicated at a nonverbal, psychobiological level” (p.84). Hypnosis, therefore, is well suited to engaging this transferential state. Freud viewed transference phenomena as integral in engaging the patient in hypnosis, a view supported in later research and writing (Bachner-Melman & Lichtenberg, 2001; Nash & Spinler, 1989; Greenberg & Land, 1971).

We believe that the trust and availability apparent in the patient were largely due to these transference phenomena aided by the de facto hypnosis requirement for it as described above and the positive transference conveyance provided by the presence of the original therapist. This quality or ambience of the hypnosis sessions should not
be understated (Banyai, 1998; Bohart, 1993; Bromberg, 1991; Lynn, Weekes, Neufeld, & Zivney, 1991; Vanaerschot, 1997).

**Conclusion**

The three components of useful treatment for PTSD were evident (van der Kolk et al., 1996, p. 319): improved managing of physiological stress reactions; processing the trauma and coming to terms with it; and increasing or establishing better social contacts and interpersonal efficacy.

This report raises questions, challenges, and opportunity for utilizing the physico-emotional system in sexual abuse survivors for accessing and relieving the symptomatic sequelae of trauma, particularly for trauma likely facilitating compromising the language formulation areas of the brain. We came to see the patient’s early therapy muteness and frozenness as not only anxiety reactions but also as the early backhanded manifestations of her (unconscious) communication medium of choice. Following the left hemisphere deficiency—right hemisphere/amygdala/limbic hyper-activation hypotheses, verbal relief was unavailable once she entered the state-dependent territory of trauma and terror. Her body was quite eloquent and articulate; it just needed to be utilized in an Ericksonian sense. It may be also that some of the anxiety and constriction in these patients results from a tension between verbal and non-verbal expressions in personal, cultural, or therapeutic biases that pull for linguistic retrieval, purgation, and healing narrative construction. Thus, this may be analogous to a deaf mute’s agonizing with vocalizing until the relief of learning to sign.

**References**


