THE AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS

THE USE OF PROGRESSIVE RELAXATION AND GUIDED IMAGERY TECHNIQUES WITH FORGIVENESS IN TREATING TRAUMA RELATED SEXUAL ABUSE

A DISSERTATION SUBMITTED TO THE FACULTY OF THE AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

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ORLANDO, FLORIDA

APRIL 2007

DISSERTATION APPROVAL

This dissertation submitted by Alicia Perez has been read and approved by three faculty members of the American Academy of Clinical Sexologists.

The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ACKNOWLEDGEMENTS

I want to express my gratitude to the many people that supported me in this project. Special thanks to Dr. William Granzig for his invaluable wisdom, guidance, leadership, intelligence and patience. His encouragement and humor were extraordinary and provided me with the drive. Dr. Walker and Dr. Norris for their willingness to chair my dissertation and providing me with support, flexibility and energy. They served faithfully on my committee. Their expertise will always be appreciated.

I would like to thank my sons, Otto and Egon for granting me with their love, understanding and patience to follow my goals. My mother Gladys, for emotionally challenging me to be in the helping business. My brother and sister-in-law, Jesus and Tania, for encouraging me. Special thanks to my friends, Gladys, Celia, Mayrita, Maritza and Nancy for their enthusiasm, energy and general joy. To Jim Dockerty for his extraordinary wisdom, humor and patience. The many friends, colleagues and co-workers all of which supported my efforts. Special gratitude to my bosses Messrs. Hosick and Meddock for providing me with time off from job responsibilities, especially for Mr. Hosick's superior help in proofreading. My clients, who provided the opportunity to work with them on their sexual abuse trauma and the intrinsic satisfaction of seeing them improve with therapy. I especially want to thank my husband Elieser for his encouragement, assistance, humor and true love, who persisted in the completion of my goals. Without his help, it would have been impossible for me to pursue the degree. Finally, I would like to thank God for helping me with life.

VITA

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ABSTRACT

A victim of sexual abuse is haunted by the devastation of the abuse. For some, the abuse becomes a trauma, for others it does not. Are we automatically to assume that when individuals are sexually abused they are traumatized? What causes the trauma in victims of sexual abuse? The literature review contained in this dissertation illustrates the many ways that victims cope with trauma by, repressing, dissociating, denying, discounting and disowning the abuse.

There are many co-morbid physiological and psychological conditions that develop as a consequence of the victim's use of coping mechanisms as stated above. It seems that trauma related sexual abuse is caused by the freeze reaction due to the fight-or-flight response. There are many empirical and qualitative studies providing support that using progressive relaxation and guided imagery techniques counteracts the fight-or-flight response. Additionally, it appears that forgiveness is a vital intervention strategy in therapeutic settings.

The basis of this dissertation is to present the reader practical information and experience on the use of progressive relaxation and guided imagery techniques in treating trauma related to sexual abuse. With the use of forgiveness as the emotional tool, I will provide the readers with the methods and describe the efficacy of using relaxation, imagery and forgiveness in treating trauma related sexual abuse. In order to provide structure to the approach used, I have combined the three techniques in what I call the Holographic Therapeutic Framework (HTF). This paper is not an empirical study it is based on my clinical observations and clients' self-reports.

The use of progressive relaxation and guided imagery techniques with forgiveness are vital treatment strategies for treating trauma related sexual abuse. The literature provides material corroborating this approach, noting that progressive relaxation and guided imagery with forgiveness are effective intervention methods in treating trauma related sexual abuse.

Most victims of sexual abuse were abused as children. They come to therapy because they feel something is wrong with them. They might have developed medical conditions, such as diabetes, hypertension, arthritis, heart disease and cancer or stomach problems. At the same time, they may have depression, anxiety, phobias, and eating disorders. The first step is to establish an environment that fosters their confidence. The therapeutic alliance is key to bringing results to treatment. Most victims do not feel that they have anything to process regarding the abuse. They might not remember or remember only fragments of the abuse. They may feel ashamed, because they feel responsible in some way for the abuse. The survivors might feel uncomfortable in talking about their abuse (especially, men). The victim, through progressive relaxation and guided imagery will come to their own realization to forgive without having to disclose any part of the abuse to the therapist until they are ready. In fact, if they do not want to talk about the abuse, as long as they are obtaining results from treatment, talking about the abuse is not important. They will have the power to heal in their hands.

The techniques used are simple and adapt well to brief therapy. The results are remarkable due to the healing power the victim brings to therapy. Also, there is substantial theoretical and empirical support for the use of progressive relaxation, guided imagery and forgiveness as practical methods which are important in treatment.

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CHAPTER 1

INTRODUCTION

Trauma related sexual abuse is connected to many psychological disorders as depression, eating disorders, anxiety disorder, Post Traumatic Stress Disorder (PTSD) and Borderline Personality Disorder (Applebaum, 1997; Beixedon, 1995; Naparstek, 2004). However, there are many victims that do not develop trauma and others that do (Naperstek, 2004; Alexander, et al. 2005). The development of trauma seems to lie in the individual's response to trauma (Napaerstek 2004; Kabat-Zinn, 1990). The response to trauma varies from person to person. It has to do with the individual mental development, specific trauma, duration of traumatization and their coping mechanisms (Naparstek, 2004; Beixedon, 1995).

Our bodies are hardwired to react whenever we feel threatened. Instinctively, our body responds to signals from the mind. This reaction is called fight-or-flight. It involves the autonomic nervous system. After the traumatic event, our body and mind seek equilibrium (Kabat-Zinn, 1990; Naparstek, 2004; Benson 1975, 1985). Homeostasis (stability) of our bodily functions is the natural state of all human beings (Naparstek, 2004; Kabat-Zinn, 1990; Benson 1975). In using progressive relaxation and guided imagery techniques, clients are able to reduce their symptoms and feel better by being able to gain homeostasis (Kabat-Zinn, 1990; Naparstek, 2004). They are able to learn to relax, to breath and to let go.

Clients who are sexually abused feel embarrassed about discussing the abuse. Perhaps it is due to the emotional pain. Many victims do not recall the abuse, only parts of the abuse (Banyard, Williams and Siegel, 2001; Reisberg, 2003; Alexander, Muenzenmaier and Dumont,

2005). In using the relaxation and imagery techniques, they are able to deal with their trauma in another place, the place where their trauma lives - in their minds. Privately, they will have the opportunity to visualize the perpetrator and slowly work on forgiveness in therapy. The client learns to relax doing the relaxation exercises at home and in therapy. In about five to six sessions, the client is able to relax faster and transition into a "relaxation response" (Benson, 1975) state (alpha state) where their brain waves are slower and their ego is restful. In this state of alpha, the person puts their guards down. They are able to contemplate forgiveness and attitude change towards the perpetrator in order to let go and achieve reduction of trauma related sexual abuse.

Purpose of the Dissertation

The principal basis of this dissertation is to present to the reader practical information and experience on the use of progressive relaxation and guided imagery with forgiveness (as an emotional tool) in treating trauma related to sexual abuse. I will provide the reader with the methods and describe the efficacy of using these techniques in treating trauma victims.

In order to present the techniques in a structured way, I have combined the intervention tools of progressive relaxation, guided imagery and forgiveness in what I term the Holographic Therapeutic Framework (HTF). The overall questions that will direct this dissertation are:

1. What causes a trauma?
2. What are the effects of progressive relaxation?
3. What are the effects of guided imagery?
4. What are the effects of forgiveness?

5. What are the processes, techniques and results of using progressive relaxation, guided imagery and forgiveness in therapy?

Limitations of the Dissertation

This paper is based on the therapeutic approach that I use in practice. It is a psychotherapy phenomenon and there are many studies supporting the techniques. As Dr. Janet (1923) explains, "Physicists wanted to make use of electricity before they had made out its laws and phenomena. From time to time they obtained some results, but they could not teach practical methods. Physics had to analyze electrical phenomena and not describe electricity in general under different names. Psychotherapy will not be able to develop unless psychologists discover ….some notions of the forces of the mind that will be more precise and more fruitful" (p. 97).

There is substantial theoretical and empirical data supporting the use of progressive relaxation, guided imagery and forgiveness as effective treatment modalities. This dissertation is not based on presenting empirical results, but on providing the readers with information on the practical and effective use of progressive relaxation and guided imagery with forgiveness in treating trauma related sexual abuse.

The data presented in this paper is derived from my clinical practice and observations as well as client's self-reports. However, the literature review provides information on the benefits involved in using progressive relaxation and guided imagery techniques in treating victims of trauma related sexual abuse (Naparstek, 1994, 2004; Kabat-Zinn, 1990; Rossman, 2000; Benson, 1975). It also confirms that forgiveness has been found to be a viable treatment tool for many emotional traumas (Enright and Fizgibbons, 2000). Many of the survivors that were abused during childhood dissociate, deny, discount and disown the abuse (Goldsmith, Barlow and Freyd,

2004; Naparstek, 1994, 2004; Beixedon, 1995; Banyard, 2001; Reisberg, 2003; Engel 1989; Gabarino et al.1992). They will seek therapy because they know something is wrong with them, but not necessarily due to the sexual abuse (Goldsmith, Barlow and Freyd, 2004). Some do not remember the sexual abuse and others remember fragments of their abuse. Many of the victims will not want to talk about the abuse because they feel shame, guilt or hurt (especially, men). Trauma is the state produced by the freeze response due to the instinctive fight-or-flight response (Naparstek, 2004; Kabat-Zinn, 1990). The freeze response is seen in the animal kingdom as an act of defeat and submission. As is the case with the victim, they become powerless and go under "shock"; the body then dissociates and they become helpless. The victim of trauma related sexual abuse is a candidate for many physical illnesses like hypertension, diabetes, heart disease, cancer and stomach problems (Kabat-Zinn, 1990; Naparstek, 2004; Benson, 1975). They are also candidates for psychological disorders such as depression, anxiety, phobias and PTSD. The therapeutic alliance is of utmost importance with this population. They need to trust and feel safe. In social psychology, influencing a person's emotions is a sure way to increase a person's susceptibility to change their attitude. Consequently, the literature supports that forgiveness is an intervention instrument to use in therapy (Konstam et al., 2000). Dr. Benson (1975) contends that the relaxation response (which can be obtained with both progressive relaxation and guided imagery) counteracts the fight-or-flight response. Therefore, I believe that relaxation and guided imagery together with forgiveness to be an antidote for treating trauma related sexual abuse.

CHAPTER 2

DEFINITIONS

This chapter provides definitions for various terms used in this paper.

Sexual Abuse

There are many misconceptions about what is and what is not sexual abuse. In defining sexual abuse, it also became apparent that there are many ways to present a definition. The American Heritage Dictionary's definition for sexual abuse is: Forcing of unwanted sexual activity by one person on another, as by the use of threats or coercion. Sexual activity that is deemed improper or harmful, as between an adult and a minor or with a person of diminished mental capacity (American Heritage Dictionary, 2006). Wikipedia (2006) defines sexual abuse as molestation as defined by the forcing of undesired sexual acts by one person on another. Different types of sexual abuse include: (1) Non-consensual, forced physical sexual behavior such as rape or sexual assault; (2) psychological forms of abuse, such as verbal sexual behavior or stalking; and (3) the use of a position of trust for sexual purposes.

According to Beixedon (1995), sexual abuse encompasses physical, verbal and psychological abuse. For example, an older brother ridicules his sister about her body as he watches her undress. Also, a toddler, whose mother is bathing and she inserts the soap into his anus, is violating her son's physical boundaries.

Child sexual abuse encumbers contact and non-contact behaviors ranging from verbal and psychological harassment to rape (Beixedon, 1995). Child sexual abuse related to contact includes:

- willfully appearing nude in front of a child or an adolescent

- disrobing in front of the child of adolescent
- forcing the child or adolescent to disrobe
- exposing one's genitals to the child or adolescent
- watching the child or adolescent (i.e. while bathing)
- kissing the child or adolescent for sexual pleasure
- fondling or touching the child or adolescent
- masturbating in front of the child or adolescent
- performing oral sex on the child or adolescent
- forcing the child or adolescent to engage in "dry intercourse"
  (e.g. rubbings one's genitalia on the child or adolescent without penetration)
- penetrating the anus or vagina of the child or adolescent with a finger or object
- penetrating the anus or vagina of the child or adolescent with the penis" (pg. 5).

Davis (1991) provides yet another definition for "sexual abuse", "the violation of power perpetrated by a person with more power over someone who is more vulnerable. This violation takes a sexual form, but it involves more than sex. It involves a breach of trust, a breaking of boundaries, and a profound violation of the survivor's self. It is a devastating and selfish crime" (p. 13).

The National Child Traumatic Stress Network's (2006) definition of sexual abuse is: Many sexual abuse behaviors that take place with a child and an older person. Sexual kissing, touching, fondling a child's genitals, intercourse, incest, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials.

Trauma

In searching, I found that there is no general definition for trauma. The Webster's Dictionary 2nd Edition (2001), lists the following psychiatry definition of trauma as: (1) an experience that produces psychological injury or pain. It appears that trauma is defined by the magnitude of the traumatic event and the person's reaction to the event. Under the DSM-IV-TR (American Psychiatric Association, 2002) trauma is listed under PTSD and its definition includes trauma which leaves the person feeling helpless, powerless, paralyzed in what is called the "freeze reaction". After a trauma event, most people are unable to think clearly. It is an overwhelming event that has meaning for the survival of the organism. Dr. Korn (2006) suggests that many victims "hide by covering up their identities, masking their feelings, or not communicating the extent of their distress to others" (p. 8).

Progressive Relaxation

Progressive Relaxation is based on the principal that tensing your muscles, holding the tension for a short period of the time then, releasing the tension will result in the muscles being more relaxed. (Peters Mayer, 2005).

Autonomic Nervous System

Autonomic Nervous System (ANS) is a subdivision of the peripheral nervous system that maintains normal functioning of glands, heart muscles, and the smooth muscles of the blood vessels and internal organs. It is a part of the vertebrate nervous system that innervates smooth and cardiac muscle and glandular tissues and governs involuntary actions (as secretion and peristalsis) and that consists of the sympathetic nervous system and the parasympathetic nervous system (Miriam Webster's Online Dictionary, 2006; Huffman, Vernoy and Vernoy, 2000).

Sympathetic Nervous System

The Sympathetic Nervous System produces the "fight-or-flight" response with the occurrence of stressful situations.

It is the part of the autonomic nervous system that contains chiefly adrenergic fibers and tends to depress secretion, decrease the tone and contractility of smooth muscle, and increase heart rate. It tells the system to "hurry" and get ready (Huffman, Vernoy and Vernoy, 2000).

Parasympathetic Nervous System

The Parasympathetic Nervous System produces "calmness" and is considered the brakes of the "fight-or-flight" response. This the part of the autonomic nervous system that contains chiefly cholinergic fibers, that tends to induce secretion, to increase the tone and contractility of smooth muscle, and to slow heart rate, and that consists of a cranial and a sacral part . Additionally, it is the part of the autonomic nervous system that is normally dominant when a person is in a relaxed non-stressful physical and mental state, and that restores the body to its "status quo" after sympathetic arousal (Huffman, Vernoy and Vernoy, 2000).

Fight-or-flight response

The Fight-or-Flight Response is defined as a bodily survival defense mechanism against danger. The body prepares a survival reaction called the "fight-or-flight" (Peters Mayer, 2005; Kabat-Zinn, 1990). To be anxious is a natural response to stress. Our autonomic nervous system is hardwired to react to situations where we feel threatened. It is the instinctive survival reaction that we inherited from our ancestors (Huffman, Vernoy and Vernoy, 2000).

Relaxation Techniques

The Relaxation Techniques procedures used to relieve the anxiety and bodily tension accompanying such problems as stress and chronic pain (Sobel and Ornstein, 1996).

Placebo

The Placebo is a substance that would normally produce no physiological effect when used as a control technique, usually in drug research. It has been found in research studies that about 1/3 of the persons using the placebo result in about 55% of the effects of treatment. The placebo, which is basically a sugar pill, is administered to a group of persons and the actual treatment pill is given to the other group. The results point out that there seems to be a connection with the mind/body and healing because of the apparent effectiveness of the placebo. There has been research that found that placebos alone are able to help in the healing of many symptoms (Skeptics Dictionary, 2006).

Placebo Effect

The Placebo Effect is a change in participants' behaviors brought about because they believe they have received a drug that elicits that change when in reality they have received a placebo, an inert substance (Skeptics Dictionary, 2006).

General Adaptation Syndrome

As described by Hans Selye in 1936, General Adaptation Syndrome is a generalized physiological reaction to several stressors consisting of three phases: the alarm reaction, the resistance phase, and the exhaustive phase (Huffman, et al., 1987). The first stage is the alarm reaction when the body responds to stress by signaling the sympathetic nervous systems (this influences the heart rate to increase, the blood pressure, and the hormones to secrete, etc.). The

body in this stage has resources to handle the stress, but not disease. The second stage is the resistance stage. This stage is achieved because the stressor has not moved and the body starts adapting to the stress level, opening up the prevalence for health problems. The third stage is called the exhaustion phase, where the body gives up and the long-term consequence being death (Huffman, Vernoy and Vernoy, 2000).

Guided Imagery

Peters Mayer's (2005) definition is, "Directed imagination used as treatment for anxiety disorders. "It is a mind-body intervention that affects a state of relaxation that provides directions on determined visualizations to promote healing" (p. 293). The words "guided imagery" provides description for various methods of visualization, and suggestion, symbolic to story-telling" (Sobel and Ornstein, 1996, 1997). It is also defined as a "range of techniques, from simple visualization and direct imagery-based suggestion through metaphor and storytelling" (Bresler and Rossman, 2003 (as quoted in Utay and Miller, 2006).

Client-centered Therapy

The Client-centered Therapy is a type of psychotherapy developed by Carl Rogers that emphasizes the client's natural tendency to become healthy and productive. Techniques include empathy, unconditional positive regard, genuineness, and active listening (Corey, 1996).

Homeostasis

Homeostasis is the body's natural tendency to maintain a state of internal balance. If we get hungry, we hunt for food. Once our hunger is satisfied, we no longer search for food and feel stable (Kabat-Zinn, 1990).

Therapeutic Alliance

The Therapeutic Alliance is the rapport, trust and safe environment established in the therapeutic setting. Developing a strong therapeutic alliance is important. Binder (2004) emphasizes that to foster a positive outcome the therapist's attitude should maintain a quality of warmth, empathy, respect and sensitivity. Clients that suffer sexual abuse trauma go to therapy because they are having co-morbid conditions and relationship problems. They have been violated and do not trust or feel safe (Everly and Lating, 2004; Alexander, et al., Naparstek 2004).

Promoting a safe environment is important in the outcome of treatment. Katbat-Zinn, (1990) insists that it is critical that the client focus on working on the problems and has enough self-discipline to continue in the process and without a strong alliance, it would not be possible.

Eclectic

The therapist selects various theoretical approaches and techniques. A therapist concentrates on the uniqueness of the individual (Peters Mayer, 2005).

Forgiveness

For the purpose of this paper forgiveness is defined as follows:

> Willingness to abandon one's feelings of resentment, revenge, negative judgment, behavior, and condemnation toward one who unjustly injured oneself while fostering undeserved qualities of compassion, generosity and even love toward that person (Enright, Freedman and Rique. 1998, p. 47, as quoted in Dictionary of Conflict Resolution, 2002).

According to Enright and Fitzgibbons (2002) the definition of forgiveness is:

People, upon rationally determining that they have been unfairly treated, forgive when they willfully abandon resentment and related responses to which they have a right, and

endeavor to respond to the wrongdoer based on the normal principle of beneficence, which may include compassion, unconditional worth, generosity, and moral love to which the wrongdoer, by nature of the hurtful act or acts, has no right (p. 24).

CHAPTER 3

REVIEW OF THE LITERATURE

This chapter covers the literature review which provides information corroborating my theory on the combined use of progressive relaxation and guided imagery techniques with forgiveness as effective therapeutic strategies in treating trauma related sexual abuse. The first section, illustrates written materials on emotions including our instincts, the limbic system and the way we are react to stimuli. The second section shows the important connection of the mind and body. Then, the literature will provide facts on the effects of the new laws of physics and our need to change the way we look at reality, people, the mind/body and therapy. Next, the literature will provide the reader with information on sexual abuse and PTSD. Then, information on trauma, the trauma response, the fight-or-flight and freeze response will be presented. The next section provides a brief history of progressive relaxation and guided imagery as well as articles and empirical studies on the benefits of using progressive relaxation and guided imagery as intervention tools. Finally, the last section points out the importance of forgiveness in therapy.

Emotions

We are being influenced daily by the many advertisements in our culture. For instance, when we are watching a sports event on television, we are constantly being bombarded with advertisements which encourage the purchase of items potentially deleterious to our health (i.e. cigarettes and alcohol) (Aronson, Wilson and Akert, 2002). The advertising company knows how to influence our attitudes and promote us to change our habits. The secret is through our emotions (Aronson, Wilson and Akert, 2002). Emotions exist before the human brain develops.

They are a major part of our mind process. Our emotions are controlled by the limbic system which is linked to the "mammalian brain" or as some call it "the lizard brain" (Ornstein, 1972). The limbic system is connected to our emotional states and it is also considered the reward center of our mind.

When a traumatic event happens, neurological connections take place that register the event. In other words, the emotional schema of the mind is reprogrammed. In order to change that program, a new program is needed that will have the same impact to produce neurological connections. It is my theory that a new program of the mind is formed by practicing progressive relaxation and guided imagery techniques with forgiveness. The victim of trauma related sexual abuse, will be able to change their attitude toward the perpetrator due to the relaxation state they are in when their alpha waves have increased and their resistance to change is down.

How many days does it take for a habit to form? I was once told that it takes about 40 days. I have searched the internet looking for information on the time it takes for habits to form, but have been unsuccessful. I agree with Dr. Cannon (1963), that our emotions are habits. These emotions (habits) form neuronal connections that act like a drug habit. These emotions need their chemical (drug). If not fed, they will develop anxiety. When we see a police officer we immediately look to see if we are driving at normal speed or if we have our seat belts on. The same way as when we start getting angry and we do not know why, it is because our anger needs feeding. Since this habit is formed as a neurological electromagnetic connection it will be there unless we break it. Hence, these emotions **(**habits) have their neurological (electromagnetic) program like a computer. To change the program we need to change our attitude. But the

emotion (habit) takes time to change. It has formed roots and it will take some time (perhaps another 40 days) for the habit to break.

For Freud (as cited in Jacobson, 1967), emotions are based on two instincts; life and death. In other words, Freud asserted that the "ego-instincts" lure us toward dying and the sexual instincts toward life and preservation. Freud's theories in relation to the ego and the personality are a reflection of our instincts and drives. For example, in Freud's psychoanalytical theory, he provided the personality structure of having the components of the id as being the most primitive part being driven by the pleasure principal, the ego that is our reality-base tests our reality and wants to stay away from pain at all costs, so it struggles between the pleasure and the superego and our moral principle that is the superego which encompasses all of our value and beliefs influenced by our culture. Freud also provided some other interesting aspects in his psychoanalytical framework, that is the drives, our innate psychological wishes for self-preservation and preservation of the species, life and death; our anxious reactivity to unconscious conflict or threat to the ego; and the defense mechanisms (Lippincott, 1996). In other words, when we are anxious, the ego will look for defense mechanisms in order to protect itself from pain (Rudyar, 1979). The ego does not want pain and anxiety and it will use whatever defense mechanism available to cope.

Freud believed that our instinctive desires are unconscious. In his practice, he used projective work like free association and the dream work. He postulated that through dreams lies the road to our unconscious mind and the world of our wishes.

In Darwin's theory of evolution by natural selection, instincts play an important part of our survival rate, and in this regard, instincts can be viewed as our actions that help survival. We

are born with instincts that respond to environmental stimuli. For instance, we can observe how we react instinctively in our sexual drive and emotions. If we observe animals, we notice that they perform certain difficult actions instinctively like feeding, fighting, courtship that would require learning, but they are able to perform because they are following their instincts (Wikipedia, 2006).

Edmund Jacobson (1967) felt that the key to emotions is the "electrical impulses that signal the messages" (p. 28). Thus, he argued that emotions are often caused by visual images. "Emotion presumably is not initiated by one neuron but comes into existence upon simultaneous action of many neurons" (p. 191). Jacobson (1967) felt that anxiety is "very often adduced or triggered upon the occurrence of eye tensions and visual imagery" (p. 138). Furthermore, Jacobson (1967) asserted that all humans with the exception of those who are born blind, experience emotional states through imagery. He believed that our tensions and "lasting imaging are relevant to emotions" (p. 142). He said, "In sum, residual tension plus imagery is the continuance of past awareness and action, the key to orientative present and to programming for the future" (pg. 23).

Lazarus (1991) explained that "perceptions of our thoughts, action tendencies, bodily changes, and the subjective feel of the emotions we experience are additional contents of cognition that are part of the emotion process and contribute to knowledge and appraisal" (p.127). If someone is in constant touch with the emotion that is causing distress, the reaction to the persistency is not going to be removed because the cycle of the "emotional impulse" has not completed its course (Cannon, 1963). According to Dr. Cannon:

> They may persist because not naturally eliminated by completion of the emotional impulse, or because completion of the impulse is made impossible by

> circumstances (recurrences of the original stimuli [memories], with emotional attachments [terror, remorse], then keep the reaction alive), or because they become associated with a common object which, repeatedly encountered, is a repeated conditioned stimulus (p. 261).

In other words, we have emotions that are innate. Like when the baby cries when born. In fact, humans have innate reflexes when we are born. For example, the Babinski reflex is one of the neonatal reactions that provides evidence about the baby's reflex reaction and capability of functioning (Dacey and Travers, 1999). It is done by gently stroking the lateral side of the sole of the foot and the infant responds by spreading their toes in an outward and upward manner. The baby comes hardwired with these reflexes. Likewise, remember the experiment by Pavlov with the dogs? Ivan Pavlov, a Russian physiologist, was experimenting with dogs, relative to the function of saliva in the digestive process and found that dogs were salivating before he put the meat powder just by the "clicking sound" made by the device that was utilized to place the meat powder (p. 218). As a result of his discovery, Pavlov experimented further with the dogs, the tone and the meat powder. The significance about the study was that "it started out as a neutral stimulus…it did not originally produce the response of salivation…by pairing the tone with a stimulus (meat powder) at did produce the salivation response…the tone acquired the capacity to trigger the response of salivation" (Weiten, 1998, p. 218).

Cannon (1963) emphasizes that the early treatment of the emotional impulsivity is important, because just like with habits, if the act is repeated it creates neuron connections and treatment becomes impossible. The connections are tied to the nervous system just like when you learn to swim, skate, or ride a bicycle, repeating and practicing a skill will make neurological connections. Another example is when we salivate while standing at the sandwich shop (i.e. Subways) while watching the attendant prepare a sandwich.

Mind/Body Connection

There is a famous quote by James Williams that says, "The things we experience in the body have effects in the brain". Researchers have studied the phenomena of the mind and body (somatic and cognitive). However, it is hard to measure and describe the somatic and cognitive states (Poppen, 1998). According to Dr. Chopra (1990), "everything is interconnected at the level of the neuropeptides" (p. 71). He also reported that the same neuropeptides impact the mind/body connection. We know that the mind is involved in processing the information we receive (Jacobson, 1967). There are many psychophysiologic disorders that are caused by the mind/body connection (Lippincott, 1996). In the diagnostic section of the DSM- IV-TR (2002) related to "psychological factors affecting medical conditions", the following are listed "cardiovascular (hypertension, angina pectoris, acute myocardial, infarction, migraine headaches, immune system (allergic disorders, cancer, autoimmune disorders), endocrine (diabetes mellitus, thyroid disorders, premenstrual syndrome), neuromuscular-skeletal (rheumatoid arthritis, Raynaud's disease, temporomandibular joint pain, back pain), respiratory (asthma, hyperventilation), gastrointestinal (peptic ulcer disease, irritable bowel syndrome, ulcerative colitis, regional enteritis (Crohn's disease), and intergumentary (psoriasis, urticaria, eczema) (psoriasis, urticaria, eczema)" (pg. 52). There are many theories explaining the cause of these medical conditions that are based on psychological response (Lippincott, 1996).

The subject of the interconnectedness of the mind/body has been a fascinating subject for many. According to Ornstein (1986), it appears that "there is a brain and mental system that has evolved to run the body and keep us healthy." Ornstein (1996) presents an interesting structure about how the brain was developed through evolutionary processes forming the following layers:

Keeping Alive:

1. Arousal and wakefulness; the brain stem
2. Emotions and the inner state of body; the limbic system

Creating Anew:

3. Making new associations (learning, memory, perception); the cortex
4. Creating symbols (language, art); the divided hemispheres" (Ornstein, 1986, p. 88).

The layer comprising of emotions and the limbic system are even more intriguing. Our emotions are primary gatekeepers of our mind this is due to their prior existence to that of the human brain (Ornstein, 1986). The "mammalian brain" is in the limbic system. This area of the brain is responsible for maintaining normalcy in our bodies by regulating emotions. It is called "mammalian brain" because it is the same structure found in mammals (Ornstein, 1986). As explained before, this area of the brain is in charge of our emotions and also the reward system.

Greenspan (1997) explained "that consciousness develops from the continuous interaction in which biology organizes experience and experience organizes biology" (p. 53). Emotions are connected to our feelings and these feelings represent visceral response. The connection of emotion and feeling is assembled in our nervous system and also in the muscular-skeleton (1997).

The formation of our conscious is through the ally of our physical experience and the interconnection of the physical experience. Greenspan (1997) postulated that our feelings are "visceral sensations" (p. 113). "Anxiety may announce itself as a pounding pulse, disappointment as a sharp pain in the gut, sadness as a tightness in the throat, stress as a throbbing in the temples" (p. 113). He contends that the interconnectedness of our physical and emotional is "wired" in our "neurology" and "musculature" (Greenspan, 1997, p. 113). Our

conscious has two structures: (1) the neurons that have to do with our physical and emotions; (2) the other is the hardwired nervous system, which interacts with experiences and we develop our sensory perceptions (Greenspan, 1997).

A description of the existence of our emotions is beautifully depicted by Greenspan (1997) as follows:

> The first sign of consciousness is simply a baby's sense of aliveness: the bubbling of his feelings in response to sensations at a time when he cannot yet distinguish himself from the world around him. This early sense of affective aliveness is not attached to any symbols or purposeful behavior. While it may be called "arousal" it might be more appropriately called a sense of affective aliveness. (p.76)

The Shifting of Thoughts – Quantum Physics

It is now known that subatomic particles (such as electrons, protons, and neutrons) that make up the atoms of which all substances, including our bodies, have properties that appear sometimes wavelike and sometimes particle like; furthermore, they cannot be said to have a particular energy at a particular time with complete certainty; and the connections between events on this level of physical reality are only describable by probability. Physicists had to drastically expand their views of reality in order to describe what they found inside the atom. . They coined the term "complementarity" to convey the idea that one "thing" (say, an electron) can have two totally different and seemingly contradictory sets of physical properties (i.e., appear as either a wave or a particle), depending on what method you use to look at it. Physicists have introduced the "Quantum Field" which provides that "matter cannot be separated from the space surrounding it (Kabat-Zinn, 1990). This means that particles are simply "condensations" of a continuous field that exists everywhere.

Dr. Benson (1985) provides that these new findings in physics related to the particles and the energy waves have changed our reality on the world. Therapists have to open their horizons and look at the all aspects for treatment interventions. Now, physics have provided a new explanation of matter. Dr. Benson brilliantly explains it as follows:

> Our world, they say, can be broken down into atoms and molecules, which can in turn be divided still further into "subatomic particles" and energy waves. These particles and waves are everywhere and in everything; also, the particles can't be said to exist as tangible objects occupying space. Rather, they might be viewed as fundamental forces or sets of movements. To put it more accurately, the particles aren't really "particles" at all in the way we normally think of that term: They are really a set of relationships between particles and waves that can't be described or visualized in our ordinary thought processes". (p. 19)

In other words, the work of quantum physics found that there is an electron that has two different properties, which can be seen as a wave or particles (Kabat-Zinn, 1990). Dr. Benson points out that the particle waves are nonexistence in "isolation" (p. 19). He postulates a universe that is interconnected (Benson, 1975).

Dayton (2003) confirms that quantum physics provides facts on "when thoughts, feelings and behaviors that are ostensibly from the past get triggered into the present, we experience them as if they are happening in the here and now" (p. 156). She suggests that the things we repress affect our health.

In essence, if we are interconnected then our mind/body and emotions are also interconnected. The field of behavioral medicine promotes the concept of mind and body noting that the mind-body is connected and fosters that scientific research effects on the functions of this connection would lead to information in the area of health and disease (Kabat-Zinn, 1990).

Sexual Abuse

Some experiences we do not want to express because they are painful and scary. Normally, people want to forget and hide unpleasant thoughts; they want to protect and prevent these feelings of shame and hurt (Kabat-Zinn, 1990). Most victims of sexual abuse are children or adults that were abused as a child by their parents, family members, friends of the family and clergy. They know their abusers. About three fourths of all crimes against children are represented by sexual abuse (Missouri Government, 2006). Estimates are that between 50,000 and 500,000 children are sexually abused each year (200,000 is the figure given but they suspect more because of enormous amount of unreported cases). Most of the victims are female, but the number of male victims is on the rise (Burkkhardt and Rotatori, 1995). Unfortunately, sexual abuse of children is believed to be the least reported. Also, victims feel shame and guilt due to the secrecy with the perpetrator and do not report until they seek therapy for other reasons and remember their abuse. Some feel they have bypassed the emotions related to the abuse. Perhaps they do not feel comfortable talking about the abuse, because they get emotional or repressed and deny the abuse. Fortunately, with progressive relaxation and guided imagery techniques, they are able to deal with their issues in a fantasy world, where they will be their own judges.

Sexual abuse is reported in many settings, like schools, day-dare centers and group homes. There seems to be many incidents of pornography related to sexual abuse (Kaplan and Sadock, 1991). As stated earlier, victims are abused 50% of the time by family members. The fathers, step-fathers, uncles and older siblings are the most common (Kaplan and Sadock, 1991). Incest is common with father-daughter than with mother-son. In a home where the mother is disabled, sick or absent, the daughter takes on the maternal role. A mother should believe what

the child is claiming regarding the sexual abuse. They need to listen to their allegation about the sexual abuse even if it is against the father, stepfather, or mother's boyfriend. The mother must not deny the abuse. Although, it is hard for the mother to acknowledge the abuse because it is going to destroy her world, the mother should question, "Why is my child acting in this manner?" (Garbarino and Stott, 1992).

There are various psychological and physiological disorders that develop in children due to sexual abuse. Phobias, anxiety and depression are increasingly high in sexually abused children. Children might feel shame because they liked being touched, were provided with special attention and received treats. Many did not know what was going on, or they dissociated as a coping tool. They develop many major trust issues with adults.

Sexual abuse trauma is not listed in the DSM-IV as such. Most people suffering from sexual abuse trauma would be diagnosed with PTSD or Acute Stress Disorder. The two diagnoses are alike except that in Acute Stress Disorder the symptoms must increase and decrease within a month. However, if the symptoms persist, the PTSD diagnosis is set. In order to provide the client with a proper treatment plan, it is important that the differentiation be made. The DSM-IV-TR, (American Psychiatric Association, 2002) criterion for both disorders are as follows:

309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play occurs in which themes or aspects of the trauma are expressed
   (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content
   (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general Responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect (e.g., unable to have loving feelings)
   (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (pp. 467, 468).

308.3 Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
   (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
   (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
   (3) derealization
   (4) depersonalization
   (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, and people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hyprevigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder. (pp. 471, 472)

Also, it seems that victims of sexual abuse are connected to Borderline Personality Disorder (Millon, Grossman, et al., 2004).

PTSD is an anxiety disorder in response to a life threatening event. As stated earlier, most victims of sexual abuse are diagnosed with PTSD. According to the DSM-IV-TR, (American Psychiatric Association, 2002) the primary characteristics of symptoms in the diagnosis of PTSD includes a large level of physiological stimulus. The stimulus factor of PTSD has been inked with hypersensitivity in the CNS, mainly the limbic area (Everly and Lasting, 2006). The survivor experiencing PTSD is in constant cycle of the nerve impulses or "arousal and avoidance, of panic and numbing, of terror and confusion" (Scaer, 2001, p.1).

Dr. Saer (2001) argues that dissociation in children is manifested in sexual abuse. They are subjected to being retraumatized if exposed to any traumatic stimuli. The diagnosis of PTSD is correlated to dissociation (van der Kolk and van der Hart, 1989, as quoted in Scaer, 2001). The persons that dissociate when undergoing a traumatic experience are likely to be diagnosed with PTSD than those who do not experience a traumatic experience (Bremner, et al, 1992, Holen, 1993, Cardena & Spiegel, 1993, as quoted in Scaer, 2001).

There is a hypotheses of the freeze response (which will be discussed later) as being a key element related to dissociating since the survivor is unable to resolve the freeze response and gain homeostasis (stability) due to their life being threatened and their subjecting to helplessness (Scaer, 2001).

Trauma

Trauma involves things that have meaning for the survival of the individual. It seems that trauma sinks deep into the onion, or as Sigmund Freud called "repression" (Grof, 1993). Langer (1972), stated:

> One of Freud's most revolutionary ideas was that forgetting, rather than remembering, is a purposive cerebral act, a process of repression, which allows nothing to remain in memory except symbolic images that disguise their meaning as they convey them. (p. 279)

Many victims of sexual abuse dissociate and repress. The person dissociates in order to protect their homeostasis. They use dissociation to cope with the fight-or-flight response. Their belief, instincts, moral (superego), trust is being threatened, they are helpless, they trust the perpetrator and love this person and now they are going against their will (their free will) by letting themselves be sexually abused.

The victims that tell are sometimes provide no empathy or served with disbelief. The experiences that cause trauma are the ones that have meaning for survival of the organism.

Greenspan (1997) asserts that trauma is reflected in a unique way depending on the constructs of the stressful event. He made the following analogy:

> Someone who has been mugged for example, might form a small encapsulation, becoming anxious in situations that remind him of the event. Or he might completely avoid any possibility of reexperiencing anything remotely like the trauma, perhaps refusing to leave the house. (p.190)

Some people rebound easily while others do not. It very much depends on several factors: (1) past coping skills, (2) character strength and sense of worth, (3) support system, (4) the degree of trauma (e.g., length, severity), and (5) belief system, cultural biases, and religious aspects (Sobel and Ornstein, 1996). Other aspects include: (1) Penetrative sexual activity (body

is not capable of size), (2) The relationship with perpetrator (the closer the relationship the more trauma response, (3) If force was used, and (4) The degree of eroticism.

Everyone reacts differently in a traumatic situation. To illustrate this, let us suppose someone is held-up at gunpoint. One person might just experience anxiety whenever he faces a situation that reminds them of the event. Another person might be afraid of being in public places and might not want to go out of the house (Greenspan, 1997).

Also, external aspects of the sexual abuse trauma play a role in the reaction, these include: (1) the length of the abuse, (2) age, (3) support, (4) if it was a family member or an outsider (Peters Mayer, 2005; Van der Hart and Steele, 1997). To move beyond the therapeutic phase, the following external aspects are also to be considered: (a) capacity to use attachment figures for self-soothing, (b) propensity to re-enact the trauma in adult life, (d) nature and severity of co-morbid psychiatric conditions, (d) intellectual endowment, (e) degree of which a persistent victim identify and can be relinquished for a focus on healing tasks, (f) unstable or unsafe current life situation, (g) extreme age, physical infirmity or terminal illness, and (h) lack of ego strength, including sever borderline or psychotic states or pathological regression (Van der Hart and Steele, 1997).

Sobel and Ornstein (1996) write that the relationship between traumas and illnesses have been connected by researchers. Studies related to diseases like, cancer, asthma, arthritis, anxiety and depression are all linked to traumas (p. 202).

Most victims that were abused as children have repressed or dissociated their abuse (Goldsmith, Barlow and Freyd, 2004; Alexander, Muenzenmaier, and Dumont, 2005). Yapko (1994) noted that repression is manifested greatly in traumatic events. Basically, there are few

sources available about why some people repress and others do not (1994). However, it has been found that the victims of sexual abuse are connected to psychological disorders as depression, eating disorders and borderline personality disorder (Applebaum, 1997).

Furthermore, sexual abuse trauma produces emotional problems, which usually has physical symptoms like "heartburn, headaches, dizziness, insomnia, or a stiff neck" (Greenspan, 1997, p. 202).

How is the trauma formed? As discussed previously, most victims of sexual abuse repress their abuse. The ones that tell feel hurt if their caretakers or friends do not believe them or if the abuse is not given importance. When it is a child, they are usually abused by someone they trust. They are often pressured by their perpetrators and told to keep their abuse a secret. In a doctoral dissertation by Moritz (2005), she included information about the psychological tactics used by perpetrators that resemble the ones used on prisoners of war. She wrote that the perpetrators tactics distort the victim making them "confused and terrified" (p. 14), believing whatever they say. The victim only expects abuse from the perpetrator, so whenever the perpetrator is kind, the victim is confused. The perpetrator provides the victim with confusing information (i.e., no one in the family loves you). The perpetrator "indoctrinates" (p. 15) the victim in a way that all the perpetrators worldviews and experiences are accepted by the victim (Moritz, 2005).

The event becomes a trauma due to the nature and the reaction of the individual. Perhaps they don't understand what is happening and the instincts take over having them dissociate to protect the individual and bringing back the memories of the event when they are older to understand what was happening. Perhaps the victim freezes, is in shock, and lose

stability. The freeze response seems to be the most damaging to psychological and physiological stability.

There are many victims that repress and others that do not. Although the victim tries to forget, intrusive memories of the trauma are reported later in life (Reisberg, 2003).

Victims do not seek therapy for the sexual abuse trauma, but for relationship problems and the way they feel about themselves (Goldsmith, Barlow and Freyd, 2004). In fact, the traumatized individual has lost or repressed memory about their abuse until they are in the "thirties or forties". It seems as though the subconscious is aware that the person needs to be older to be able to process the traumatic memories (Yapko, 1994).

Apparently, sexual abuse becomes traumatic due to the freeze response. As we explore sexual abuse trauma we find that it affects everyone in a unique way due to the many external aspects of the trauma.

The trauma is imprinted in memory and is revealed through flashbacks. The flashbacks are revived through the amygdala. The limbic brain, which is considered the "mammalian brain" puts out pleasure as well as disturbing emotions. It is identified as "the reward system" of the brain (Kotulak, 1997, p. 119). The amygdala plays the role in the reward system of the brain, and it warns the individual that there is something that will produce fear and the person should try to stay away from it (like a snake). Sexual abuse is imprinted into the memory through the amygdala (Kotulak, 1997).

When the body disconnects from the mind there is a term called the "numbing" effect and it appears that this effect influences being unable to attain homeostasis and therefore developing PTSD. There was a study done by Brown and Kulick in 1977 regarding the assassination of

President Kennedy where the findings acknowledged that through a dreadful event the response for the brain is to “freeze” the moment “like a camera takes a snapshot” (Peters Mayer, 2005, p.82).

Prolonged trauma is when the victim is unable to escape the perpetrator. For example, there is probability that women subjected to prostitution in brothels, prisoners of concentration camps, and family environments experience prolonged traumatization (McNally, 2003).

As mentioned earlier, most victims do not seek therapy for the sexual abuse trauma. They start facing many problems in relationships and feel that something is wrong (Goldsmith, Barlow and Freyd, 2004).

There are also many people who bounce back from the trauma rapidly. They reestablish their lives and relationships. However, there are others that do not bounce back. These individuals relive their trauma constantly causing them distress in relationships and daily performance. They suffer flashbacks, nightmares and daydreams. They feel a sense of numbness avoiding events or situations and places that remind them of the traumatic event. They are anxious and lack concentration, react to things in with anger, have problems with sleep and are subject to being overwhelmed when meeting with a problem (Sobel and Ornstein, 1996). In fact, there was a study done by a group of doctors in King’s College Hospital in London (as quoted in Kabat-Zinn, 1990) that found that the prevalence of women with breast cancer was high amongst women who had suppressed their stressful emotional life, not being able to talk about their feeling and denying their emotions (Kabat-Zinn, 1990).

Trauma Response

A victim of sexual abuse goes through the devastation of the abuse. However, for some the event becomes traumatic, but for some it does not. Are we to automatically assume that when someone is sexually abused they are traumatized? I believe the response to the abuse is what determines the trauma. The literature review expresses many of ways the victims repress, dissociate, deny, and discount the abuse. It is obvious that they do not want to deal with the abuse due to some intuitive nature that protects humans from sustaining the shock of being a victim. Most of the persons that are sexually abused were abused when they were children. With that being said, it brings another question to mind which has many ramifications. How do children know that they are being abused?

Using Kohlberg's moral development and Piaget's (Dacey and Traves, 1999), a child starts building some moral rules after the age of four. So, I ponder if the victims' innate instincts warn them of danger. The hard-wired instincts like Freud's ego instincts that are impulses for individual self-preservation (Penguin Dictionary of Psychology, 2006) take over the emotional aspect of the abuse and the victim feels helpless and uncomfortable with their situation. On the physical side, the threatened reaction starts the fight-or-flight response and the victim might employ freeze (become helpless) or employ defense mechanisms to cope. The body loses homeostasis (stability). The body will try to attain homeostasis, but because of the extreme and overbearing instinctual reaction of fight-or-flight, there may be a barrier preventing the body in achieving equilibrium. Thus, the victim is unable to gain homeostasis and is in a constant disequilibrium which leads to flashbacks, nightmares, phobias, hypertension, etc.

Dayton (2003) contends that the way you respond to a traumatic event varies depending on the aspects that are affecting your response. He provides the following aspects:

(1) History of prior traumatization or loss, such as death, divorce or addiction.
(2) Age of developmental level: how old was the person at the time of the traumatic event.
(3) Preexisting personality: How sensitive is the person? How resilient?
(4) Severity of the stressor: How significant was the trauma? How many senses were involved?
(5) Genetic predisposition: What is the person's physical makeup?
(6) Access to support surrounding the actual events and general support system: Was the person able to talk about the event(s) and process the emotions, or did he or she have to go it alone and tough it out? (pp. 360-361)

Alfred Adler (1956) writes that we make our traumas to satisfy our purpose. He said, "Meanings are not determined by the situations, but we determine ourselves by the meanings we give to the situation" (p. 208). He argued that the traumatic experience is not "…which dictate … actions; it is the conclusions which… draws from his experience." (p. 209).

We are born with instincts that respond to environmental stimuli. For instance, we can observe how we behave instinctively in our sexual drive and emotions (Wikepidia, 2006). If we observe animals, we notice that they perform certain difficult actions instinctively like feeding, fighting, courtship that would require learning, but they are following their instincts. The persons who undergo the severe fight-or-flight response resulting in the freeze are the ones that develop trauma. Just like the survivors of the Nazi concentration camps (Frankl, 1984) and some people under dictatorship governments like the Cubans under the government of Fidel Castro. I have a friend that after being in the U.S. developed irritable bowl syndrome. When he went to see the doctor, the doctor told him to relax because his visceral muscles were stiff. My friend could not relax the muscles, he would tell the doctor that he was relaxed, but the visceral muscles were still

stiff. The doctor referred to my friend's problem as the "Castro syndrome". Some of the Cubans that want to flee the Castro government, especially the professionals, go through a lot of anxious provoking moments being threatened and harassed (The Nation, 2006). They become traumatized and have flashbacks similar to the ones that traumatized sexually abused individuals face.

Fight-or-Flight

To illustrate the fight-or-flight reaction, imagine that you drive to New York City for the first time "it is late in the evening and you want to get to your relatives home. Your car breaks down, you look around and all you see are tons of garbage, graffiti walls, homeless people sleeping on the sidewalks and a group of men that seem to be unfriendly. Immediately, your emotion of fear would start creeping elevating your heartbeats, feeling warm, your breathing would increase and perhaps you would be trembling. Such reactions are in response to the autonomic nervous system" (Mind/Body Education Center, 2006).

The fight-or-flight response was first illustrated by Dr. Walter Cannon a physiologist who worked at the Harvard Medical School (1963), as he called it an "emergency reaction" (Cannon, 1963; Benson, 1975). When we have an alarm reaction, our body calls an internal reaction of the body to help. The sympathetic alerts the body to get energized and ready for fight; the parasympathetic puts the breaks, its function is to return us to the calm mode. The fight-or-flight response is our body's reaction to threat. Kabat-Zinn (1990), explained the response as follows:

> The fight-or-flight reaction involves a very rapid cascade of nervous-system firings and release of stress hormones, the most well known of which is epinephrine (adrenaline), which is unleashed in response to an immediate acute threat. This leads to heightened sense of perceptions so that we can take in as much relevant information as possible as quickly as possible: the pupils of our eyes dilate to let in more light, the hair on our body stands erect so that we are more sensitive to vibrations. We become very alert and attentive. The output of

> the heart jumps by a factor of four or five by increasing the heart rate and the strength of the hear-muscle contractions (and thereby the blood pressure) so that more blood and therefore more energy can be delivered to the large muscles of the arms and legs, which will be called upon if we are to fight or run. At the same time the blood flow of the digestive system shuts down, as does digestion itself. After all, if you are about to be eaten by a tiger, there is no point in continuing to digest food in your stomach. It will get digested by the tiger's stomach just as well if you are caught. Both fighting and running require that your muscles get as much blood as possible. You may feel this rerouting of your blood flow in times of stress as "butterflies in your stomach. (p.251)

The reaction of alarm in your body is processed by the automatic nervous system which "regulates states of your body such as your heart rate, blood pressure, and the digestive process." The automatic nervous system reacts in the fight-or-flight response as the sympathetic branch. The assignment of the sympathetic branch is to hurry the process. The parasympathetic branch is the one that calms the process. For example, with a man's erection, the parasympathetic system provides the romantic love and the ejaculation comes from the sympathetic system. The function of the hypothalamus is to control the automatic nervous system (Kabat-Zinn, 1990). The hypothalamus is part of the limbic system which is the "heart of our emotions" and also our rewards systems. The limbic system regulates our emotions and drives. The response to the fight-or-flight reaction of the limbic systems is to fire many nerve signals throughout the body. There are ways the body sends the signals: by the neurons or the neuropeptides. The neuropetides secret hormones and the neurons are connected to various internal organs. The information is transmitted to the different cell groups. It is like turning a switch "on and off". Kabat-Zinn (1990) postulated that "It may well be that all of our emotion and feeling states are dependent on the secretion of specific neuropeptide hormones under different conditions" (1990, p. 252).

The fight-or-flight response is innate and built into our limbic system and the "mammalian brain" which is the primitive brain connected to emotions. We have a built-in response to danger and threatening events. The amygdala also sends signals to the nervous system. In laboratory settings, rats that have their amydgalas removed do not react to fear (Naparstek, 2004). The body gets ready to react by the process that the sympathetic which is the "speed peddle" the function of the brakes is done by the parasympathetic systems**.** It seems that most persons suffering from sexual abuse trauma live in constant state of arousal. Having been exposed to a traumatic event releases the fight-or-flight alarm reaction, tensing the muscles, releasing hormones and losing their homeostasis (stability).

Dr. Cannon coined the term "homeostasis" to describe the alarm reaction of some systems (Kabat-Zinn, 1990). Dr. Cannon argued that if someone is in constant touch with the emotion that is causing distress, the reaction to the persistency is not going to be removed because the cycle of the "emotional impulse" has not completed its course (p. 261). It appears that people suffering from PTSD are in constant search for stability. That is why there is a theory of the vagus nerve being altered and that relaxation provides a possible way for the nerve to attain normalcy and the body to acquire stability. The vagus nerve is reacted and tenses when the person goes through the fight-or-flight response. The vagus nerve locks in during the freeze response; the body/mind feels unstable and it is in a constant anxious state trying to gain stability. To illustrate this, let's trace the following. Remember the old record players that sometimes would get stuck and the song would be playing over and over again at the same spot? Well, sometimes it took a nudge to get it going again and get unstuck. It is the same with the vagus nerve theory. The vagus nerve is stuck due to the freeze response and it takes an attitude

change the reaction of forgiveness and the emotional catharsis that produce the neurological changes that will get the mind/body unstuck. There are vagus nerve stimulators being used to treat depression, asthma among other disorders. The vagus nerve has been studied by many researchers. Jacobson, (1967), noted that a known doctor by the name of Dr. Lester Dragstedt severed the vagus nerve and attained decreasing repetition potential for a person with ¨peptic ulcer¨ (p. 130). I believe that stimulation of the vagus nerve would also help with treatment of PTSD. It is my opinion that more studies related to the effects of the vagus nerve and PTSD are needed.

The fight-or-flight response is a necessary instinct that provides also positive outcomes. There have been reports of mothers lifting cars to save a child and fireman dashing through flames to save someone trapped in their homes. These people would not have been able to accomplish their feat without the help of the hardwired fight-or-flight response (Kabat-Zinn, 1990).

One of the ways the body protects itself from harm is by using the nervous system. When the body perceives danger, the body gets prepared to fight-or- flight and the parasympathetic system shuts down, (Greenspan, 1997).

Dr. Benson (1985) presented an excellent analogy of how we "turn-on our sympathetic nervous systems through the mind-body connection (p. 97)". Dr. Benson's analogy is:

> When you slam on the breaks in your car, impulses from your brain cause the nerves of the sympathetic nervous system to release adrenaline or noradrenaline, which produces an increased heart rate, higher blood pressure, a faster respiratory rate, more blood flowing to the arm and leg muscles, and a higher metabolism. In an emergency, the action of these substances stimulates your system, to prepare you for "fight-or-flight". These hormones were especially important in helping our ancient ancestors meet the challenges of more primitive times when human beings were hunters facing regular danger from

> wild beasts and predators. Acting as stimulants, they put the human's nerves and muscles "on edge" so that he was ready to repel an aggressor or run away from him. (pp. 98-99)

Researchers have found that long-term activation of the fight-or-flight response leads to hypertension (Benson, 1975). Therefore, it is important that we counterattack the fight-or-flight response.

Dr. Benson expressed his thoughts about the fight-or-flight response and the way to counterattack, as follows:

> Our Western society is oriented only in the direction of eliciting the fight-or-flight response. Unlike the fight-or-fight response, which is repeatedly brought forth as a response to our difficult everyday situation and is elicited without conscious effort, the Relaxation Response can be evoked only if time is set aside and a conscious effort is made. (p. 125)

Eliciting the "relaxation response" which is brought practicing progressive relaxation and guided imagery stops the "vicious cycle by blocking the action of the hormones of the sympathetic nervous system. This blockage prevents anxiety and other harmful effects" (p. 99).

Dr. Benson argues that the "relaxation response" which is assessed by doing progressive relaxation and guided imagery, "may also enhance your belief in your ability to be healed, and an effective treatment may result" (p. 100).

In the physiological aspect, in 1936, Hans Seyle (who was a physician born in Vienna but spent his professional career at McGill University in Montreal) provided the General Adaptation Syndrome, whereby the body goes through a three step process of (a) Stage I, Alarm Reaction: this is where the individual is overwhelmed by a problem (stressor) that is perceived a threat to the homeostasis; the fight-or-flight: response is triggered by our brain (hypothalamus) triggering the sympathetic part of the autonomic nervous system; the trigger activates the adrenal gland to release hormones to the blood and they produce the physiological effects in the

fight-or-flight response (e.g., the heart begins pounding to provide blood to the brain and muscles, breathing is increased to supply more oxygen to the muscles, heart and brain, the blood pressure increases, dilation of pupils, digestive systems slows down, the muscular tenses, and there is increased awareness, attentiveness) and the body is prepared to attack - ready for any real or imagined danger; Stage II, is the resistance stage, the body tries to adapt to the stress and return to normal, but the defenses are almost extinguished. The last stage is the exhaustion which is all of the energy is depleted from the body. The second and last stages are described in the following paragraph.

According to Seyle, we are born with a specific threshold of energy. Remember the topic of thermodynamics on energy postulating that energy cannot be depleted but only be transformed. The universe has the same energy from the beginning of time. An illustrated way is to look at how energy transforms in an internal combustion engine. In a car engine, the gasoline burns and transforms into gases and heat. The engine uses the expansion of the gases in order to produce mechanical work (so the car runs).

Seyle noted that we use some of the energy in our bodies when we go through the fight-or-flight (or freeze) response and the adaptive energy changes. Thus, when our energy supply is drained the obvious would be death (Bright, 1979).

Seyle's studies continued the tract of Dr. Walter Cannon who originally described the fight-or-flight response. However, Seyle continued his research by exposing animals in a laboratory setting to prolonged stress. This led him to develop the second stage of stress, the state of resistance whereby energy is being exhausted in an attempt to adapt the hormones to increase sodium retention and therefore increase blood pressure. The level of adaptation is

dependant on the individual's coping, physical health and the strength of the stressor and, later, to the final stage of exhaustion when all energy is depleted. Seyle's research has proven that the psychological aspect can lead to serious physical aspects even death (Weiten, Wayne, 1998; (Huffman, Vernoy, and Vernoy, 2000).

History of Progressive Relaxation

Progressive relaxation, as described by Edmund Jacobson (1925) is a "method to bring quiet to the nervous system" (p. 73). The patient tenses the muscles or muscle groups to learn the sensations associated with tension in particular muscles, relaxes the muscle tension to recognize the contrast between tension and relaxation, and learns to recognize minute levels of muscle "tenseness" to relax all of the skeletal musculature (Jacobson, 1938 (as quoted in Scheufele, 2000).

A natural state of all humans to rest. Resting has been found to be a natural way of our bodies to cure (Jacobson, 1946). However, Jacobson (1946) noted that although a person might be resting under the premise of being "relaxed", they are still tense. It is very hard to release tension. People deny being tense, full of anger and hurt, and that puts a barrier on releasing tension. (Kabat-Zinn, 1990).

If a person is anxious, that would escalate the physiological and psychological conditions. The word "relax" is used by many clinicians and physicians to inspire calmness to help them downsize their symptoms. Many physicians have reported patients improved with their illness just by relaxing. When we relax our muscles we go to rest (Jacobson, 1946). Relaxation quiets the effect of the nervous system (Jacobson, 1946). Tremors and trembling cease with relaxation.

Beginning in 1908, Edmund Jacobsen found that when he used relaxation techniques on his clients, they were reporting increase progress. He decided to use the scientific methods that led others to investigate the phenomena of relaxation and for the techniques to grow (Jacobson, 1946). He began his research in 1908, at Harvard University. Other researchers also began to experiment on the psychological and physiological response in muscular tensions (Jacobson 1946). All of the early work, helped him determined that the tension was gathered by the shortening of the muscle fibers and that the tension happened due to anxiety as reported by the patients and that removing the tension would decrease the anxiety (Bernstein, 2000). He noticed that if the client would tense and then release different groups of muscles they could eliminate tension and relax. Jacobson published several books on the progressive relaxation technique. His work continued in the Laboratory for Clinical Physiology in Chicago until the 1960s. Jacobson (1946), noticed that his patients were unaware of the tensions in their muscle and how there bodies responded. Furthermore, he concluded that when he would ask his clients to relax, they would only partially relax since there was only small evidence of muscle tension. In addition, he noticed that it was impossible for the muscle to be tensed and relaxed at the same time, he formed the progressive muscular relaxation technique. His patients were trained to voluntarily tense and relax muscles of the body and observe their response thereby relaxing even further.

Every person relaxes when he or she goes to rest. There are those who claim to relax by driving, playing golf or doing a pleasurable activity. Our emotions are inclined to drop when we relax. His work at the clinic proved that the patient who learned how to relax had improved their visceral and also the ¨heart, blood vessels and colon" (Jacobson, 1962, p. 91). There is a connection between the visceral nervous reaction and the central nervous system. If one is

agitated the other becomes agitated and, if one is calm the other is calm (Jacobson, 1962). Jacobson (1962) wrote, ¨The person whose visceral muscles are overtense, as presented in certain states of nervous indigestion, spastic colon, palpitation and other common internal symptoms, shows clearly to any qualified observer that his external muscles also are overtense" (p. 92). He offered his techniques to the public in 1934 with his first book entitled, ¨You Must Relax¨. Latter, in 1938, he finished his research and published his book entitled, ¨Progressive Relaxation¨, where all the procedures and theories are illustrated (Bernstein, 2000). Jacobson´s techniques are easy to learn and are being taught in colleges and universities around America.

Jacobson´s progressive relaxation techniques entail fifteen muscle groups. The training required approximately 56 sessions, however, it sometimes lasted up to 200 sessions (Bernstein, 2000). The therapist's role is to have the client voluntarily tense and release the muscles (Everly and Lasting, 2006).

Progressive relaxation has become a therapeutic tool for therapists to use in their treatment modalities. Furthermore, using progressive relaxation as an intervention tool produces the following: (1) Reduction of tension for therapy communication, (2) Decrease in tension caused physical ailments; and, (3) Removes insomnia (Bernstein, 2000). Currently, there are many variations of the techniques (Seaward, 1999). However, they are all geared to affect the tensing and releasing of muscle and to intercept the stress response by directly influencing the firing of the neurons to the muscles. Seaward (1999) presents a brief synopsis of the original progressive relaxation technique as follows:

1. The progression of muscle groups should start with the lower extremities and move up to the head.
2. Muscle groups should be isolated during the contraction phase, leaving all remaining muscles relaxed.

3. The same muscle groups on both sides of the body should be contracted simultaneously.
4. The contraction should be held for 5 to 10 seconds, with a corresponding relaxation phase of about 45 seconds. (p. 108)

Relaxation training is easy. The client is given the cue to relax. This in itself produces cognitive and physical changes. It has been documented that physicians that encounter an anxious patient, use the word "relax" to help the patient calm down. The client is asked to assume a relaxed condition and to engage in deep breathing. Breathing has been noted as an ingredient in the relaxation process. Breathing is both a voluntary and involuntary function. If you want you can hold your breath (Peters Mayor, 2005). Breathing is a helper in the relaxation process. From the first breath we take when we are born until death, breathing follows our lives (Kabat-Zinn, 1990). We exchange energy while breathing. The body's carbon dioxide molecules and oxygen molecules from our surrounding air are exchanged by breathing. Breathing is very much a part of our emotional chemistry. If we get anxious, our breathing gets faster and we might hyperventilate. If we become stressed, we lose our breath, and during resting periods our breath is slow. We can observe how the relaxation affects visceral activity by looking at the effects of breathing (Poppen, 1998).

After the client is relaxed, they are guided mentally to "let go" by being guided to an enjoyable scene. The client learns how to tighten and relax the muscles. This has an overt effect of their physiological state. The relaxation exercises are being practiced to alleviate many psychological and physiological ailments (Corey, 1996). It is being used to treat stress and anxiety, which are often manifested in psychosomatic symptoms (Corey, 1996). This helps,

other ailments like “high blood pressure, and other cardiovascular problems, migraine headaches, asthma, and insomnia” (p. 291).

One of the most used abbreviated versions of the Jacobson’s original progressive muscle relaxation was developed by Joseph Wolpe. Joseph Wolpe was a South African psychiatrist that started to study the reaction to fear using cats. He found that fear could be removed by inducing an inappropriate reaction in the process of “presenting a feared stimulus” (Bernstein, 2000, p. 6). Wolpe believed that the effects of the relaxation would serve to “countercondition” the tense response (p. 6). Wolpe shortened Jacobson’s progressive relaxation exercises and adapted his “systematic desensitation” technique. Wolpe added to Jacobson’s findings the importance of the therapists involvement in eliciting a response from client’s through progressive relaxation techniques that would reduce the anxiety responses to certain stressors. Jacobson’s (1929, 1938, as quoted in Bernstein, 2000) original procedure emphasized the importance of tensing and releasing dozens of muscle groups and for the client to pay attention to the muscle tensing. It required many months of instructions and training. However, Wolpe shortened Jacobson’s version with his procedures and the shortened version still proved to be effective (Bernstein, 2000; Poppen 1998).

In systematic desensitation, the client is guided to an “anxiety hierarchy (Corey, 1996, p. 293). The client is instructed to keep their eyes closed, and practice progressive relaxation (the abbreviated version) and then, they are presented with the anxiety evoking cue. After, the client practices progressive relaxation technique to regain calmness. Therapy concludes when the client is able to maintain calmness during the triggering of the anxiety producing stressor (Corey, 1996).

The "relaxation response" is another technique which was founded by a Harvard cardiologist, Herbert Benson, M.D., in the late 1960s. Dr. Benson studied transcendental mediation and found that there was reduction in measures of heart rate, blood pressure, respiratory rate and oxygen consumption (Benson, 1975). Dr. Benson described the state as a "relaxation response" and provided that many relaxation techniques induce the relaxation state. Among the relaxation techniques pointed out by Dr. Benson was progressive relaxation and imagery (Benson, 1975). Dr. Benson suggested the relaxation response is the "natural way to counteract increased sympathetic nervous system activity associated with the fight-or-flight response" (p.104). His experiments showed empirical findings that using relaxation response plays significantly in providing positive health and well-being.

Dr. Benson's (1975) relaxation response has four components as outlined below:

(1) A Quiet Environment – a place where there will be no distractions
(2) A Mental Device – a word or phrase repeated to keep focus on one thing
(3) A Passive Attitude – don't worry on performance
(4) A Comfortable Position – sit comfortably in order to maintain good muscle tone. (pp. 112-113)

Progressive relaxation has become a tool for many behavioral and cognitive-behavioral therapists. There has been scientific research demonstrating the profound effects of progressive relaxation to elicit a "relaxation response" (Benson 1975, 1985). Progressive relaxation has been found effective in treatment of "vascular and muscle tension headaches (Blanchard et al., 1991 as quoted in Everly and Lasting 2006), peptic ulcers (Thankachan & Mishra, 1996 as quoted in Everly and Lasting 2006), hypertension" (Argas, Taylor, Kraemer, Southam, & Schneider, 1987 as quoted in Everly and Lasting 2006).

What is Progressive Relaxation

Jacobson (1967) contended that the "Free and independent life" is allied with the nervous system and the neuromusculature (p. 4). He stated that to learn behavior we need to learn how the nervous system works. Most individuals overlook the important contribution of our muscle activities and their connection with emotions. Muscle relaxation provides many physical benefits like, "digestion, blood circulation and blood pressure, the conduct of urine and the secretion and excretion of glandular products" (Jacobson, 1967, p. 63).

It was found that relaxation techniques have been found to be a feasible treatment for conditions such as hypertension, heart disease and cancer (Benson, 1975). The techniques are used by many individuals in the medical field to treat many health problems "including back pain, allergies, fatigue, arthritis, headaches, and high blood pressure (Eisenberg, et al., 1998 (as quoted by Scheufele, 2000)). Relaxing causes opposite physiological reaction than anxiety, "…slow heart rate, increased peripheral blood flow, and neuromuscular stability" (Kaplan and Sadock, 1991).

Other effective methods of relaxation are Yoga and Zen which have been known for centuries to produce health benefits (Kaplan, Sadock, 1991).

Jacobson stated, "A lasting tension and lasting imaging are relevant to emotions". He said, "In sum, residual tension plus imagery is the continuance of past awareness and action, the key to orientative present and to programming for the future" (p. 23). An example of this is when you know that you will be getting a foot massage. Before going to the place, you feel good about the massage, you get relaxed just thinking about the foot massage. Jacobson insists that the muscles are neglected and they are the ones that contribute to all of our movements and emotions. He

disputes that “in man, emotion is always a visceral, but always also a neuromuscular response” (Jacobson, 1967, p. 27). Again, by teaching client the relaxation techniques, they are able to do the exercises without depending on the therapist. Jacobson (1967) said that “imagery triggers the emotional state” (p. 147). However, it is very hard to release tension; people deny being tense, full of anger and hurt, and that puts a barrier on releasing tension (Kabat-Zinn, 1990).

The striated muscles play an important function in the emotional-physical aspect of well being. Findings from studies done by Gellhorn (cited in Jacobson, 1967) stated that with muscle relaxation there is improvement in emotional reactivity. The relaxation exercises are utilized with other techniques that relate to the cognitive aspect of behavior. The rationale behind the beneficial aspects in the use of the relaxation exercises is still a mystery (Scheufele, 2000).

Scheufele (2000) describes that the shortened relaxation exercises being practiced by therapist have been modified to include the therapist making suggestions for the client to relax in a “soft voice” which implies the use of hypnotic suggestions different than the Jacobson’s original progressive relaxation training, which focus was on the muscles (2000). The “relaxation response” is a result of any relaxation exercise (Benson, 1975). Relaxation response” brings forth physical changes and also a reduction in the autonomic nervous system. The cognitive-behavioral model of relaxation (as quoted in Scheufele, 2000), affirms that the effects of “relaxation response” is attained by the involvement of behavior and cognitive structures.

History of Guided Imagery

Throughout history there have been healing rituals that involve the use of imagery. In fact, imagery is the “oldest and most ubiquitous form of medicine” (Rossman, 2000, p. 208). These rituals had healing powers which might be considered today as “placebo effects” to

healing. Rituals of the shamanic traditions used imagery. It was thought that the healers had supernatural powers that would cure or would cause illness to some. For example, in the shamanic tradition, it is customary for the healer to travel to meet with "the spirits or gods that affect health or illness" (p. 209). The trip would bring "altered states of consciousness may involve fasting, sweat lodges, dancing, chanting, drumming, or ingesting hallucigenic plants" (Rossman, 2000, p. 209).

Native American Indians use "sand pictures by slowly placing individual grains of various colored sands into an image that depicts how the illness came about and how it can be healed" (Rossman, 2000, p. 209).

It is the belief of the Indian Hindu culture that the gods send communications using images. Their yogic beliefs are full of methods that use imagery. They practice using breathing and muscle tension to concentrate on the energy of the body and mind. The definition of yoga is "union" and relates to the body, mind and spirit (Rossman, 2000).

For thousands of years, the Chinese use imagery in their practice of medicine for curing. Imagery is used in religious rituals of chi gong, tai chi, where they imitate actions of animals and birds in an effort to fuel energy juices throughout the body. Another culture that employed imagery for healing is the Tibetan. They derive from "colors, sounds, deities, and images" for healing (Rossman, 2000, p. 210).

The beginnings of the Western civilization continued to foster prayer and guided imagery in practices of "healing and medicine". The Judea religion promoted the use of "kavanah, a state of peaceful concentrated awareness, and practitioners used this state to focus on images within the cabalistic model of healing" (Rossman, 2000).

In Egypt, their medicine uses “ritual, sacrifice, prayer, and dream interpretation”. There were other cultures that also used imagery, like in ancient Greece. Hippocrates believed that imagination was a limb like the heart. The Greek’s beliefs focused on the senses and how the senses formed images that remained in the “psyche” which was considered the soul and represented the heart. The ancient Greeks believed that the images resembled emotions that transcended the four “humors” of the human being’s physical health. Galen (129-ca. 199 a.d.), who was a leading authority in Western medicine for “a thousand years” (p. 211), believed that the use of imagination played a key role in disease and cure. Paracelsus, who was physician of the fifteenth century, agreed with Galen and developed holistic methods in medicine. Many of his ways of practice was questioned by others, however, he was valued for the outcome of his practices (Rossman, 2000).

Rene Descartes said that the mind (consciousness) could exist independently of the body (Hospers, 1988). This changed the confines of many philosophers to discover the world free of the religious doctrines that restricted their study. Carl Jung, postulated that the way to the unconscious was through imagery. He designed a technique called “active imagination” that would help tap into the unconscious mind of the person. His method was to have the client “relax and focus their attention on their symptoms and describe the images that came to mind” (Rossman, 2000, p. 213). Psychosynthesis was developed by an Italian psychiatrist name Roberto Assagioli. Psychosynthesis was a method of using imagery to tap into the unconscious for repression, desire and positive attributes like creativeness, vision and philanthropy. His work was influenced by some of the metaphysical teachings. There were many more European visionaries in the imagery school of thought that developed methods with the imagery foundation

(Rossman, 2000). Leaders in the psychology field like William James significantly used imagery in his work. Throughout the twentieth century, the school of thought in psychology was behaviorism. It resulted in the need for academic psychologist to make a science out of psychology (Rossman, 2000). Perhaps, since there were writings by medical doctors as to the unverifiable (phenomenological) data that was being written by those in the psychology field. For more than fifty years, the research was done by "clinical psychologists refer to as a "ratamorphic" view of psychology, being based largely on experiments with laboratory rats running mazes" (p. 214). The United States, R.R. Holt, in 1964, wrote a paper on imagery, entitled, "Imagery: The Return of the Ostracized" that revived the interest in imagery. Many "psychologists such as Arnold Lazarus, Akhter Ahsen, and Joseph Shorr began once again to develop, research, and write about imagery applications in psychology and mind/body medicine" (Rossman, 2000, p.214). In the late 1960s, an oncologist by the name of O. Carl Simonton and his wife Stephanie, began to treat some of their cancer patients with relaxation and imagery. They were astonished with the results and reported to the public, their positive results in using imagery and "visualization to stimulate the immune response" with cancer patients (p. 215). Although the Simonton report created much controversy, it did not generate any studies in the area of imagery. However, in 1980, the field of "psychoneuroimmunology inspired studies that corroborated the Simonton findings, e.g., "that people can stimulate their immune response through imagery" (p. 215). Simonton developed a rating scale for use with cancer patients called the "Image CA" which focused on imagery. "They found that certain aspects of the imagery work may predict clinical outcome, and they have developed similar scales and imagery

interventions in the areas of chronic pain, diabetes, and spinal injuries as well as cancer" (Rossman, 2000, p. 215).

The work on the up-and-coming field of psychoneruoimmunology has found that using relaxation and imagery increases a person's immune system (Rossman, 2000).

It was found in a study by the University of California, that using guided imagery resulted in reducing the adverse effects of various medical treatment "from childbirth and delivery to MRIs, chemotherapy, biopsies, and radiation treatments" (Rossman, 2000, p. 233). Imagery is not a panacea. However, a vast majority of studies, (Naparstek, 1994, 2004; Kabat-Zinn, 1990) have confirmed the efficacy of guided imagery in reducing symptoms and improving psychological aspects.

Using guided imagery has produced profound effects on reducing symptoms of "depression, anxiety, blood pressure, cholesterol, lipid peroxides, healing from cuts, fractures, burns; shortened the hospital stay for surgery patients, improve immune systems, reduce arthritis pain, lower hemoglobin A1c in diabetics, improve motor deficits in stroke patients, reduce fear in children undergoing MRIs and needles, control symptoms of eating disorders (bulimia, anorexia), improved success rate of infertile couples, accelerated the weight loss, improved concentration in developmentally disable adults" (Naparstek, 2004, p. 149). I wonder why this technique has not become the general health and therapy method to use in treatment.

Imagery forms part of the right hemisphere of the brain " it is taken by the way of primitive, sensory, and emotion-based channels in the brain and nervous system, using our capacity for sensing, perceiving, feeling, and apprehending rather than our left-brain thinking, judging, analyzing, and deciding" (Naparstek, 2004, p. 150). Due to the way imagery is

processed in the right hemisphere, imagery is a perfect technique to use in the treatment of PTSD. The effectiveness of using imagery lies in part because of the way it presents "linear thinking and logical assumptions and sends its healing messages straight into the center of the whole person where it can affect unconscious assumptions and jostle defeating self-concepts, while floating soft, appealing reminders of health, strength, meaning, and hope" (p. 150). Naparstek (2004) sees it healing every "surface of the muscle tissue and bone, all the way down into the cells, where it tweeks the DNA into remembering its original miraculous blueprint" (p. 150).

Some studies have proven that guided imagery is effective in producing "visceral and verbal responses appropriate to the scenes described" (Poppen, 1998, p. 24).

The positive results of using guided imagery have been demonstrated by many. It is no wonder that Utay and Miller (2006) endorsed its use and declared that guided imagery "has earned the right to be considered a research-based approach to helping" (p. 40).

The victims of trauma need to gain some of their self-efficacy through their choice of imagery and voluntarily wanting to forgive. Guided imagery alters the neuronal structure of the brain and influences the healing process. The guided imagery intervention is important in the treatment of trauma.

What is Guided Imagery

Guided imagery is the process of voluntarily employing your imagination to influence the mind and body to heal. We are all capable of being influenced. In fact, "suggestibility is inherent in human nature" (Kapko, 1994, p. 91). It is like daydreaming. There are different mental states produced with our thoughts. For instance, hearing a sad story or seeing a sad movie would

perhaps affect us emotionally. At the same time, when a team is getting ready for a game and the coach provides the players with a pep talk, the players are motivated to play better. If someone provides an inspirational speech, we might feel inspired. Also, seeing funny movies might induce us to laugh. With guided imagery, the individual would be guided to a specific safe place, and the most interesting part, is that the person is visualizing the place voluntarily.

The imagination is being persuaded during our life time. When we are watching a movie or reading a book, we are provided with details and emotional components that bring life to the protagonist. Some people are influenced by watching movies like "Jaws" and when they go to the beach, they think about the shark attack producing fear of going into the water and may even have nightmares.

Experiences using our senses can bring back an image of walking on the beach, running through the woods, the smell of wood burning. However, these experiences are unique to the individual (Dachman and Lyons, 1990).

I concur with ideas expressed by Naparstek's (2004) in her book "Invisible Heroes", that imagery is eminent in the treatment of trauma. She provided various principles about imagery, e.g., "Our bodies don't discriminate between sensory images in the mind and what we call reality" (p. 18). She noted many studies done in the area or imagery producing profound effects in the body and illnesses (e.g., elevating levels of immunoglobulin A and histamine response to poison ivy and even breast enlargement). Moreover, she adds that when the person is in the relaxed state they are able to heal, grow, learn and change. I agree with her thinking that we feel better when we have a "sense of mastery over what is happening to us" (p. 26). The client is voluntarily affecting their reality, and it is beneficial. As the person is guided through

the imagery, they are producing the effects and consent to the treatment. Children respond well to imagery (Naparstek, 1994). Using my method as a treatment approach with children has been successful in many of the sexual abuse/PTSD clients.

Guided imagery activates the body's chemical blood and this reaction establishes that "the mind is not limited to the brain; the mind is part and parcel of the whole body" (Naparstek, 2004, p.209). Images have strong influence over the body and can affect the healing process. Images in the mind are genuine actions in the physical body. For example, it is like when you imagine a tree, the leaves and the way it feels. Or imagine the emotions of taking a test, or the emotions of going to your grandmother's home.

Kaplan and Sadock (1991) endorsed imagery as a relaxation method where a person is instructed to see themselves in an enjoyable and peaceful place and with this they will enter the relaxation state of mind/body or, as Dr. Benson (1975) puts it, the "relaxation response" (1991). There are therapists that use guided imagery to help trauma victims relief emotional pain such as fear, rage and confusion they were experiencing at the moment of the trauma (Naparstek, 2004, p. 40). People attain a "split-consciousness" when they are relaxed and the person goes consciously somewhere else which makes the experience tolerable (Naparstek, 2004, p. 40). The guided imagery script I use has several symbolic tools which help the client interact in resolving their internal conflict, feel self-efficacy while they are promoting their healing. One of the symbols is a door. When they walk through the door, they will be able to face their fear and control their exposure. The next symbolic reference is the garden, where they will feel safe and peaceful and where they would tolerate visualizing the perpetrator and would be able to process forgiveness.

The guided imagery tool goes to the right side of the brain, influencing the nervous system and fostering healing. It helps the person achieve compassion (Naparstek, 2004). Many authors advocate the use of visualizations and imagery for healing to be successful (Kabat-Zinn,1990; Naparstek, 1984, 2004; Rossman, 2004).

Studies Using Progressive Relaxation and Guided Imagery

The use of progressive relaxation and guided imagery has proven to be a successful technique to use in therapy. In this section of the dissertation, I provide various research papers supporting the efficacy of progressive relaxation and guided imagery in treatment modalities.

There was a study done in the Vanderbilt University to explore the efficacy of relaxation training and guided imaging in reducing the aversiveness of cancer chemotherapy (Lyles Naramore et al., 1982). The group of researchers studied a group of 50 patients being treated with chemotherapy. These patients were under two treatment processes; a group of about 25 were receiving the chemotherapy by push injections, the other group of 25 by drip infusion. The results of the study found relaxation and guided imagery a viable approach for cancer patients to deal with the unfavorable side-effects of chemotherapy (Lyles Naramore et al., 1982).

Petroff and Teich (2003) provided an article addressing the importance of using relaxation and guided imagery to help deaf-blind with self-control to situations. They wrote that relaxation and guided imagery are key elements to use with the people who are deaf-blind in interventions of maladaptive reaction caused by stressful event. The article illustrates the positive effects of using relaxation and guided imagery to help the deaf-blind population achieve self-control and integrate in our society (Petroff and Teich, 2003).

A school-based intervention study for children with asthma was conducted by a group from the University of Connecticut. Four middle school children with asthma were studied o determine the effects of relaxation and guided imagery on lung function, force expiratory flow and anxiety. The findings demonstrated that "forced expiratory volume" increased and anxiety decreased in all the children with the use of relaxation and guided imagery. Additionally, they argued that the use of relaxation and guided imagery alone can be a successful intervention in improving the operation of the lungs and alleviating anxiety (Peck, Bray and Kehle, 2003).

In a study at a laboratory setting, a group of researchers investigated the different aspects of altered states including the physiological, neurological and behavior. The study concluded that the techniques provoked a relaxation response and that relaxation techniques are helpful and important tools to add when provoking an altered state of consciousness (Vaitl et al., 2006).

Scogin et al. (1992) studied the effects of using progressive and imaginal relaxation in reducing anxiety in elderly persons. The imaginal relaxation is different that progressive relaxation since it does not require the tensing and releasing of the muscles. They found that relaxation exercises with the older adults resulted in their decreasing anxiety. They also noted that the group which tensed and released the muscles showed the same relaxation than those that imagined the muscle tension. This report supports that imagery is a powerful tool in therapy (1992).

Becht (1982) in a doctoral dissertation investigated the effects of using deep muscle relaxation with positive imagery and cognitive meditative therapy in treating stress from subjective continuous tinnitus in hearing adults. Her results revealed the use of deep muscle

relaxation with positive imagery and cognitive meditative therapy as a successful intervention in "relieving awareness of tinnitus" as well as provides the individuals with coping tools (Becht, p. v).

In a doctoral dissertation, Richardson (1997) tested the effects of using progressive relaxation and guided imagery on critically ill persons suffering from insomnia. Her paper presented many studies that used either progressive relaxation together with guided imagery or progressive relaxation or guided imagery by itself and their efficacy in interventions. The results pointed out that the use of these techniques vastly improved the sleep of "patients with pulmonary disease, on men following one exposure, and on women following two exposures" (p. 217).

The information presented above validates the efficacy of using progressive relaxation and guided imagery in therapy.

Studies Using Progressive Relaxation

Researchers have demonstrated that loneliness, separation and divorce are related to people having lower immune levels and that by practicing relaxation, they increase their immune levels. These studies on immune levels are important due to their role in combating diseases like cancer and viral infections (Kabat-Zinn, 1990).

A Swedish group studied the effects of using floatation-rest in a floatation tank in eliciting the relaxation response and lowering stress related psychological and physical symptoms. The study had two purposes: (1) to confirm the results of a previous study on the efficacy of the use of the floatation tank in treatment approach and, (2) to determine the long-lasting effects of treatment. The researchers noted that people develop psychological and

physiological symptoms effecting arousal to the central nervous system by the overwhelming amount stimuli and information in the environment. The body gets into the fight-or-flight response. This is automatic, as we are hardwired for this through our autonomic nervous system. The latter produces psychological and physiological illnesses. The results of using the floating tank in eliciting relaxation response and thereby lowering stress were successful (Bood, et al., 2006).

Nakaya et al. (2004) investigated the psychological effects of muscle relaxation on juvenile delinquents. The study employed 16 juvenile delinquents who were subject to practicing muscle relaxation for 4 weeks. The findings indicated that there was "improved frustration tolerance" in the group of juvenile delinquents. Therefore, suggesting that muscle relaxation is a viable tool for therapy inducing "frustration tolerance" for juvenile delinquents (p.179).

Rausch, Gramling, and Auerbach (2006) evaluated the efficacy of group meditation and progressive relaxation training for stress reduction, reactivity and recovery within a single group session. A group of 378 undergraduate students were subjected to the study using 20 minutes of progressive muscle relaxation or 20 minutes of meditation, then, being exposed to 1 minute of stress and then 10 minutes of intervention. The results indicated that there was a decline in anxiety in the group that were subjected to meditation and progressive relaxation. It was also found that progressive muscle relaxation produced reduction of anxiety immediately (2006).

Scheufele (2000) studied the effects of classical music to use in combination with progressive relaxation to reduce stress reaction. There were 67 male participants subjected to this research. The results indicated that progressive relaxation significantly affected the

physiological response by reducing arousal. The report also suggested that by practicing progressive relaxation, the individual is persuaded to relax and this in itself produces relaxation (2000).

Everly and Lasting (2006) reviewed various studies that used behavioral techniques. Their review focused on determining the efficacy of different techniques in the capacity to produce: (1) An opposing therapeutic effect that serves to lower physiological arousal and reduce the intensity of the neurological hypersensitivity; and (2) A therapeutic increase in self-efficacy and self-control as a result of their ability to serve as a means of physiological self-regulation (2006). In their investigation, with breathing, Everly and Lasting (2006) found that breathing provokes relaxation in an automatic way. Their findings in a study related to progressive relaxation and demonstrated that muscle relaxation produces a "relaxation response". They concluded that using relaxation would provide efficacy to any therapeutic work (2006).

From a chapter in a book entitled "Relaxation and Sleep" (Griffith, 1934), the author asserted that sleep is a normal function for an individual to get rest. At the same time, using progressive relaxation techniques induces relaxation and rest by relaxing the muscles and that this technique can be done anytime during the day. Consequently, many of those suffering from insomnia benefit from the use of progressive relaxation techniques to help relax and stop their mental activity. Griffith (1934) noted that most people who cannot sleep believe that it is due to the mind chattel (ruminations). Hence, it seems that by utilizing the relaxation techniques, the mental activity stops and the individual is able to sleep.

The studies presented in the preceding section support the efficacy of using relaxation in therapy.

Studies Using Guided Imagery

A study performed on the use of imagery and the effects on hyperventilation proposed that hyperventilation has been considered to be part of the fight-or-flight response. This study provided participants three scripts depicting the following themes: relaxing, fearful, depressive, and pleasant situations. They noted that feeling anxious had been linked to many illnesses. They argued that when an emotional event is stored in memory, the information is registered in memory as a concept and that is when there is anything remote that might remind the individual of the event, they will have an automatic physiological reaction resembling the actual event. The results of the study found that hyperventilation reaction is set-off by the imagery provided in the scripts "with and without response information" (Van Diest, Proot, Van de Woestijne, 2001, p.635). The findings confirm that imagery can produce physiological reactions.

Utay and Miller (2006) presented a comprehensive review of the effectiveness of guided imagery as a therapeutic tool. They noted that guided imagery is being used in the medical field to help cancer patients, patients who suffered a stroke and also those patients with stomach pain (2006). They reported that guided imagery is being used to "improve motivation and performance" in sports training (p.3). Another research study that they mention, was one done by Hill (2001) (as quoted in Utay and Miller, 2006, p. 42), where the treatment was focused on eating disorders. The use of guided imagery as an intervention tool resulted in helping the clients with their eating disorders. The overview of guided imagery provided by Utay and Miller (2006) established that guided imagery is an effective technique to treat physiological and psychological problems.

Studies have shown that guided imagery creates "visceral and verbal responses appropriate to the scenes described "(Carroll, Marzillier, & Merian, 1982; Dadds, Bovbjerg, Redd, & Cutmore, 1997; Lang, 1979; as quoted in Poppen 2006).

Wish (1975) provided a comprehensive paper describing the successful outcome he attained in using imagery techniques in treatment of sexual dysfunction. The author concluded that using imagery and a combination of other procedures, is a "powerful tool" for therapists (p. 54).

In conclusion, these studies presented that using guided imagery provides therapeutic benefits.

Forgiveness

"Forgiveness is a process, not an event" (Dayton, 2003, p. 56).

There is empirical research providing that forgiveness is an important intervention tool in treating sexual abuse. However, forgiveness intervention is not being used in therapy to treat sexual abuse (Walton, 2005). I concur with the various points made by Dr. Walton (2005) that by providing forgiveness interventions to the sexual abuse victims, they will display changes in their attitudes. Some of those changes according to Dr. Walton (2005) are:

1. She might take action in bringing the offender to justice;
2. She might feel motivated to reach out to the offender and develop or restore a healthy relationship; or
3. She might be free of the link she has had to the offender – he no longer occupies space in her life and her mind. (p.205)

Dr. Jensen (2000) points out that researchers have demonstrated the benefits of using forgiveness interventions in producing positive health benefits and putting a stop to any alteration in the physiological chemistry of the body (2000).

Victor Frankl's famous quote communicates the importance of presenting the forgiveness ingredient to therapy methods when he said, "What is to give light must endure the burning". In my approach, I employ forgiveness as an emotional tool to invoke change and promote healing of psychological pain. It has been proven that forgiveness therapy is a practical instrument to use in therapy (Konstam et al., 2000).

Dayton (2003) claims that we go through several phases during the process of "letting go". As we gain insight on the pieces of the puzzle that we had buried into the onion, we start becoming more complete, like we grow the roots of forgiveness and the plant starts growing. The process of forgiveness is everlasting. Similarly, in compassion, the inclination is for the "impulse to reach out to mitigate the other's plight, to help the other person, to express sympathy, and yet to maintain sufficient detachment to avoid being overwhelmed with distress ourselves" (Lazarus, 1991, p. 290).

Enright and Fizgibbons (2000) emphasize that it is imperative that the therapist provides the victim with an understanding of the definition of forgiveness. The victim needs to realize that the person they trusted is still the same person, although they became the perpetrator. Just because the person had a mustache, and now the person removed the mustache, the person is still the same person. For example, if the perpetrator is the victim's father, he is still the father. But, forgiving is not downplaying the abuse or forgetting the action. Most people do not know what forgiveness means. They believe it is forgetting or dismissing the abuse. There are many cases where forgiveness played a major role in client's succeeding in treatment (Enright and Fizgibbons, 2000). In their "Process Model of Forgiveness Therapy", Enright and Fizgibbons (2000) provide a comprehensive methodology to follow for therapeutic work in many modalities.

They present the “Goals of the Phases of Forgiveness” and “The Phases and Units of Forgiving and the Issues Involved”, as follows:

Goals of the Phases of Forgiveness:

Phase	Goal
Uncovering	Client gains insight into whether and how the injustice and subsequent injury have compromised his or her life.
Decision	Client gains an accurate understanding o the nature of forgiveness and makes a decision to commit to forgiving on the basis of this understanding.
Work	Client gains a cognitive understanding of the offender and begins to view the offender in a new light, resulting in positive change in affect about the offender, about the self, and about the relationship.
Deepening	Client finds increasing meaning in the suffering, feels more connected with others, and experiences decreased negative affect and. At times, renewed purpose in life. (p.67)

The Phases and Units of Forgiving and the Issues Involved:

Uncovering Phase:

1. Examination of psychological defenses and the issues involved (Kiel, 1986)
2. Confrontation of anger; the point is to release, not harbor, the anger (Trainer, 1981/1984)
3. Admittance of shame, when this is appropriate (Patton, 1985)
4. Awareness of depleted emotional energy (Droll, 1984/1985)
5. Insight that the injured party may be comparing self with the injurer (Kiel, 1986)
6. Insight that the injured party may be comparing self with the injurer (Kiel, 1986)
7. Realization that oneself may be permanently and adversely changed by the injury (Close, 1970)
8. Insight into a possibly altered “just world” view (Flanigan, 1987)

Decision Phase:

9. A change of heart-conversion/new insights that old resolution strategies are not working (North, 1987)
10. Willingness to consider forgiveness as an option (Enright, Freedman & Rique, 1988)
11. Commitment to forgive the offender (Neblett, 1974)

Work Phase:

12. Reframing, through role-taking, who the wrongdoer is by viewing him or her in context (M. Smith, 1981)
13. Empathy and compassion toward the offender (Cunningham, 1985; Droll, 1984/1985)
14. Bearing/accepting the pain (Begin, 1988)
15. Giving a moral gift to the offender (North, 1987)

Deepening Phase:

16. Finding meaning for self and others in the suffering and in the forgiveness process (Frankl, 1959)
17. Realization that self has needed others' forgiveness in the past (Cunningham, 1985)
18. Insight that one is not alone (universality, support) (Enright et al., 1998)
19. Realization that self may have a new purpose in life because of the injury (Enright, et al., 1998)
20. Awareness of decreased negative affect and, perhaps, increased positive affect, if this begins to emerge, toward the injurer; awareness of internal, emotional release (Smedes, 1984) (p. 68)

A client that comes to therapy with the conclusion that they have been "wronged" and that they need to do something about it, will result in a successful therapeutic response (Enright and Fizgibbons, 2000, p. 69). However, the latter is not the case in most instances. There is information on the emotional drain that the victim carries due to the emotions related to the abuse. One method for a therapist to employ, is to tell the victim they are wasting an enormous amount of their energy and they are not resolving the problem (Enright and Fizgibbons, 2000).

In another chapter, Enright and Fitzgibbons (2000) provide a thorough reviewed on five studies that presented empirical results on forgiveness therapy. The results demonstrated that forgiveness therapy is a important intervention tool.

The victim will need to reforgive the same hurt many times because the "layers of the onion" must be peeled. The roots of repression have grown and we need to pull the roots out. It is not one thing to forgive, there are many and forgiveness is a growth process. Every time we forgive it will be different (Dayton, 2003).

"Letting go" are words that describe the feelings that victims of trauma related sexual abuse share when they undergo the techniques of progressive relaxation, guided imagery and forgiveness. Kabat-Zinn (1990) writes that "Letting go is a way of letting things be, of accepting

things as they are" (pg. 40). The experience of letting go is not strange to us, we practice it every night when we go to sleep. We let our mind and body rest, we let go. Because, if you do not let go, you would not sleep (Kabat-Zinn, 1990). An important emotional instrument is compassion and it can be achieved through imagery. One way of achieving compassion, is by encouraging the client to consider that the perpetrator did not know what they were doing (Naparstek, 2004).

Forgiveness is an important ingredient in therapy. It fits into the spiritual aspect of the intervention. I like the profound thoughts expressed by Smedes (1984) in his book, "Forgive & Forget: Healing the Hurts We Don't Deserve" which I have adapted as follows:

1. We accept people for the good they are to us.
2. We forgive for the bad they did.
3. Forgiving takes time; it goes slowly .
4. Forgiving replaces confusion – who did what to whom and when and how.
5. You are not a failure at forgiving just because you are angry. (pp. 48-95)

CHAPTER 4

TRAUMA RELATED SEXUAL ABUSE TREATMENT

In this section, I will discuss the treatment rationale, the assessment, treatment process, and the role of the therapeutic alliance in the treatment of sexual abuse. In order to provide the techniques in a structured way, I combined progressive relaxation, guided imagery with forgiveness in what I term the Holographic Therapeutic Framework (HTF). The foundation for developing the holographic therapeutic framework will be explained as well as step-by-step instructions on the therapy sessions, the progressive relaxation exercise and guided imagery (forgiveness) script. Finally, the last section reveals the effects of alpha waves in lowering resistance to attitude change.

Treatment Rationale

I concur with Van der Hart and Steele (1997) who emphasized that the focus of therapy be put on the uniqueness of the individual, not on the approaches for treating trauma. In this regard, they note that some trauma survivors will need just a few sessions while others might benefit from going through a process of interventions and sessions (Van der Hart and Steele, 1997). In my practical experience using relaxation and imagery and forgiveness, there are clients who feel revived with just one session. They tell me, “I feel like I have let go a lot”.

There are some biases regarding trauma survivors’ recollection of their abuse (Yapko, 1994). When an individual is submerged in an overwhelming event where they dissociate or repress in order to cope, there seems to be part of the event that has been lost. When relating their traumatic experience, their representation of the event might be somewhat different than

what actually happened (Yapko, 1994; Van der Hart and Steele, 1997). However, if the person improves in their affective and physical aspects, and they reduce their problems, I believe that progress has been achieved and that is the focus of therapy. The therapist' job is for the client to improve his psychological and physiological symptoms and learn to use coping tools. Positive results are important to me. The fact that the story behind the trauma is not accurate, does not concern me in the least. I am vested only with the trauma and the client's recovery. Van der Hart and Steele (1997) confirm that, "Traumatic memory is a representation of a traumatic state of consciousness, and should not be viewed as a literal replication of an event" (p. 534).

Trauma treatment is being discounted by psychologists due to the time limits being imposed by managed care for interventions. Treatment strategies for trauma have been "focused primarily on the problems of fear, anxiety, and hyperarousal (Goldsmith, Barlow and Freyd, 2004).

In Chapter 10 of their book, "Neurologic Desensitization in Treatment of Posttraumatic Stress: Personality-Guided Therapy for Posttraumatic Stress", Everly and Lasting (2006) pointed out that PTSD is due to the tremendous amount of stimulus to the limbic system and the arousal autonomic nervous system basically the sympathetic nervous system thus the individual might develop a disorder called "behavioral sensitization" (p.16). This disorder is due to the repeated arousal to the limbic system. Everly and Lating also mentioned that the "relaxation response" (Benson, 1975; 1985) is important to use as an intervention technique to induce a "neurologic desensitation" which is ideal for treating PTSD. The best treatment for PTSD is one where the client systematically accomplishes treatment and healing. Important in therapy is the victim's role of gaining control with their therapy, by dealing with their trauma in a relaxed state, where

the alpha waves have increased and they are able to be less resistant to change (Everly and Lating, 2006).

In another chapter from a book entitled “Relaxation and Sleep”, the author asserted that sleep is a normal function in order for an individual to get rest. Also that using the progressive relaxation technique induces relaxation and rest by relaxing the muscles. The beauty of relaxation is that it can be done anytime during the day. Many individuals suffering from insomnia benefit from using of progressive relaxation techniques to help them relax and stop their mental activity (Griffith, 1934). Many people who cannot sleep report that it is due to their ruminations. Indeed, it seems that by utilizing the relaxation techniques the mental activity stops and the person reports getting their rest (Griffith, 1934).

People who undergo the traumatic experience of sexual abuse do not disclose because they feel shame, hurt and self-blame regarding the abuse. The victims are unaware that their psychological problems are related to the abuse (Barlow, 2001). They are afraid to talk about their abuse, due to any previous doubts or blame inflicted on them by others whom they trusted with their secret. They bury the reminders. Some of the victims downplay their abuse.

Due to the intense emotional anxiety experienced by the trauma, the individual dissociates or represses the emotions, because it would damage their ego, they would not be able to survive, and it would kill them emotionally. With this said, I ask, what would be the treatment for someone who dissociates or represses? The answer is a place where they feel safe within themselves, where they are able to face all of the emotions, the relaxation response (Benson, 1975:1985) state where the alpha waves are higher and the resistance is down. My therapy approach offers the victim of trauma related sexual abuse the antidote.

Assessment Phase

Client undergoes a Psychosocial History assessment that is customary to all clients. The outcome is to work with the client in setting goals for their future and developing coping. Since the person is relaxed, they will be open and receptive to accept the thought of forgiveness.

Treatment Process

1. Establish rapport
2. Resonance board – hear client, listen to them
3. Explain treatment rationale – They have a great asset: "free will" "freedom of choice" and praise them for having taken the first step – by coming to therapy. Explain the treatment will be focused on doing relaxation and imagery techniques. Give them verbal information on the techniques being used and provide them with a copy to take home.
4. Inform client on the positive results of others using these techniques
5. Educate the client on the "fight-or-flight" response; the person's predisposing aspects to the trauma response, on the connectedness of the mind-body and on sexual abuse traumas' association with diseases such as depression, anxiety, asthma, rheumatoid arthritis, diabetes, cancer, insomnia, hypertension, etc.

Therapeutic Alliance

People that undergo a traumatic experience, require therapy to be focused on building their sense of safety. A therapeutic relationship providing nurturing and security is eminent (Greenspan, 1997).

In my opinion, therapy is much more than using techniques to help the client. The therapeutic alliance is key to developing a collaborative effort with the client. My focus is on

the client's needs, using interventions from all schools of thoughts with emphasis on the Carl Roger's therapeutic approach - the "Person-Centered Therapy".

Carl Rogers (1961) explained that individuals that come to therapy are searching to find themselves. He emphasizes the importance of providing a safe harbor for the client to create a place where the client is not judged. Traumatized client's need to have this place where they will be free to be themselves. Roger pointed out that clients start to change when they "…find themselves involved in removing the false faces which they had not known were false faces. For the most part, I try to avoid structuring the therapy and focus on listening to the client and being empathetic. The framework is humanistic as it fosters that the client focuses on being free and become themselves again. Client is provided with unconditional positive regard, empathy, trust, understanding and acceptance. The focus is on the person; on their moving away from their fears to a safe environment (Rogers, 1961).

Doctors may not receive enough training in the way to help their patients look for the inner resources for cure. The person's emotional mode and family and friends support plays role in the healing process of the patient. Kabat-Zinn (1990) describes that "A cardinal aphorism of traditional medicine has always been that "care of the patient requires caring for the patient (p.193).

Goldsmith, Barlow and Freyd (2004) insist that therapist needs to check their personal biases at the door when treating victims of trauma. They stipulated the following regarding establishing the proper therapeutic environment:

> When therapists provide safe environments for clients' exploration of their experiences, tolerate strong affect, respond empathically, facilitate shareability, and respect clients as the experts on their own memories and feelings, they create a setting vastly different from the individuals' traumatic childhood, and often subsequent environments. (p.455)

Some therapist provide a safe environment for the clients to process their trauma, while others take a more directive approach and confront the problem directly. The therapeutic alliance is critical in every psychotherapy approach (Goldsmith, Barlow and Freyd, 2004).

Holographic Therapeutic Framework (HTF)

Talbot (1991) describes that, "A hologram is produced when a single laser light beam is split into two separate beams. The first beam is bounced off the object to be photographed. Then the second beam is allowed to collide with the reflected light of the first. When this happens, they create an interference pattern, which is then recorded on a piece of film" (p.14). When another laser beam passes through the film, a three dimensional image is created. However, what is amazing about the holograms is that if the film containing the holographic picture is cut in pieces and any of these pieces is illuminated by the laser, the image of the whole object will still be projected. In other words, unlike normal photographs, every small fragment of a piece of holographic film contains all the information recorded in the whole (Talbot, 1991).

As mentioned before, the sexual abuse victim brings only fragments of the trauma to therapy. Based on the holographic metaphor, the fragments contain the whole information. The fragments brought by the victim, contain the whole sexual abuse trauma. Using HTF, the victim is able to work with fragments of the abuse. The three-dimensional approach intervention techniques of progressive relaxation, guided imagery with forgiveness have the direct characteristics of a hologram to produce a complete therapeutic approach.

In therapy, a hologram represents the interconnectedness of all the parts that produce change. The famous Swiss psychiatrist Carl Jung postulated that we all share our dreams, myths, hallucinations, and religious visions in what he called the "collective unconsciousness" (Talbot,

1991, p.60). Dr. Grof (1990) explains that in therapy, change and healing is derived from the collective unconscious and not the therapist. The role of the therapist is "someone who intelligently cooperates with the inner healing forces of the client" (p. 211). I agree with Dr. Grof (1990) that the holographic model presents the possibility of understanding the connection between the "parts and the whole".

I believe that sexual abuse trauma has to be looked at in a holographic "wholeness" way for treatment to work. My eyes have seen the positive results achieved by using the methods presented in this paper. The therapy approach for sexual abuse trauma has to contain components that will address both the psychological and physiological needs of the individual. The therapy approach which is presented in this paper addresses these elements by working on the body with relaxation techniques, with the mind with guided imagery and finally, it addresses a key ingredient like sugar is to a recipe, the trauma (the hurt) so that it heals through forgiveness.

The Holographic Therapeutic Framework (HTF) takes into account the person as a whole. It is a brief, unstructured, directive, psychoeducational, shared and energetic framework that utilizes progressive relaxation, guided imagery techniques with forgiveness to treat trauma victims of sexual abuse. All techniques being used in this therapy model have been tested in empirical studies (as noted in the literature review) and conclusions have been favorable in using these techniques in therapy to achieve positive treatment results.

Itemized below is the process to follow:

(1) Therapeutic alliance – establishment of trust and providing a safe environment

(2) Psychoeducational – explaining to client the fight-or-flight response their power to heal

(3) Training – showing them how to do the breathing, relaxation and imagery exercises

(4) Praise – providing support

(5) The use of progressive relaxation

(6) The use of guided imagery

(7) Give client the opportunity to forgive

(8) Homework – relaxation and imagery exercises to practice at home

(9) Termination and commitment to use the tools they have learned for the future

Following, are further definitions of the procedures of this therapy structure:

(1) Therapeutic Alliance: The therapist provides the victim of sexual abuse with unconditional positive regard, validates their feelings, a trusting attitude and a safe place.

(2) Praise: The therapist encourages participation and provides client with words that will inspire the client to achieve a successful treatment goal.

(3) Psychoeducational/training: The client is to be informed about the fight-of-flight response, the disorders that develop due to the freeze response. The client learns how to use progressive relaxation and imagery to use in coping with triggers, life stressors, anxiety and for good health benefits. The client is empowered through their self-efficacy belief system, by providing them with tools to successfully heal. The therapist creates a safe place where the client will be able to deal with the trauma.

(4) The Use of Progressive Relaxation: Explain to client that the exercises have been found effective in treating an array of psychological and physiological disorders. Let she/he know about the "relaxation response" that will be elicited by doing the relaxation and imagery

exercises which counteracts the PTSD response. Practice the brief progressive relaxation exercises with client (see Appendix C).

(5) The Use of Guided Imagery: Explain the benefits about guided imagery, e.g., that she/he will be eliciting the "relaxation response" which counteracts the PTSD response. Practice the guided imagery exercise with the client (see Appendix D).

(6) Give the client the Opportunity to Forgive: In a study that investigated the relationships between survivors of sexual abuse and forgiveness, it was found by Beckenbach (2002), that forgiveness is an important treatment tool for survivors of sexual abuse. The client is to be explained the definition of forgiveness (e.g., forgiveness is not forgetting, discounting or reconciliation, but an act to free themselves from the chains of the perpetrator). Present she/he with the rationale of not wasting too much energy dealing with this problem.

(7) Homework: The client is to understand that the homework will result in achieving their therapy goals faster. The client is to practice the progressive relaxation exercises on a daily basis. For example, if actors on the theatre do not read their lines and practice or do not do their homework, they would not function correctly in the theatre. The client is to be encouraged to maintain the same attitude as the actors and do the homework assignments. Also, the client must be encouraged to monitor how they felt each day before and after the completion of the exercises (Appendices A & B).

(8) Termination and Relapse Coping: The termination is accomplished by client's self-report and observations by therapist. Accomplishments made will be pointed out to client and the sessions that started as a once a week, turn to once every other week, and so on. The therapist assigns the responsibility to the client of monitoring their moods. If client

experiences flashbacks or nightmares, they should employ the exercises they have learned to gain "relaxation response" and cope. They are also welcome to make an appointment to see the therapist for "refresher" training on relaxation any time they wish.

Step-by-Step Process of Sessions (Sessions I through VI)

The Holographic Therapeutic Framework (HTF) is a structured way of using the progressive relaxation, guided imagery techniques with forgiveness. Presented below, is the step-by-step process to follow in treatment:

Session I

1. Established rapport
   a. Trust and safe environment
   b. Therapist role is as a facilitator
   c. The client must feel empowered to achieve a successful treatment
2. Outline treatment program and goals
   a. Introduce progressive relaxation and explain how it works
   b. Introduce guided imagery and explain how it works
   c. Explain how using progressive relaxation and guided imagery elicits the "relaxation response"
   c. Ask client how they are feeling – explain their symptoms
   d. Explain the physiological and psychological implications of trauma related to sexual abuse
   d. Explain the fight-or-flight response
   e. Explain the freeze response
   f. If client has dissociated, explain why this happens

3. Emphasize the importance of homework

Session II

1. Ask the client how they feel
2. Train the client on breathing by inhaling through the nose and exhaling through the mouth
3. Train the client on guided imagery; ask them to close their eyes and see if they can visualize a color. For example, the color "red"; if they say they cannot then ask them if they can visualize their car, keep going until they accomplish visualization. Sometimes it takes a few times for the client to start visualizing
5. Train the client on progressive relaxation
6. After the exercises, ask the client how they feel
7. Encourage clients to practice the techniques at home
8. Provide the client with the homework handout sheet; remind them of the importance of doing the exercises at home and monitoring them on the sheet to bring back to the next therapy session.

Session III

1. Ask client if they practiced any of the techniques they learned at home
   a. Review homework sheet
   a. Provide feedback
   b. Ask client if they have observed changes
   c. Again, let the client know the importance of doing the relaxation exercises at home
2. Introduce the forgiveness component of therapy; explain to the client what forgiveness means, e.g. it does not mean forgetting or discounting the act. That they are giving their

perpetrator power by still being angry and that they are wasting energy and developing symptoms due to their mental states.

3. Practice progressive relaxation with client
4. Practice guided imagery with client
5. Explore the client's reaction to the exercise – how they felt about forgiveness
6. Explain that forgiveness takes time, that they will have to reforgive many times

Session IV

1. Review the homework sheet
    a. Provide feedback
    b Ask client if they have observed changes
2. Practice progressive relaxation and guided imagery with client
3. Use forgiveness in the exercise
4. After the exercise, ask the client how they felt about forgiveness
5. Praise them for their efforts; remind them that forgiveness takes time and that we need to reforgive many times
6. Remind them of the importance to continue doing their homework

Session V

1. Review the homework sheet
    a. Provide feedback
    b. Ask client if they have observed changes
2. Let clients know that therapy sessions will soon be ending and that they will have the exercises for them to use as a coping mechanism. Provide them with comfort

on their self-efficacy to continue with the exercises.

3. Practice progressive relaxation and guided imagery with client
4. Ask client how they feel after the exercise

Session VI

1. Review the homework sheet
    a. Provide feedback
    b. Provide client with feedback on their progression through the therapy
2. Congratulate client for having achieved progress in therapy
3. Ask client how they feel about ending the therapy sessions
4. Discuss the many accomplishments made by client in therapy
5. Ensure that they may come back anytime for therapy

Progressive Relaxation Exercise

This section is directed at covering the progressive relaxation technique. Relaxation is being used as an intervention method to treat approximately 11 of the top 14 health problems, "including back pain, allergies, fatigues, arthritis, headaches and high blood pressure (Eisenberg, et al., 1998 (as quoted in Scheufele, 2000)).

The literature review provided information on the benefits involved in using progressive relaxation, guided imagery in treating victims of trauma related sexual abuse. It also provided that forgiveness has been found to be an important intervention ingredient to treat the emotional pain of traumas. The literature presented that trauma is the state produced by the freeze response due to the instinctive fight-or-flight response and that the muscle tenses. Doing progressive relaxation counteracts the freeze response and relaxes the muscles.

Below is a shortened version of the Jacobson's Progressive Relaxation Training that I adapted to use with my clients:

Progressive Relaxation Technique

1. Sit in a comfortable way with your hands on top of your thighs faced down.
2. Take a deep breath- inhale through your nose- exhale through your mouth.
3. Take another deep breath, hold it… now exhale through your mouth.
4. Take another breath and hold it… now exhale and relax.
5. Very good… you are doing excellent.
6. Tense your face (pause) relax- inhale/exhale.
7. Bring your eyebrows up as far as they go (pause) relax- inhale/exhale
8. Make a fake smile that moves all the way back to your ears (pause) relax- inhale/exhale
9. Bring your head back as far as it goes; bring your head forward and feel the relief- inhale/exhale.
10. Bring your shoulders up as high as they go- bring your shoulder down slowly and feel the relief- inhale/exhale.
11. Bring your chin down to your chest; bring your head up and feel the relief- inhale/exhale.
12. Make two fists with your hands- inside the fists you will place gestures, words, actions that you want to throw away- grab them tight (pause) Now -open your hands and throw that garbage out- inhale/exhale.
13. You are doing great.
14. Put your tummy in by tensing your stomach, because sometimes in the bellybutton a word hides – relax – inhale/exhale.
15. Tense your thighs – relax – inhale/exhale.
16. Bring your leg up with toes pointed up like a penguin – tense the muscles in your legs – bring your legs down – relax; inhale/exhale.
17. Now, bring your legs up and point the toes like a ballerina – imagine that on each toe you have a rocket – visualize putting all of the negative things that might be left in your body in those toes to send off into space – visualize the rocket taking off – bring your legs down and relax.
18. You did an excellent job. How do you feel?

After the relaxation exercise, the client feels relaxed and we can proceed with the guided imagery script.

Guided Imagery Script – Forgiveness

The guided imagery script focuses on continuing the relaxation response of the client, increasing of alpha waves in order to help the client be less resistance to change and providing them with a safe haven where they will be open and receptive to accept the thought of forgiveness.

Visualization of a safe haven and the forgiveness script:

1. Take a deep breath, by inhaling through your nose and exhaling through your mouth.
2. Close your eyes and relax.
3. Visualize a door, the most beautiful door made of 14 karat gold. The door is engraved with grapes, leaves, birds it is spectacular.
4. Now, look at the knob and open the door, step through the door. When you walk in, you will see the most wonderful garden your eyes have ever seen (pause for a few seconds). On the right side, you will see the trees that you like; you will see your favorite flower (e.g., daisies); you will see your favorite birds; you will also start building a wall around your garden, it could be made of wood, of brick, of block you will chose (pause for one second).
5. Now start building the wall just by looking, you will build your wall.
6. Please take a look at the left side of the garden, there you will see a waterfall and a pond under the waterfall, also, you will see a bench in front of the waterfall.
7. Walk to the direction of the waterfall and sit on the bench in front of the waterfall, feel the mist of the water on your face (pause).
8. Visualize removing your shoes, putting your feet in the water. It feels so refreshing - your feet feel good.
9. Take a deep breath and exhale. You feel relaxed.
10. Now, look into the waterfall, hear the sound of the waterfall and visualize those people that have done you wrong, see them on their knees asking for forgiveness.
11. Remember, you are not going to forget what they did, because that is an action and it is done, but you are going to forgive them to be free, because you are giving this person power every time you get upset about what happened, wasting energy and this person does not deserve to have any power over your will.
12. Contemplate the possibility that the person was sick, they lost it, they were not themselves, think whatever you want, but you are going to see them asking for forgiveness and you are going to say to them “I forgive you”.
13. Also, if you have done anything to anyone that you would like to ask them to forgive you may visualize that person and ask them to forgive you.
14. I will give you a pause for you to visualize the forgiveness (pause for about a minute).
15. Now, keep looking into the waterfall and take a deep breath, exhale, and put your shoes back on.

16. Walk over to the door, the beautiful 14 karat door, and take the knob and open it.
17. Look back at your garden because this is where you will be coming back to reforgive many times.
18. Take a deep breath and exhale. Remember that you can do this at home whenever you want.
19. Now, close the door and open your eyes.

The experience of letting go is not strange to us, we practice it every night when we go to sleep. We let our mind and body rest, we let go, because if you do not let go, you would not sleep . "Letting go is a way of letting things be, of accepting things as they are" (Kabat-Zinn, 1990, p. 40).

Dachman and Lyons (1990) noted their success with about 1,000 patients who effected guided imagery, which were able to reduce their pain.

Alpha Waves – The Reduction of Resistance in Attitude Change

What is reality? A king once asked that question. He had a wise advisor by his side, who took his head and emerged it into water, the king started dreaming that he was in another castle that he had a large family and was getting ready to go to war, when the wise advisor pulled his head out of the water, the king said, "Now, I am really confused."

We use different levels of our brain. For example, we might be listening to the radio, paying attention to the road, and listening to our passenger. Or perhaps, we might be paying attention to the road, listening to the radio, and thinking of the things to do when you arrive at the office. The use of different levels of the brain is correlated to the different levels of the mind which we use for sleep. The beta is the first stage where we are in complete consciousness. The frequency of the beta waves are approximately 13-30 Hz. (that is, a rhythm of 13 to 30 cycles per second) (Hutchinson, 2006). The alpha is the second level and that level is our subconscious

level. The alpha waves frequency is slower at about 8-12 HZ. Although you are at a subconscious level the brain is alert but unfocused (Hutchinson, 2006). The next level is the theta; this is when we are in light sleep. The theta waves frequency is about 4-7 Hz. Finally, the last level is the delta, which is associated with deep sleep and the "Rapid Eye Movement" (REM). The frequency in the delta level is very slow .5-4 Hz (Wikipedia, 2006; Hutchinson, 2006). Hence, the increase in alpha waves is produced by being relaxed and helps the client be less resistant to changing their attitudes. When the person is relaxed, they assume the "relaxation response" (Benson 1975; 1985). In this relaxed state, the individual has increased alpha wave activity. In this state the client is able to report memories of long-forgotten childhood events. They start communicating more because they are less resistant. When the alpha waves are higher – the person's resistance to change is lowered.

All relaxation techniques as per Benson (1975) elicits a general "relaxation response", he added that this response consists of "physiological changes that are mainly evoked by decreased autonomic nervous system activity, such as slowing of the heart rate, low and shallow breathing, peripheral vasodilation, reduced oxygen consumption, and decreased in spojaneous skin conductance response"(p. 70).

Neurophysiologically, the relaxation response is most frequently accompanied by changes in EEG indicating reduced cortical arousal (Wallace, Benson and Wilson, 1971). The alpha wave increases and the person's resistance to change are lowered. In a study performed by Drs. Wallace, Benson and Wilson (1971) they demonstrated that the "alpha rhythm is the classical EEG correlate for a state of relaxed wakefulness" (p.796). The investigation also found that the alpha level of sleep is "most conducive to creativity and to the assimilation of new

concepts” (798). Benson (1975) provided scientific data regarding the increase in alpha waves as a result of relaxation.

Everly and Lasting (2006) in their research study also suggested that alpha waves produce a state of serenity and inert conscientiousness.

CHAPTER 5

CASE STUDIES

Presented in this section are four case studies where I use the Holographic Therapeutic Framework (HTF) to treat trauma related sexual abuse. Some details of the cases have been changed to conceal the client's identity.

Case of Ethel

Ethel is a 26 year-old single white female who was referred by her physician due to depression. A psychosocial history was completed by another clinician, and I had some information on the client prior to the first therapy appointment.

The client entered the room and she bluntly told me, "I was raped last weekend". She began to cry and said in an angry tone, "I am tired". I asked her, "How come you feel tired?" She responded, "Because, I have been sexually abused many times and I am tired." Ethel's psychosocial assessment indicated that she had been sexually abused by her father, brother, stepfather, an uncle and now, she had experienced a date rape. I wondered why is Ethel vulnerable to sexual abuse? Why is she targeted by perpetrators? Does she emit some scent (like pheromones) that produces sexual feelings and brings out the innate animal nature in predators? I felt perplexed with the thought of how and why a person would be subjected to being abused by so many people and, also how she could ever trust anyone. Ethel is an attractive woman. She was raised by church going parents, although her mother and father divorced when Ethel was 11 years old. She is a high school graduate and has taken some college courses. However, she has been unable to hold a job due to getting anxious during the day and

not being able to handle any kind of stress. She admitted to attempting suicide three times. Once, when she broke up with her high school sweetheart, the second time when she was found homeless due to an abusive relationship and, the third time because she was "tired". Her history of sexual abuse began when she was five years old. She remembered only pieces of the abuse. When her parents were not home, her brother would take off her clothes and give her a bath. He would touch her parts and put her hand on his penis. Ethel liked the attention she received from her brother since her parents were not affectionate. However, she felt guilty for not saying anything about the abuse. When she was about 10 years old, Ethel said that her father would touch her breasts and say, "nice". She discounted her father's abuse. In fact, she said, "I do not consider it abusive any longer". She explained that she and her father have an excellent relationship and that he is her only support. Ethel recalled having a trusting and loving relationship with her uncle until she reached the age of 12. She recounted one weekend when she stayed at her uncle's home; he slipped next to her in bed and started touching her parts. Ethel remained quiet and did not move. She wanted her uncle to think that she was sleeping. She felt dirty and cried after her uncle left the room. Ethel told her mother about the incident, but her mother did not say anything and kept quiet like if nothing happened. Ethel's mother remarried when she was thirteen years of age. She felt apprehensive by her stepfather's presence. Ethel slept with her bra on and pajamas covering her up to the neck. One day, while sleeping, she heard heavy breathing and was afraid to look. She felt instinctively that something was wrong. She looked through the corners of her eyes and saw through the hallway mirror her stepfather smelling her underwear and masturbating. She remembers thinking, "Oh, no, please God, don't let this be happening to me". The next day, she tried to hide all of her underwear. She said,

"Every night, when I went to bed, I would be hoping that he would not do this again". Ethel remained hypervigilant at night, opening the corners of her eyes whenever she heard a noise. Another morning, there he was in the hallway mirror, she remembered his face changing - the "metamorphosis - the evil face, the face of desire and lust." "I hated that face." Ethel wanted to tell her mother about the problem, but she was unsure about the consequences since her mother did not believe her before. Her stepfather continued to masturbate and since Ethel wanted it to stop she told her mother. Again, her mother did not believe her and even implied that Ethel wanted her to break up with her stepfather because she was jealous. Ethel felt helpless. She did not know where to turn. She had to keep looking at the perpetrator's face and was not able to tell him how she felt. Years passed and Ethel was able to move out and have a new life. But the abuse followed her. Ethel was raped. She met her date through a friend. They had a lovely evening of dining and dancing. When he took her home, she gave him a good night's kiss. He began touching her breasts. She told him to stop but he kept lifting her skirt and took her underpants off. She started crying and pushing him away, but he went right ahead and penetrated her. She remembers remaining still and letting him finish. She kept thinking, "Why me again?"

Ethel felt depressed and anxious. However, she did not seek psychological help for the sexual abuse. She was referred to the clinic by her physician due to depression. With HTF, Ethel was able to gain stability. She practiced guided imagery and progressive relaxation techniques and forgiveness. She remarked after the second session, "I let go of a lot", "I feel light". On the fourth session, Ethel told me that she was starting to remember more of her abuse. I praised her and encouraged her to continue her self-healing practices. The therapy concluded

after the sixth session. She told me, “I feel cleansed”. Ethel is enrolled in college. She feels happy and continues to do the relaxation exercises.

Case of Patricia

Patricia is a 56-year-old white married female who was referred by the crisis unit after attempting suicide. Patricia stated that she was depressed, anxious, being unable to sleep at nights and having chronic pain. She said, “I tried suicide because I wanted to shut people out. I hate confrontations”. Patricia has all sorts of medical illnesses. She had three strokes and surgery was performed to unclog arteries. Patricia is taking an enormous amount of medication. In her psychosocial history, Patricia noted her unhappy-unstable childhood. She was adopted when she was five years of age by neighbors. She said, “My adoptive family was as bad as my real family”. Further, Patricia complained of being the maid to the adoptive family. She described a childhood of “being afraid and remaining quiet”. Patricia sustained emotional, verbal and sexual abuse during her childhood and adolescent years of development. In fact, she recalls receiving no love or nurturing during her childhood. Additionally, she remembers only fragments of her childhood. Although Patricia admitted to being sexually abused during her childhood/adolescent years, she indicated that she did not want to discuss the sexual abuse.

Using HTF, Patricia improved tremendously both physically and mentally. She manifested a great amount of release of negative emotions, by breaking down and crying during the forgiveness section of therapy. I never knew the details of her story. I did not get the details of her abuse but I did observe Patricia’s improvement in mood, character and health during therapy. Patricia learned coping tools, she feels better and continues to work with her emotional pain in therapy. She has demonstrated a great amount of self-efficacy.

Case of Melissa

Melissa is a 32-year-old white married female who self-referred due to relationship problems. She was separated from her husband and noted having trust issues that was affecting her relationship. After reviewing Melissa's psychosocial history, I noticed that she had disclosed having seen a therapist during her college years due to childhood sexual abuse. Melissa complained about having trust issues with her husband. She asked that I work with her on this problem (trust issues). When I asked her to explain what she meant by "trust issues", she was hesitant and was unsure. At the very first session, Melissa disclosed that she was having intimacy problems. She noted that after being married for three years, out of the blue, she felt uncomfortable and dirty again with sex. I asked Melissa if she wanted to discuss the sexual abuse. She said she felt uncomfortable and did not want to talk about the sexual abuse. Besides, she had mentioned to me that she was in therapy to deal with the trust issues. Melissa came to therapy for a couple of sessions, and talked about her relationship and trust issues. During one later session, I used HTF with Melissa. By third session of using HTF, Melissa informed me that she was remembering more aspects of her sexual abuse. She reported feeling better about life and that she liked doing the exercises. Melissa is now back with her husband, she went back to school to finish her Master's degree and she reported feeling "complete" and "at peace".

Case of Arthur

Arthur is a 23 year-old black single male. He had been receiving psychiatric services for many years in New York City. He had been diagnosed with Schizoaffective Disorder from the age of 18. Arthur's psychosocial history included a long period of placement in an orphanage and being adopted at the age of 12. Arthur is a college graduate. He did not want to talk much

about his early childhood, but he did mention that he loved his adoptive parents. Arthur expressed having problems in maintaining relationships with the opposite sex. He felt he was too "rough" with the opposite sex. I asked him what he meant by "rough". He told me, "being crude, coarse, and offensive to them". He explained that his older brother has always laughed at the way he acts. Arthur complained about many instances when his brother ridiculed him in front of his peers in school and at home. When asked if he had ever been sexually molested, he responded that he did not know. I used HTF in treatment. At the second session, Arthur remarked that he had never felt as relaxed as he did. In fact, he commented that in all the therapy work that he had received, he had never experienced such a feeling of comfort. After the third therapy session, Arthur told me he "let go of a lot"; he said that he was feeling good about the therapy. In the fourth session, Arthur said that he had been remembering some of the events of his childhood and that he recalled being sexually molested. I asked him if he wanted to spend some time talking about the events, he stated, "Is this confidential?" to which I responded, "Yes". He seemed eager to talk but then said, "Never mind, I want to do the relaxation techniques". It is my opinion that most men do want to talk about the abuse. They have been taught to hold emotional pain. They do not want to manifest to the therapist any sign of weakness. It is something similar to the way men feel about asking for directions when they are lost in the highway. At the end of the fifth session, Arthur said, "I felt like I was wearing a mask and now I am seeing myself for the first time". After the sixth session, therapy concluded. Arthur shared that he had experienced peace for the first time. He continues to do the relaxation exercises.

CHAPTER 6

CONCLUSION AND FUTURE RESEARCH

Conclusion

Sexual abuse trauma is like a virus. It can lie dormant for years during the childhood-adolescent years and attacks when the individual reaches adulthood, by manifesting psychological and physiological problems. The survivor of sexual abuse is sometimes unaware of the physiological and psychological damage caused by the abuse. Most of the victims come to therapy because they know something is wrong with them but do not know the cause. Some do not remember the abuse; only fragments. The therapeutic alliance plays an important role in every treatment modality. If therapy is conducive to the client's improvement, and the therapist observes the improvement, it is not necessary to have the client relive the abuse or try to remember the abuse, the most important aspect of therapy is treatment outcome. The Holographic Therapeutic Framework (HTF) presented in this dissertation combines three intervention ingredients necessary to combat the virus like damage that evolves from trauma related sexual abuse. The purpose of this paper is to provide the readers with information on the therapeutic approach I have developed and used in my work, and recommend its use for treating trauma related sexual abuse. This paper presents information supporting my techniques. The information also emphasizes that it is important for therapists to use progressive relaxation and guided imagery techniques with forgiveness in a combined form in treatment interventions. I believe the combination of these intervention techniques greatly improves treatment outcomes.

Future Research

There is a lack of research in using progressive relaxation and guided imagery techniques with forgiveness in treatment interventions. Also, more research is warranted on the effects of using progressive relaxation, guided imagery with forgiveness interventions to treat sex offenders in forensic settings, in diverse group settings, with drug addicts, and with children. Another area worth exploring is "virtual reality". Imagine, a virtual reality device projecting images of the "safe haven" evoking more imagination and interaction with the client's emotional pain. Finally, another significant study would be on the effects of the vagus nerve and PTSD. The medical field has vagus nerve stimulators on the market which they claim help ease depression and asthma. There are theories arguing that with the "freeze response", the vagus nerve gets stuck and that the body loses stability and that trauma will end when the body is able to achieve stability. I ponder if perhaps stimulating the vagus nerve while using the techniques presented in this paper would provide the ultimate treatment breakthrough for trauma related sexual abuse.

APPENDIX A

RELAXATION SELF-REPORTING SCALE

Appendix A. Self-Report Rating Scale

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1. Feeling deeply and completely relaxed throughout my entire body
2. Feeling very relaxed and calm
3. Feeling more relaxed than usual
4. Feeling relaxed as in my normal resting state`
5. Feeling tension in some part of my body
6. Feeling generally tense throughout my body
7. Feeling extremely tense and upset throughout my body

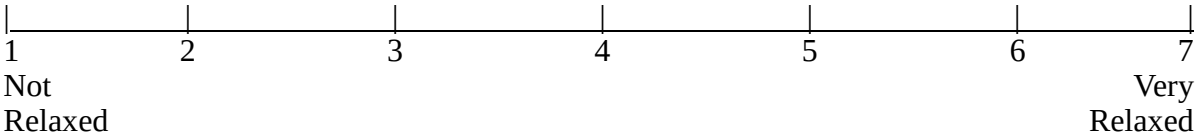
Adapted from Poppen, Roger. 1998. Behavioral Relaxation Training and Assessment. 2nd ed., Thousand Oaks, CA: Sage Publications

APPENDIX B

RELAXATION INTENSITY SELF-REPORT WORKSHEET

Appendix B. Relaxation Intensity Self-Report Worksheet

Rate how relaxed you feel below and bring to therapy.



Take a minute to write how you feel after the relaxation exercises. Please write, "I am feeling_____" (filling in a word to describe your feeling).

To rate, use the Self Report Rating Scale (Appendix A)

Adapted from Poppen, Roger. 1998. Behavioral Relaxation Training and Assessment. 2nd ed., Thousand Oaks, CA: Sage Publications

APPENDIX C

PROGRESSIVE RELAXATION SCRIPT – HOMEWORK

Appendix C. Progressive Relaxation Exercise - Homework

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1. Sit in a comfortable way with your hands on top of your thighs faced down.

2. Take a deep breath- inhale through your nose- exhale through your mouth.

3. Take another deep breath, hold it… now exhale through your mouth.

4. Tense your face (pause) relax- inhale/exhale.

5. Bring your eyebrows up as far as they go (pause) relax- inhale/exhale

6. Make a fake smile that moves all the way back to your ears (pause) relax- inhale/exhale.

7. Bring your head back as far as it goes; bring your head forward and feel the relief- inhale/exhale.

8. Bring your shoulders up as high as they go- bring your shoulder down slowly and feel the relief- inhale/exhale.

9. Bring your chin down to your chest; bring your head up and feel the relief- inhale/exhale.

10. Make two fists with your hands- inside the fists you will place gestures, words, actions that you want to throw away- grab them tight (pause) Now -open your hands and throw that garbage out- inhale/exhale.

11. Put your tummy in by tensing your stomach, because sometimes in the bellybutton a word hides – relax – inhale/exhale.

12. Tense your thighs – relax – inhale/exhale.

13. Bring your leg up with toes pointed up – contract the muscles in your legs – bring your legs down – relax; inhale/exhale.

15. Relax for a few minutes.

Adapted from Bernstein, Douglas A. 2000. New Directions in Progressive Relaxation Training: A Guidebook for Helping Professionals. Westport, CT.:Greenwood Publishing Group.

APPENDIX D

GUIDED IMAGERY SCRIPT - FORGIVENESS

Appendix D. Guided Imagery Script - Forgiveness

Visualization of a safe haven.

1. Visualize a door, the most beautiful door made of 14 karat gold. The door is engraved with grapes, leaves, birds - it is spectacular.
2. Now, look at the knob and open the door, step through the door. When you walk in, you will see the most wonderful garden your eyes have ever seen (pause for a few seconds).
3. On the right side, you will see the trees that you like; you will see your favorite flower (e.g., daisies); you will see your favorite birds; you will also start building a wall around your garden, it could be made of wood, of brick, of block you will chose (pause for one second), now start building the wall just by looking, you will build your wall.
4. Now, please take a look at the left side of the garden, there you will see a waterfall and a pond under the waterfall, also, you will see a bench in front of the waterfall.
5. Walk to the direction of the waterfall and sit on the bench in front of the waterfall, feel the mist of the water on your face (pause). Visualize removing your shoes, putting your feet in the water. It feels so refreshing, your feet feel good.
6. Take a deep breath and exhale. You feel relaxed.
7. Look into the waterfall, hear the sound of the waterfall and visualize those people that have done you wrong, see them on their knees asking for forgiveness, remember, you are not going to forget what they did, because that is an action and it is done, but you are going to forgive them to be free, because you are giving this person power every time you get upset about what happened and this person does not deserve having the power over your will. Think that perhaps this person was sick, they lost it, they were not themselves, think whatever you want, but you are going to see them asking for forgiveness and you are going to say to them,"I forgive you".
8. Also, if you have done anything to anyone that you would like to ask them to forgive you, visualize that person and ask them to forgive you. I will give you a pause for you to visualize the forgiveness (pause for about a minute).
9. Now, keep looking into the waterfall and take a deep breath, exhale, and put your shoes on.
10. Walk over to the door, the beautiful 14 karat door, and take the knob and open it. Look back at your garden because this is where you will be coming back to re-forgive many times.
11. Take a deep breath and exhale.
12. Open your eyes.

APPENDIX E

HEMISPHERES OF THE BRAIN

Appendix E. The Controls of the Hemispheres of the Brain

Left Brain:	Right Brain:
- Creativity	- Receptive
- Text	- Context
- Intellectuality	- Intuitive
- Analysis	- Synthesis
- Positive Emotions	- Negative Emotions
- Normal State of Consciousness	- Altered State of Consciousness

Left Brain Controls:	Right Brain Controls:
- Sympathetic Nervous System	- Parasympathetic Nervous System
- Fine Motor Activity	- Gross Motor Control
- High Frequency Perception	- Low Frequency Perception

Adapted from Relaxation Theory .2006. Online. Available from Internet, http://www.ou.edu/class/hss4534/stress/presentations/Relaxation/tsdl001.htm (Assessed 12/26/06).

APPENDIX F

INITIAL RESPONSE TO TRAUMA

Appendix F. Initial Responses to Trauma

- **Disbelieve:** Events don't make sense within context of normal life; life feels surreal like a movie.

- **Numbness:** A trauma response that allows us to function through times of danger
Disorientation or confusion: Things aren't working in their normal way.

- **Somatic disturbances:** Nausea, headaches, heart racing, sweating, vomiting, muscle tension or soreness.

- **Feelings of helplessness alternating with anger or rage:** Unusual fear with an increased sense of vulnerability.

- **Dissociation:** The mind goes somewhere else; doesn't feel in sync with emotions.

- **Clarity:** A heightened sense of awareness.

Ongoing Responses

- **Sleep disturbances:** Trouble falling or staying asleep; nightmares.
A shaken sense of trust and faith.

- **Flashbacks:** Snatches of memory; often frightening, that flash across the mind.

- **Hyper-vigilance:** Waiting for the other shoe to drop; edgy, jumpy, reactive.

- **Free-floating anxiety:** Anxiety that is not easily connected to specific events in the present.

Stimulation of previous painful emotions and memories

- **Survival guilt:** Guilt about being the one who "got away".

- **Continued somatic effects:** Muscle tension or soreness, unusual tiredness, head-or backaches, stomach problems.

- **Difficulty modulating emotional reactions:** swinging from shutdown to high intensity, no shades of gray.

- **Depression with feelings of despair.**

- Desire to engage in high-risk behaviors.

- Impaired ability to conceptualize a positive future.

- Desire to self-medicate with drugs, alcohol, food, sex, spending, etc.

- Fear for personal safety.

- Denial and minimization.

Adapted from “The Magic of Forgiveness” Tian Dayton, Ph.D., 2003 (pp. 359-360)

APPENDIX G

FORGIVE AND FORGET POINTS – BY SMEDES

Appendix G. Forgive and Forget by Smedes

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6. We accept people for the good they are to us.
7. We forgive for the bad they did.
8. Forgiving takes time; it goes slowly .
9. Forgiving replaces confusion – who did what to whom and when and how.
10. You are not a failure at forgiving just because you are angry.
    (pp. 48-95)

Adapted from the book entitled, “Forgive & Forget: Healing the Hurts We Don’t Deserve” by Lewis B. Smedes, 1984.

APPENDIX H

SYMPTOMS OF PTSD

Appendix H. Symptoms of PTSD

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1. **Learn Helplessness:** A person loses the feeling that she can affect or change what is going on, and this becomes a quality of personality.

2. **Depression:** Unexpressed and unfelt emotion may contribute to flat internal world–agitated/anxious depression. Anger, rage and sadness that remains unfelt, unexpressed or unprocessed in a way that leads to no resolution.

3. **Emotional Constriction:** Emotional numbness and/or shutdown as a defense against overwhelming pain and threat. Restricted range of affect or authentic expression of emotion.

4. **Distorted Reasoning:** Convoluted attempts to make sense of chaotic, confusing, frightening or painful experience that feels senseless.

5. **Loss of trust and faith:** Because of deep ruptures in primary, dependency relationships and breakdown of an orderly world.

6. **Hypervigilance:** Anxiety, waiting for the other shoe to drop–constantly scanning environment and relationships for signs of potential danger or repeated rupture.

7. **Traumatic Bonding:** Unhealthy bonding style resulting from power imbalance in relationships and lack of other sources of support at the time trauma (s) occurred and subsequently.

8. **Loss of Ability to Take in Support:** Due to fear of trusting and depending upon relationships and PTSD's numbness and emotional shutdown.

9. **Loss of Ability to Modulate Emotion:** Go from zero to ten and ten to zero without intermediate stages, black–and–white thinking, feeling and behavior, no shades of gray as a result of trauma's numbing versus high–affect responses.

10. **Easily Triggered:** Stimuli reminiscent of trauma, e.g., yelling, loud noises, criticism, gun fire or subtle stimuli (such as vocal changes or eye movements) trigger person into shutting down, acting out or intense emotional states. Or subtle stimuli such as changes in eye expression or feeling humiliated, for example.

11. **High–Risk Behaviors:** Speeding, sexual acting out, spending, fighting or other behaviors done in a way that puts one at risk. Misguided attempts to jump-start numb inner world or act out pain from an intense pain-filled inner world.

12. **Disorganized Inner World:** Disorganized object constancy and/or sense of relatedness. Fused feelings (e.g., anger and sex).

13. **Survival Guilt:** From witnessing abuse and trauma and surviving, from "getting out" of a particular family system.

14. **Development of Rigid Psychological Defenses:** Dissociation, denial, splitting repression, minimization, intellectualization, projection, idealization for some examples or developing rather impenetrable "character armor".

15. **Cycles of Reenactment:** Unconscious repetition of pain-filled dynamics, the continual recreation of dysfunctional dynamics from the past.

16. **Somatic Disturbances;** The body gets traumatized as well as the mind and stores trauma in its tissues and musculature.

17. **Desire to Self-Medicate:** Attempts to quiet and control turbulent, trouble inner world through the use of drugs and alcohol or behavioral addictions.

Adapted from Tian Dayton, Ph.D. 2003. "The Magic of Forgiveness: Emotional Freedom and Transformation at Midlife". Deerfield Beach, FL: Health Communications, Inc

APPENDIX I

AUTONOMIC NERVOUS SYSTEM (ANS) RESPONSE

Appendix I. The Autonomic Nervous System (ANS) Response

Sympathetic		Parasympathetic
Pupils Dilated, dry; far vision	**Eyes**	Pupils constricted, moist; near vision
Dry	**Mouth**	Salivating
Goose bumps	**Skin**	No goose bumps
Sweaty	**Palms**	Dry
Passages dilated	**Lungs**	Passages constricted
Increase rate	**Heart**	Decrease rate
Supply maximum to muscles	**Blood**	Supply maximum to internal organ
Increase activity	**Adrenal glands**	Decrease activity
Inhibited	**Digestion**	Stimulated

Adapted from "Psychology: Themes and Variations". 1998. Wayne Weiten, Brooks/Cole Publishing Company (p. 407)

WORKS CITED

Alexander, Mary Jane, Muenzenmaier, Kristina, and Dumont, Jeanne. 2005. Daring to Pick Up the Pieces in the Puzzle: A consumer-survivor model of healing from childhood sexual abuse. In *Recovery in Mental Illness: Broadening Our Understanding of Wellness*, Ralph, Rucht O. and Corrigan, Patrick W., 207-231. Washington, DC: American Psychological Association.

American Heritage Dictionary. 2006. Online. Available from the internet http://www.answerss.com/topic/sexual-abuse (assessed 12/17/06).

Applebaum, Paul, S. (1997*). Trauma and Memory: Clinical and Legal Controversies*. Cary, NC:Oxford Press.

Aronson, Elliot, Wilson, Timothy D. and Akert, Robin M. 2002. *Social Psychology*. 4th ed. Upper Saddle River, New Jersey: Prentice Hall.

Banyard, V., Williams, L., and Siegel, J. 2001. Understanding links among childhood trauma, dissociation and women's mental health. *American Journal of Orthopsychiatry*. 71(3):311-321.

Barlow, David H. 2001. *Handbook of Psychological Disorders*, 3rd ed., New York: The Guilford Press.

Becht, Adeline Charlotte. 1982. *The effectiveness of deep muscle relaxation with positive imagery and cognitive meditative therapy in treatment of stress resulting form subjective continuous tinnitus in hearing adults.* Ph.D. diss., University of Oregon.

Beckenbach, John Anthony, Ed.D, 2002. Sexual abuse and forgiveness. Ph.D, diss., Northern Illinois University.

Beixedon, S. Yvette, Ph.D. 1995. *Lovers & Survivors: a partner's guide to living with and loving sexual abuse survivor*. San Francisco: Robert D. Reed Publishers.

Benson, Herbert, M.D. 1985. *Beyond the Relaxation Response.* New York: The Berkley Publishing Group.

_____. 1975. *The Relaxation Response.* New York: William Morrow and Company.

Bernstein, Douglas A. 2000. *New Directions in Progressive Relaxation Training: A Guidebook for Helping Professionals.* Westport, CT.:Greenwood Publishing Group.

Binder, Jeffrey L. (2004). *Brief Cynamic Psychotherapy: Clinical practice beyond the manual.* New York; Guilford Press.

Bood, Sven A., Sundequist, Ulf, Kjellgren, Anette, Norlander, Torsten, Nordenstrom, Knut, Nordstrom, Gun. 2006. Eliciting the Relaxation Response with the Help of Flotation-REST (Restricted Environmental Stimulation Technique) in Patients with Stress-Related Ailments. *International Journal of Stress Management,* 13(2) (May):154-175

Bright, Deborah. 1979. *Creative Relaxation: Turning Your Stress Into Positive Energy.* New York: Harcourt Brace Jovanovich, Inc.

Burkhardt, Sandra A. and Rotatori, Anthony F. 1995. *Treatment Prevention of Childhood Sexual Abuse: A Child-Generated Mode*l. Washington: Taylor & Francis.

Cairns-Smith, A.G. 1996. *Evolving the Mind: on the nature of matter and the origin of consciousness*. New York: Cambridge University Press.

Cannon, Walter B. 1963. *Bodily Changes in Pain, Hunger, Fear and Rage*. 2nd ed., New York: Harper & Row.

Chopra, Deepak, M.D. 1990. *Quantum Healing: exploring the frontiers of mind/body medicine*. trade edition, New York: Batman Doubleday.

Corey, Gerald. 1996. *Theory and Practice of Counseling and Psychotherapy,* 5th ed., Pacific Grove, CA: Brooks/Cole Publishing Company.

Dacey, John and Travers, John. 1999. *Human Development Across the Lifespan*, 4th ed., New York: McGraw Hill.

Dachman, Ken and Lyons, John. 1990. *You Can Relieve Pain: How Guided Imagery Can Help You Reduce Pain or Eliminate It Altogether*. New York: Harper & Row Publishing.

Davis, Laura 1991. *Allies in Healing: When the Person You Love Was Sexually Abused as a Child*, New York:HarperCollins.

Dayton, Tian, Ph.D. 2003. *The Magic of Forgiveness: Emotional Freedom and Transformation at Midlife*. Deerfield Beach, Florida: Health Communications, Inc.

Diagnostic and Statistical Manual of Mental Disorder DSM-IV-TR. 2002. 4th ed., text revision, Washington, American Psychiatric Association.

Enright, Robert D., and Fitzgibbons, Richard P. 2000. The process model of forgiveness therapy. *In Helping Clients Forgive*: An empirical guide to resolving anger and restoring hope. 65-88. Washington, DC: American Psychological Association.

_____. 2000. Empirical validation of the process model of forgiveness. *In Helping Clients Forgive*: An empirical guide to resolving anger and restoring hope. 89-109. Washington, DC: American Psychological Association.

_____. 2000. The social-cognitive development of forgiveness. *In Helping Clients Forgive*: An empirical guide to resolving anger and restoring hope. 53-64. Washington, DC: American Psychological Association.

_____. 2000. Other forgiveness interventions. *In Helping Clients Forgive*: An empirical guide to resolving anger and restoring hope. 287-304. Washington, DC:American Psychological Association.

Everly, G. and Lating, J. 2006. *Neurologic Desensitization in Treatment of Posttraumatic Stress: Personality-Guided Therapy for Posttraumatic Stress Disorder*. American Psychological Association (pp. 161-176). On-line. Available from Psycbooks database.

Frankl, Victor. 1984. *Man's Search for Meaning*. New York: Simon and Schuster.

Garbarino, James, Stott, Frances M. and Faculty of The Erickson Institute. 1992. *What Children Can Tell Us*. San Francisco: Jossey-Bass Inc.

Goldsmith, Rachel, E., Barlow, Rose M., and Freyd, Jennifer J. 2004. Knowing and not Knowing About Trauma Implications for Therapy. *Psychotherapy Theory Research, Practice, Training*. 41(4):448-463.

Gothelf, C., Petroff, J., and Teich, J. (2003). 'Imagine': Relaxation and guided imagery with people who are deaf-blind. *Journal of Visual Impairment & Blindness* 97(2):97-105.

Greenspan, Stanley I., M.D. with Benderly, Lieff Beryl. 1997. *The Growth of the Mind*. Cambridge, MA: Perseus Books.

Griffith, Coleman R. 1934. *Relaxation and sleep. In An Introduction to Applied Psychology*. 43-56. New York: MacMillan Co.

Grof, Stanislav, M.D.1993. *The Holotropic Mind.* New York: HarperCollins Publisher.

Hospers, John. 1988. *An Introduction to Philosophical Analysis*. Englewood Cliff, New Jersey: Prentice-Hall.

Huffman, Karen, Vernoy Mark and Vernoy, Judith. 2000. *Psychology in Action,* 5th ed., New York: John Wiley & Sons, Inc.

Hutchinson, Michael. 2006. *The Brain Wave Explanation*. Online. Available from internet, http://www.floatdreams.com/brainwaves.htm (assessed 12/24/06).

Jacobson, Edmund, M.D., Ph.D. 1967. *Biology of Emotions*. Fort Lauderdale, FL: Charles C. Thomas.

_____. 1962. *You Must Relax*. Chicago: McGraw Hill Book Company, Inc.

_____. 1946. *Progressive Relaxation*, 4th impression, Chicago: The University of Chicago Press.

Janet, Pierre, M.D. 1923. Le Medecine Psychologique (Reviews). *Flammarion*, Paris, p.37.

Jensen, Bernard, Ph.D. 2000. *Dr. Jensen's Juicing Therapy*: Nature's Way to Better Health and a Longer Life. Los Angeles: NTC.

Kabat-Zinn, Jon, Ph.D. 1990. *Full Catastrophe Living: Using the Wisdom of your Body and Mind to Face Stress, Pain, and Illness*. New York: Dell Publishing.

Kaplan, Harold I., M.D. and Sadock, Benjamin J., M.D. 1991. *Synopsis of Psychiatry*. Baltimore, MA:Williams & Wilkins.

Konstam, Varda, Marx, Fern, Schurer, Jennifer, Harrington, Anne, Emerson Lombardo, Nancy and Deveney, Sara. 2000. Forgiving: What mental health counselors are telling us. *Journal of Mental Health Counseling* 22(3): 253-267.

Korn, Dr. 2006. Online. Available from internet, (http://www.medscape.com/viewarticle/420329 (assessed 12/23/06).

Kotulak, Ronald. 1997. *Inside the Brain: Revolutionary Discoveries of How the Mind Works.* Kansas City, MI: Adams McMeel Publishing.

Langer, Susanne K. 1972. *Mind: An Essay on Human Feeling*, vol. 2, Baltimore: MD

Lazarus, Richard S. 1991. *Emotion and Adaptation*. New York: Oxford University.

Lippincott, Ann Isaacs. 1996. *Mental Health and Psychiatric Nursing*, 2nd ed., Philadelphia, PA: Lippincott-Raven Publishers.

Lyles Naramore, Jeanne, Burish, Thomas G., Krozely, Mary G. and Oldham, Robert K. 1982. Efficacy of relaxation training and Guided Imagery in Reducing the Aversiveness of Cancer Chemotherapy. *Journal of Consulting and Clinical Psychology* 50(4):509-524.

McNally, Kathryn. 2003. *Victims, Perpetrators and Bystanders*. Ph.D. diss., Atioch New England Graduate School, Keene, New Hampshire.

Millon, Theordore, Grossman, Seth, Millon, Carrie, et al. *Personality Disorder in Modern Life*, 2nd ed., Hoboken, New Jersey: John Wiley & Sons, Inc.

Mind/Body Education Center. 2006. Online. Available from internet, http://www.thebodysoulconnection.com/EducationCenter/fight.html (assessed 12/16/06).

Missouri Government. Sexual Abuse. 2006. Available Online at http://www.dmh.missouri.gov /cps/facts/sexualabuse.html (assessed 12/17/06).

Moritz, Catherine. 2005. *Sexually based post-traumatic stress disorder*. Ph.D. diss., Maimonides University.

Nakaya, Naoki, Kumano, Hiroaki, Minoda, Keiji, Koguchi, Takashi, Kanazawa, Motoyori and Fuduko, Shin. 2004. Preliminary study: psychological effects of muscle relaxation on juvenile delinquents. *International Journal of Behavioral Medicine* 11(3): 176-180.

Naparstek, Belleruth. 2004. *Invisible Heroes: Survivors of Trauma and How They Heal*. New York: Bantam Dell.

_____. 1994. *Staying Well with Guided Imagery*. New York: Warner Books, Inc.

Nation, The. 2006. *Fidel Lives*. On-line. Available from internet, http://thenation.com/doc/20061009/sublette/2 (assessed 12/28/06).

National Child Traumatic Stress Network's, The. 2006. Online. Available from internet, http://www.nctsn.org/nccts/nav.do?pid=typ (assessed 12/16/06).

National Sexual Assault Online Hotline. 2006. Online. Available from internet, http://www.rainn.or/statistics/victims-of-sexual-assault.html (assessed 12/16/06).

Ornstein, Robert Evans. 1986. *The Psychology of Consciousness.* 2nd rev. ed., New York: Penguin Group.

Peck, Heather L., Bray, Melissa A. and Kehle, Thomas J. 2003. Relaxation and Guided imagery: A school-based intervention for children with asthma. *Psychology in the Schools* 40(6).

Reber, Arthur S. 1995. *Penguin Dictionary of Psychology*, 2nd ed. New York: Penguin Group.

Peters Mayer, Diane. 2005. *The Everything Health Guide to Controlling Anxiety*. Avon, MA: Adams Media.

Petroff, J., and Teich, H. 2003. 'Imagine': relaxation and guided imagery with people who are deaf-blind. *Journal of Visual Impairment & Blindness* 97(2):97-105.

Poppen, Roger. 1998. *Behavioral Relaxation Training and Assessment*. 2nd ed., Thousand Oaks, CA: Sage Publications.

Rausch, Sara M., Gramling, Sandra F. and Auerbach, Stephen M. 2006. Effects of a single session of large-group meditation and progressive muscle relaxation training on stress reduction, reactivity, and recovery. *International Journal of Stress Management* 13(3):273-290.

Reisberg, Daniel, Heuer, Friderike. 2003. *Memory and Emotion*. Cary, NC:Oxford Press.

Relaxation Theory. 2006. Online. Available from internet, http://www.ou.edu/class/hss4534/stress/presentations/Relaxation/tsdl001.htm (assessed 12/26/06).

Richardson, Stephanie Jean. 1997. *The effects of autogenic relaxation and guided imagery on insomnia in the critically ill adult*. Ph.D. diss., The University of Utah

Rogers, Carl R. 1961. *On Becoming a Person*. Boston, MA: Houghton Mifflin

Rossman, Martin L., M.D. 2000. *Guided Imagery for Self-Healing: An Essential Resource for Anyone Seeking Wellness.* Tiburon, CA: H. J. Kramer Book.

Rudhyar, Dane. 1979. *Beyond Individualism: The psychology of transformation*. Wheaton, IL: Quest Books.

Scaer, Robert C., M.D. 2001. The Neurophysiology of Dissociation and Chronic Disease. *Applied Psychophysiology and Biofeedback* 26(1): 73-91. Online. Available from internet, http://www.trauma.pages.com/a/scaer-2001.php (assessed 12/26/06).

Seaward, Brian Luke. 1999. *Managing Stress: Principles and Strategies for Health and Wellbeing*. Boston, MA: Jones and Barlett Publishers, Inc.

Scogin, Forest, Richard, Henry C., Keith, Steven, Wilson, Jennifer and McElreath, Lisa. 1992. Progressive and Imaginal Relaxation Training for Elderly Persons with Subjective Anxiety. *Psychology and Aging* 7(3):419-424.

Smedes, Lewis B.1984. *Forgive & Forget: Healing the Hurts We Don't Deserve*. New York: Harper & Row Publishers, Inc.

Sobel, David, S., M.D. and Ornstein, Robert, M.D. 1996. *The Healthy Mind, Healthy Body Handbook*. Los Altos, CA: DRX

Talbot, Michael. 1991. *The Holographic Universe*. New York: HarperCollins Publishers

Utay, Joe and Miller, Megan. 2006. Guided Imagery as an Effective Therapeutic Technique: A Brief Review of its History and Efficacy Research. *Journal of Instructional Psychology* 33(1) (March):40-43.

Van Diest, Ilse, Proot, Patricia, Van de Woestijne, Karel P., et. al. 2001. Critical Conditions for Hyperventilation Response: The Role of Autonomic Response Propositions During Emotional Imagery. *Behavior Modification* 25(4) September: 621-639.

Van der Hart, Onno and Steele, Kathy. 1997. Relieving or Reliving Childhood Trauma? A Commentary on Miltenburg and Singer. *Theory & Psychology* (9)4:533-540.

Scheufele, Peter M. 2000. Effects of Progressive and Classical Music on Measuments of Attention. Relaxation and Stress Response. Journal of Behavioral Medicine, Vol. 23, No. 2, pp. 207-228.

Vaitl, Dieter, Bierbaumer, Niels, Gruzelier, Graham A., Kotchoubey, Boris, Kubler, Andrea, Lehmann, Dietrich, Miltner, Wolfgang, Thomas, H. 1998. Psychobiology of Altered States. *Psychological Bulletin* 131(1) assessed 12/14/06 from PsychArticles.

Wallace, Robert, Benson, Herbert and Wilson, Archie. 1971. Wakeful Hypometabolic Psysiologic State, A., *American Journal of Physicology* 221(3): 793-799.

Walton, Elaine. 2005. Therapeutic forgiveness: developing a model for empowering victims of sexual abuse. *Clinical Social Work Journal* 33(2):193-207.

Weiten, Wayne. 1998. *Psychology: Themes & Variations*. 4th ed., Pacific Grove, CA: Brooks/Cole Publishing Company.

Wikipedia. 2006. Online. Available from internet, http://en.wikipedia.org/wiki/Sexual_abuse) (assessed 12/18/06).

Wish, Peter A. 1975. The use of imagery-based techniques in the treatment of sexual dysfunction. *The Counseling Psychologist* 5(1):52-55.

Yapko, Michael. 1994. *Suggestions of Abuse: True and False Memories of Childhood Sexual Trauma*. New York: Simon and Schuster.