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Treating "Frozen" Latent Fantasies in Trauma Therapy

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Abstract

Trauma involves dissociation, and dissociation from the reality of the present moment can produce varieties of fantasies, such as a revenge fantasy or a fantasy that the traumatic event did not occur. These fantasies can become an integral aspect of the trauma itself, capable both of triggering posttraumatic symptoms, and interfering with treatment and healing. Throughout the history of psychology, fantasy has been discussed in relation to trauma in a number of ways, but generally in a negative light, as a dissociative symptom or a cognitive distortion resulting from trauma. But it has not been discussed as an integral element of the trauma that actively contributes to the ongoing cycle of posttraumatic symptoms. This article outlines a positive perspective on trauma-related fantasies and the importance of treating them in the therapeutic process.

Key words: trauma therapy, posttraumatic stress disorder, dissociation, fantasy, Energy Psychology, Logosynthesis.

> *In both PTSD and what we might call "ordinary" trauma, conscious and unconscious memories brutally intrude upon and corrupt the present moment... When these kinds of memories arise, they corrupt the present moment by inserting past events into present perception.*
>
> - Robert Scaer, MD (2014)

I was referred a client who was in his early 20s. He was bright, intelligent, articulate, but he had not finished High School and was living in his mother's basement. He was wracked with constant, chronic anxiety, to the point that he was unable to function in any healthy way. He could not sleep at night as he was engulfed in worry, replaying his interpersonal interactions of the day, wondering whether he had said anything to anyone that would anger them. He would imagine then having to deal with the consequences of that anger the next day. He had quit school because he was unable to sleep, and was unable to focus or concentrate enough to study and learn. For the same reasons, he was unable to work. He had previously seen four other therapists. He had been diagnosed with Generalized Anxiety Disorder, but was not benefitting from the Cognitive-Behavioral treatment he had been given.

A little bit of exploration into his history revealed that he was actually suffering from Posttraumatic Stress Disorder. When he was young his father was an active alcoholic who was prone to violent rages. Treating this client through Cognitive Behavioral Therapy, addressing his multiple cognitive distortions and the resulting anxiety as they manifested in the present, was fruitless. He was completely overwhelmed in his state of re-experiencing hypervigilance and hyper-reactivity; that is to say, his present was most of the time completely overwhelmed by the past. We focused on the history of trauma (i.e. *the story of* his trauma) as well as ongoing, dysfunctional family dynamics. This helped him to better understand why he was the way he was, and the true nature of what he was experiencing on a daily basis. But insight alone did not result in significant improvement in his symptoms or functioning, and he was only able to engage in very limited behavioral changes insofar as current family dynamics were concerned. I used a number of different types of interventions to begin addressing his traumatic memories, including cognitive techniques such as reframing and exposure-based techniques focused on modulating responses, and an approach called Logosynthesis, but these did not result in significant improvement, either. It is only when I finally *heard* him, when he told me for the third time or so, how as a child he would lie terrified in his bed, convinced that his father would come in at some point and kill him, that I realized that the core of his trauma was not something that had happened, but something that he *imagined could have happened*. Once we treated this aspect of his trauma, he began making significant strides forward in therapy and, over time, in his outer life.

My ability to identify and address this aspect of his trauma was the result of participating in advanced Logosynthesis training workshops by Swiss psychologist Willem Lammers. In these workshops, he actively incorporates teachings about addressing such latent fantasies that can be present in trauma. These fantasies can lie anywhere on a spectrum of awareness in the client's consciousness, from fully conscious wishes and fantasies, to fully unconscious or subconscious ones. These are fantasies that may be related to what *did not* happen, or what *might have* happened, as opposed to what *did* happen. They are sometimes fantasies about what *should have* happened. For example, a child who was sexually abused by a parent might carry a latent fantasy of being rescued by the other parent or, at least, of having been defended by that parent. With trauma related to neglect and abandonment, there is very likely a latent, or implicit, fantasy of a (non-existent) parent who was nurturing, present and loving.

Lammers credits his insight to:

> ... people who did trauma research after the Ramstein air show disaster in 1984, where jets crashed into the audience. When they tried to find out what traumatized those present, they discovered that it was not only caused by what people had experienced. The trauma was also in what *could have* happened. A man who was momentarily blinded was traumatized by the fear of (i.e. the fantasy of) losing an eye. A mother who couldn't find her child in the explosion, was traumatized by the fantasy she had of her child dying. After the danger was gone, and the situations successfully resolved, the frozen fantasies remained along with associated posttraumatic symptoms.
>
> I realized this was an extremely important insight, and I have developed it since, to the point that in my conceptualization, memories and fantasies have the same value when it comes to trauma: both are dissociations from the reality of living in the present. (Lammers, 2014)

Fantasies of this nature sometimes emerge explicitly in the treatment process, but they are usually implicitly buried in statements related to the material that emerges. When the client makes statements beginning with: "I wish that…" or, "If only…" or, "She (he) should have…" then he or she is expressing some degree of conflict between the fantasy of a desired reality, and reality itself. When we don't listen for such statements as expressions of fantasy, we may hear what is expressed as "normal"

thoughts and reactions, given the nature of the experience. But if these statements are heard as expressions of holding onto something, of not being able to completely accept the experience exactly as it was, of holding on to a different (feared, or wished-for) story of the events, we can hear them in the same vein as someone who is stuck in the bereavement process, having difficulty accepting a loss. Lammers' characterization of these fantasies as "frozen energy structures" seems to me to be not only an apt description, but also a useful way to think of them and to work with them; his definition of the problem as a dissociation from the present moment is also useful.

We can see these latent fantasies most clearly in the bereavement process. The bereavement process is a one of coming to terms with a loss. This necessitates coming to a state of acceptance of the loss, and of any and all losses associated with the primary loss. This may mean letting go of envisioning a life with another person in it, or of envisioning a life without the physical capacities one has lost, or of things we envisioned we would do or accomplish. For example, a soldier who lost limbs, who had planned on taking over the family carpentry business when he retired from the military, may need to grieve not only the loss of his limbs, not only the loss of a "normal" life and functioning. He might also have to grieve the loss of his plans for his future, of this basis for financial security, and of an activity he found highly meaningful – if these are the outcomes of his injuries. This means letting go of the subconscious or conscious mental constructs of the future that had been previously held. It is quite common among people who present as "stuck" in the bereavement process to find that they are stuck in letting go of how they had envisioned some aspect of their life that is now no longer possible. There is an aspect of the loss which they are having difficulty accepting. In other words, they are holding on to what had been their expectations of the future, which is now a "frozen fantasy."

Fantasy and trauma

Throughout the history of psychology, fantasy has been discussed in relation to trauma in a number of ways. Perhaps the most (in)famous and seminal relating of fantasy to trauma has been Freud's abandonment of his "seduction theory," replacing it with the idea of a "seduction fantasy".(Ahbel-Rappe, 2011; Brown & van der Hart, 1998; Scaer, 2001). To summarize this in broad strokes, Freud initially theorized that the source of his patients' neuroses and particularly hysteria, lay in repressed memories of childhood sexual abuse. He specifically referred to these "seduction" experiences as trauma that had damaging, life-altering consequences on the psyche and on a person's functioning. He later abandoned this theory on the basis that the unconscious cannot differentiate between actual reality and imagined reality - and that it was inconceivable that so many fathers had sexually abused their children - and suggested that the origins of these neuroses lay, rather, in the unconscious sexual *fantasies* of his patients' childhood minds. (The trajectory of this theoretical development is far more complex than is generally understood and than can be presented here (Ahbel-Rappe, 2011).)

This has contributed to debates on repressed memories and on whether authentic, repressed memories can be distinguished from fantasy (Person, 1994). "Longitudinal attachment research demonstrates an association between traumatic childhood events and proneness to dissociation". (Schore, 2009). "Others have proposed that dissociation makes individuals prone to fantasy, thereby engendering confabulated memories of trauma." (Dalenberg, et al, 2012). There are suggestions that memories "recovered" in therapy are suspect, because depending on the means by which these memories have been recovered, they may have been influenced by, or may even be the product of suggestion, rather than being based in fact. However, this theory is controversial and research evidence supporting it is generally considered poor (Brown & van der Hart, 1998)

In their paper entitled “Trauma-related Structural Dissociation of the Personality,” Nijenhuis, Van der Hart and Steele (2004) note that "Although the (Emotional Personality's) traumatic memories include reproductive elements, they are not exact replications of overwhelming events. Apart from the

individual's experience of the event, they may include his or her fantasy and misperceptions at the time, and exclude parts of the experience. For example, the traumatic memory of Charcot's patient LeLog included the idea that he had been run over by a wagon (Charcot, 1889). In fact, before losing consciousness, he had seen the wheels approaching him, which impressed upon him the idea of being run over, though he was actually never hit. Also, elements of other (traumatic) experiences may become associated with the traumatic memory, and thus confound it." In this case, while fantasy is noted as a feature of a person's traumatic memories, it is not focused on as a critical element that needs to be addressed.

Within the field of trauma therapy, Herman (1994) has discussed the Revenge Fantasy, the Forgiveness Fantasy and the Compensation Fantasy. These are various forms of fantasies of resolving the trauma, without having to fully face the seemingly unresolvable aspects of the experience, including feelings of helplessness, feelings of rage and feelings of loss. Others have discussed quite the opposite: how dissociation, either at the time of the trauma or later, can permit denial - a fantasy that there was no trauma, or that aspects of the trauma have not occurred (Brown & van der Hart, 1998) - or even amnesia (Scaer, 2001). Yet others discuss the phenomenon of fantasy as dissociation pertaining to the relationship with the abuser. For example, the fantasy that it is, in fact, a loving and caring relationship (Wang, 2013).

Finally, the above case study is an example of the "Annihilation – Survival fantasy" (Hurvich, 2014). An event perceived as a threat to survival has resulted in a pervasive and persistent subconscious fantasy that the threat to survival continues to exist, resulting in posttraumatic symptoms.

While various writers have identified these diverse forms of trauma-related fantasies, and their relationship to posttraumatic symptoms, I have not seen any discussion about addressing and treating them as traumatic stressors in their own right - elements that are traumatizing in an ongoing manner. While a cognitive approach to treating the annihilation-survival fantasy would conceivably be to work at increasing the strength of adaptive thoughts recognizing that the threat no longer exists, that the reality of the situation is that the person survived, and that the experience is in the past, in my experience this is not always sufficient.

Bessel van der Kolk (1994) has discussed that since trauma is not primarily a cognitive experience but a physiological one, then to be effective, trauma therapy must be primarily focused on the body, on physiological processes: "The imprint of trauma doesn't 'sit' in the verbal, understanding, part of the brain, but in much deeper regions - amygdala, hippocampus, hypothalamus, brain stem - which are only marginally affected by thinking and cognition. These studies showed that people process their trauma from the bottom up - body to mind - not top down." But if trauma is situated in these subcortical areas, "then to do effective therapy, we need to do things that change the way people regulate these core functions, which probably can't be done by words and language alone" (Wylie, 2014).

That is to say, cognitive approaches do not significantly shift the physiological processes involved in trauma, whereas body-oriented therapies effect a direct modulation of physiological responses. We might assume that a cognitive approach is most suited to addressing fantasies, by correcting irrational thoughts and replacing them with a rational appraisal of the situation or event. However, this is not my experience; trauma-related fantasies often seem to maintain their dissociative effect even when treated in this way.

In discussing trauma-related dissociation, Scaer (2001) notes that while declarative memory, the form of memory that relates to the facts of an event, may be "notoriously inaccurate," it is also subject to decay. Cognitive therapy is therefore likely to be effective in addressing and/or correcting such conscious memories. *Procedural memory*, on the other hand, is more powerful and harder to change.

It is involved in the development of emotional memories and associations, and in the storage of conditioned sensorimotor responses. "Procedural memory is unconscious, implicit and extremely resistant to decay, especially if it is linked to information of high emotional or threat-based content" (van der Kolk, 1994). Although declarative memory may account for much of the arousal-based cognitive symptoms of PTSD, procedural memory provides *the seemingly unbreakable conditioned link that perpetuates the neural cycle of trauma and dissociation*."[My emphasis] (Scaer, 2001) Trauma-related fantasy is not associated with declarative memory, but with procedural memory. It is not a conscious part of the event or experience, but represents a dissociative response to the event or experience that occurred subconsciously, that is implicit rather than explicit, and that is firmly linked in a cycle of dissociation related to unsuccessful attempts to be safe.

Fantasy is always inherently present in all the ways that the traumatized person is *not in the present moment.* Fantasy therefore involves dissociation, and is an implicit and inescapable aspect of trauma that needs to be addressed in treatment. However, one of the most powerful fantasies that needs to be addressed in treatment is often neglected because the focus tends to be on *what happened* and, perhaps, on the ultimate victory of survival. The *imagined worst-case scenario* – of which the above case study is an example – is a powerful fantasy that can continue to haunt or rather, continually retraumatize the victim, and interfere with resolution of the trauma. This fantasy is not always a conscious element of the process, but it can be critical to the success of treatment to identify it and resolve it (Mills, 1998).

Treating trauma related fantasies

There is an aspect of trauma therapy which is virtually the same kind of process as bereavement: that of coming to terms with what happened, coming to full acceptance of that reality in order to be able to move on, and to be in the present, rather than to be reacting to the past. Here, again, when people are "stuck" we often find that what holds them back is difficulty accepting, and difficulty letting go – not only of what happened, but of what will now never be: an innocent childhood, a loving and protective parent, a sense of safety in the world, a close family, etc. I have found that these types of latent fantasies are invariably present in trauma resulting from childhood abuse because, invariably, the child was disappointed in his or her expectation (or fantasy) of being protected by the parent(s). There are many other possibilities of latent fantasies in these situations, but I have found that this is the most common, recurring one.

If a child was abused sexually (or otherwise) and was threatened with a statement such as, "If you tell anybody I will kill you," then an immediate fantasy is formed of being killed by the perpetrator. This fantasy will become "frozen" in the psyche and can inhibit the therapy process. With victims of bullying, I have often found a "frozen" fantasy of the "worst-case scenario" continuing to affect the person's interpersonal and social functioning decades later.

With victims of bullying I have also found a more subtle form of traumatic fantasy that seems to hold even greater power. Even if the individual was "only" actively bullied, say, once a week, every evening when he or she thought of going to school the next day, and every morning when going to school, that individual was playing out a fantasy of what *might* happen. This fantasy activates or perpetuates a continual freeze response regardless of whether or not bullying is actually occurring. The freeze response is, of course, a trauma response (Levine,1997; van der Kolk, 1994). It can persist well past the time that the traumatic event and the actual threats are over, and become a chronic pattern of response. These types of "frozen" responses become traumatic experiences in their own right. For example, when the chronic physiological freeze response is activated, it creates an experience - including a perception - that the person is unsafe and under threat. At the minimum, it triggers a sense of not being in control of one's own body and mind, one's own experience of the present moment. In

this case, the chronic response itself triggers a re-experiencing of the original traumatic event, but as a *physiological* event. In PTSD, therefore, people may be continually re-traumatized by their psychological and physiological responses - not always to a memory, per se, but to a "frozen fantasy."

If a distinguishing feature of unresolved trauma is "a sense that the trauma has not yet ended" (Rothschild, 2000, p 12) then an ongoing fantasy element perpetuates that aspect of the trauma experience and, therefore, the trauma itself. If we continue, for example, to fantasize about a worst-case scenario, then our brain continues to react either as if this may, indeed, occur or as if it is actually occurring, rather than processing the memory of the event as it was, and as something that is over. If we continue to fantasize (even subconsciously) about the ideal or desired reality that did not exist - such as a nurturing and protective parent - then our brain continues to suspend our full apprehension and acceptance of the reality of our experience. In both cases, there is dissociation from the reality of our experience which not only prevents accepting and adjusting to the reality of the event as it occurred, but also the reality that it has now passed and that the person is safe.

"The hippocampus...gives time and space context to an event, putting our memories into their proper perspective and place in our life's time line. Hippocampal processing gives events a beginning, a middle, and an end... It has been shown that the activity of the hippocampus often becomes suppressed during traumatic threat; its usual assistance in processing and storing an event is not available... When this occurs, the traumatic event is prevented from occupying its proper position in the individual's history and continues to invade the present." (Rothschild, 2000, p.12)

After having encountered this type of "frozen fantasy" among victims of bullying, I also became aware of it in treating military personnel with war trauma. One client of mine related how he arrived in Afghanistan and on his way to the compound saw a huge, burned-out, pile of sand. He was told the story of how four soldiers were trapped and died in their burning vehicle and sand was piled on the vehicle with a tractor to put the fire out. Arriving in the compound, he saw the burned-out shell of the vehicle. This immediately "imprinted" him. Beyond being vicariously traumatized, he now had a fantasy of this possibility happening to him, which was activated every time he went out in a motorized patrol. Another trauma involved watching a live video feed monitor, and witnessing some of his friends being gunned down in an ambush in a specific location. This also became a fantasy of what might happen to him. Every time he had to go to that location on patrol, he had a fantasy in his mind of what might happen, and found himself actively reacting to that fantasy.

These aspects of his trauma only surfaced through close questioning and listening, and by exploring beyond the usual definitions and expectations of what constitutes traumatic experiences. While they may have otherwise been seen and framed as either *vicarious trauma*, or as trauma resulting from the *perception* of a threat, addressing these occurrences in this way would not completely capture the meaning, the impact or the very nature of these traumatic triggers.

Lammers' comment that "both triggering memories and fantasies are denying the fact that we're living in the present" is consistent with the framing of posttraumatic symptoms as a disorder of the ability to be in the present moment. This has been described in terms of somatic experience (Levine, 1997) as well as in terms of psychological (Scaer, 2014) and physiological processes (van der Kolk, 1994; Ruden, 2011). Whenever posttraumatic symptoms are activated, the person is reacting as though they are currently *in* the traumatic situation, as if that past situation is occurring in the present. Dissociative symptoms and symptoms of re-experiencing are by definition about *not* being in the present moment. The reality of the present moment and cognitive awareness of it are distorted, if not altogether erased, by psycho-bio-physiological responses related to the past.

> If our "nows" are perpetually interrupted by intrusive memories, we're essentially stuck in a time warp formed by those stored perceptions. We can't problem-solve, we can't experience

> a daffodil or a sunset, we can't relate to other people, resolve old conflicts, or form new attachments. Only in the here and now can we directly experience, and move ahead with, our lives. (Scaer, 2014)

With the resolution of trauma, memories are perceived and experienced as located in the past and as no longer affecting the present in any immediate way, and there is little emotional, psychological or physiological reactivity to them. Whatever reactivity there may be is experienced as a normal, passing emotion that does not interfere with functioning in the present moment, and with cognitive awareness and clarity of the present moment. The person is able to notice what *is* going on and to respond appropriately, as opposed to reacting to what he or she *feels like* is going on, a perception of reality defined by the traumatic responses that have been triggered. Memory of the traumatic event itself shifts from unmediated sensations -- repetitive and un-integrated -- to an integrated story. (Scaer, 2014)

Application in treatment

Since encountering these ideas about working with latent, "frozen" fantasies in the context of Dr. Lammers' workshops, I have incorporated these into much of my treatment of trauma and of bereavement, with considerable success. When I hear these fantasies being implicitly expressed or suggested by the client, and I verbalize them in the treatment process, they are rarely something the client has thought of, but there is often an instant, perceptible moment of recognition and of connection when they are verbalized. Almost invariably, when they are treated, there is a shift in the client's feelings, and significant progress in the treatment process.

These latent fantasies, these "frozen structures," can be conceptualized on several levels, or according to several different constructs, such as: cognitive, somatic, psychodynamic, neurological, and energetic ones. The energetic construct has been an integral concept in psychology since the origins of psychodynamic psychotherapy (Freud, 1922) and is well-known in somatically-focused therapies (Lowen, 1997; Levine, 1997; van der Kolk, 1994). In my integrative approach I have found it useful to keep all of these different "levels" or constructs in mind, as some are more useful to engage at different times, with different people. Overall, however, I have found that the energetic construct effectively encompasses and integrates all of the others (Gallo, 2000) and that the new, Energy Psychology approaches offer the most effective methods for addressing all of these levels in an integrated and holistic manner. These are the most effective and efficient treatments for resolving posttraumatic symptoms, along with the traumatic experiences themselves, that I have ever tried or been trained in (Isler, 2012). Scaer (2104) also supports these modalities as useful and effective, as does van der Kolk (1994).

Energy psychology is a fairly large umbrella of methods and techniques. These techniques are currently not fully accepted in mainstream psychology, although increasing numbers of practitioners are using them. There is also an ever-increasing body of research supporting their effectiveness (Church, 2013; Feinstein, 2012). This acceptance was further validated in 2012 when the American Psychological Association approved CE credits for Energy Psychology courses (ACEP, 2012). In many ways, Energy Psychology seems to me to be at a stage similar to that which EMDR was, perhaps, 10 years ago – before it became accepted as an evidence-based treatment for trauma (though not without ongoing controversy). There is still very strong resistance to EP but at the same time there is an increasing amount of evidence for its efficacy and a substantially growing number of clinicians using it. All indications is that it is building a critical mass of both evidence and acceptance that will result in its eventual acceptance as a form of treatment.

There are some similarities between the two types of treatments (Scaer, 2014). Treatment of trauma with Energy Psychology (EP) techniques is, in essence, a form of exposure and desensitization therapy, as is EMDR. Both types of approaches involve having the person access the memory of the event, or of discrete aspects of the event, while engaging in procedures that alter their physiological responses to the memory. However, EP techniques differ from standard exposure therapy techniques, in that re-experiencing and "reliving" is minimized to prevent re-traumatization. Techniques are utilized that effectively alter the client's experience *in the moment* – including the physiological experience – partly through distraction, partly through calming the physiological responses, and partly by keeping the attention in the present moment. The most widely used EP techniques involve tapping on acupressure points. The tapping is purported to have a direct calming effect (Feinstein, 2015) while simultaneously disrupting the person's focus on the past by maintaining part of the attention on the present. These types of approaches also facilitate a fluid process of working with the cognitive associations, emotional reactions and physiological responses that emerge spontaneously in the process.

The most commonly used and well-researched energy psychology technique is called Emotional Freedom Techniques (EFT). I sometimes use this technique - especially for military trauma - as it is not only effective in reducing symptoms and resolving trauma, but it is an easy-to-learn technique that clients can use for self-management of their symptoms. However, I prefer the approach developed by Dr. Lammers called Logosynthesis (Lammers, 2015) and use it consistently in my practice.

Logosynthesis is a simple and elegant technique that combines aspects of mindfulness and somatic focusing, along with exposure and desensitization, and cognitive reframing (Isler, 2014). The method guides the person to disengage from the narrative of the experience, on the premise that re-engaging a narrative reinforces the narrative itself and, more importantly, reinforces the constellation of responses associated with that narrative. Instead, people are guided to focus on the responses they are having in the present moment as they think or speak about the event, and to identify the stimulus to that response: the image, thought, perception, etc. that is present to the person, *in the present moment*, as associated with that response. They are then guided in repeating specific statements. Each statement is an affirmation of relocating the energy associated with the stimulus. Between each statement is a moment of mindful focusing, allowing processing of the mind and body's responses. As I have described elsewhere (Isler, 2014), I have invariably found that this method is conducive to positive changes in feelings, perceptions and thoughts about the experience, and that it facilitates resolution of trauma (as well as other types of issues).The process of this approach itself facilitates the surfacing of latent fantasies, and I find that using this technique to treat those fantasies invariably results in a significant, positive shift in the client's treatment process. Shifts result on a cognitive level as well as in feelings and symptoms. Memories are reframed, and the symptoms related to these memories - symptoms of re-experiencing, and of psychological and physiological reactivity - are reduced or resolved, as is reactivity to triggers related to that memory.

I have used this technique with great success to address and resolve clients' traumatic memories, reactions and posttraumatic symptoms. Use of the technique usually leads to the very outcome identified above as necessary for successful resolution of trauma: an ability to be in the present moment, and not to be "yanked back" into the past through any and all of the classic posttraumatic symptoms. Whereas, at the beginning of the session, thinking about a particular memory, or particular aspect of the traumatic experience might elicit active physiological and psychological reactions, after the Logosynthesis treatment, clients will say such things as: "it's in the past now, it doesn't bother me anymore." If they were accessing a visual image or memory they will often describe the image as being more indistinct, further away, or blurry. The process often leads to spontaneous, cognitive reframing once the memory no longer triggers a reaction. In other words, whereas they had been

experiencing *the past in the present*, they are now experiencing the past as the past, and the present in the present.

Conclusion

In the process of treating, or otherwise addressing and trying to resolve the impacts of traumatic experiences, there are times when the process may seem to be at an impasse. This may sometimes be perceived as "resistance," and may manifest as unresponsiveness to strategies that are usually effective. It is often apparent in a sense of being unable to "get past"a specific aspect of the event, a specific thought about the event, or the event itself. In these cases, it is always worthwhile to explore the possibility that there may be latent, "frozen" fantasies that are preventing a resolution of the trauma. These fantasies are highly treatable and easily resolved with Energy Psychology methods, once identified. Their treatment results in cognitive reframing that facilitates resolution of the trauma.

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