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[2]References to the other eight volumes in Spielberger and Sarason's series can be found in this recent volume.

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Dissociation and Hypnosis in Post-traumatic Stress Disorders

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After noting the fundamental differences between the agenda of ordinary psychotherapy and the treatment of post-traumatic stress disorder (PTSD), the paper discusses the concept of trauma vis-à-vis PTSD using Yalom's (1981) four existential themes of death, freedom, isolation, and meaninglessness as organizing principles. The middle section of the paper focuses on the role of dissociation in the symptomatology of PTSD, suggesting, among other things, that many PTSD symptoms are dissociative in nature; that it is a defense against both memories of the event and the experience itself. Research is reviewed supporting the connection between PTSD and hypnotizability and the use of hypnosis in treating traumatic stress is discussed followed by two case examples. The latter section focuses on the limitations of hypnosis, transference considerations, and ends with a summary of the author's eight "C's" treatment approach: confront, condensation, confession, consolation, consciousness, concentration, control, and congruence.

KEY WORDS: post-traumatic stress disorder; death; freedom; isolation; meaninglessness; dissociation; hypnosis.

INTRODUCTION

Plato defined courage as knowing when to be afraid. This problem of knowing when to be afraid haunts many individuals with post-traumatic stress disorders and becomes one of the challenges in psychotherapy. The treatment of these individuals also involves helping return to them a sense of control over their lives, a control which is wrested from them by the traumatic event. This occurs symbolically in the therapy by giving them a sense of con-

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trol over their states of mind and trying to teach them a sense of integration. Ironically hypnosis, a technique long associated with fears of losing control, can be especially effective in helping such patients regain control over traumatic memories and their effects.

Traditional psychiatric theory has been especially weak in dealing with post-traumatic stress disorders, because developmental dynamic theories are unequipped to account for the sudden intrusion of a major life stress. In fact, to apply traditional techniques to individuals suffering from a rape or combat experience is by its very nature to belittle the importance of the trauma and attempt to interweave it into the pattern of the person's development. Many patients with post-traumatic stress disorders find this demeaning and humiliating since it relegates to the periphery the importance of their emotional reactions to the trauma itself. Further, it reinforces the common irrational belief that they were somehow responsible for the tragedy which befell them, and thereby encourages them to avoid working through the helplessness which is at the core of PTSD symptomatology.

Therefore, there is a fundamental dichotomy between warded off wishes and traumatic memories, and the relevant therapeutic tasks are exactly the opposite. The traditional psychotherapist's task in dealing with unconscious developmentally based conflicts is in essence responsibility assumption, helping patients recognize and assimilate their own unconscious conflict-laden wishes and fears. On the other hand, most trauma victims blame themselves inappropriately for bringing the traumatic event upon themselves. Therefore, teaching them in psychotherapy to accept responsibility for the event only further reinforces their denial of the absolute helplessness they experienced at the moment of trauma, and reinforces rather than relieves inappropriate guilt related to the trauma. Thus, the therapeutic challenges in ordinary psychotherapy and the treatment of post-traumatic stress disorder are quite different.

TRAUMA AND POST-TRAUMATIC STRESS DISORDER

Trauma can be understood as the experience of being made into an object: the victim of someone's rage, of one's own limitations, of nature's indifference. For Vietnam veterans, it was the experience of being made into a killing machine or an object of mutilation. For rape victims, it means being brutalized, threatened with death, and made into a sexual object. The traumatic event is a situation which wrests from patients control over their own states of mind. People who have suffered these events will often delineate the sharp contrast between the pretraumatic state of mind, a sense of fellowship with buddies in combat, a sense of well-being or happy anticipation, and that which is imposed by participation in combat or assault: helplessness, fear, pain, anxiety, guilt, and a variety of other dysphoric emotional states. Specific defensive patterns emerge in an effort to control the imposition of these dysphoric states of mind, and it is not just the dysphoria but the loss of control over one's own state of mind that constitutes the full depth of post-traumatic symptomatology.

The phenomenology of this disorder can also be organized along the lines of Yalom's (1981) four existential themes: death, freedom, isolation, and meaninglessness. However, they occur in a special sense in a traumatic event, in reality rather than in the abstract, and the victim of trauma or participation in it is not so much avoiding these themes unconsciously as struggling with their stark reality.

Death is the first. Combat veterans clearly have overwhelming confrontations with their own finitude. Ron Kovic (1976) expresses this starkly in his book *Born on the Fourth of July*:

> The blood is still rolling off my flack jacket from the hole in my shoulder and there are bullets cracking into the sand all around me. I keep trying to move my legs but I cannot feel them. I try to breathe but it is difficult. I have to get out of this place, make it out of here somehow....
> Oh get me out of here, get me out of here, please someone help me. Oh God oh Jesus! "Is there a corpsman?" I cry. "Can you get a corpsman?"
> "Sarge, are you all right?" Someone else is calling to me now and I try to turn around. Again there is the sudden crack of a bullet and a boy's voice crying. "Oh Jesus! Oh Jesus Christ!" I hear his body fall in back of me.
> I think he must be dead but I feel nothing for him, I just want to live. I feel nothing. (pp. 14-15)

It is not only his own finitude that Kovic faces in combat but also a loss of faith, faith in others, a sudden realization of the extremes of what others will do to him, a loss of faith in himself. Along with the death of friends, combat soldiers face the death of their own secure sense of themselves, their image of themselves as fearless and omnipotent. It is these kinds of deaths as well that must be mourned. Further, the absence of the emotion is a dissociative defense against the overwhelming nature of the trauma.

The second issue is freedom. Yalom defines the distinction between neurotic guilt, which "emanates from *imagined* transgressions" (p. 276), and existential guilt, in which he cites Heidegger's notion of being "guilty to the extent that one has failed to fulfill authentic possibility." The victim of the post-traumatic stress disorder suffers from what Yalom would call real guilt, a painful sense of responsibility. One is not worried about the possible failure of self-fulfillment in the future; one is worried about one's actual or imagined responsibility for events in the past. In fact, the intertwining of real and imagined responsibility is a particularly difficult issue. The task in normal psychotherapy is to help people accept responsibility for the pattern of events, unfulfilling relationships, failure at work, and so on, that comprise a pa-

tient's life. In many ways, the challenge in post-traumatic stress disorders is exactly the opposite: helping patients recognize the realm of events which was beyond their control and responsibility. This is complex because there often are events in combat for which patients feel profoundly and appropriately guilty. At the same time, their overall situation in a zone of combat or in a place of vulnerability may well be beyond their responsibility, and learning to delineate those areas where they had control and those that were beyond them is a crucial task.

The events on record for which combat veterans have taken appropriate responsibility are legion. Vietnam veterans have reported having been ordered to murder children who were thought to be Viet Cong. One man who immersed himself in community activities in an effort to make up for his fundamental sense of guilt had been involved as a radar officer directing B-52 strikes at hospitals. His responsibility, on direct orders from the Joint Chiefs of Staff, was to line up the red crosses on the roofs of hospitals in North Vietnam in the cross hairs of his radar screen and then order the bomb releases. He found it impossible to overcome his sense of responsibility for what he had done, despite his having direct orders from superiors to do it.

The sense of isolation among victims of traumatic stress is well known. Many Vietnam veterans suffer long-standing impairment in the capacity to develop intimate relationships, as Haley's (1974) work has documented. The fact that many of these individuals have actually committed acts of extreme violence necessarily makes intimate relationships riskier. The development of intimacy involves stirring strong feelings of love and hatred. It is often a great reassurance to people who are swept with extreme anger to know that they have never actually acted on it. When individuals have, the development of intimate relationships is thus fraught with increased risk because the person has less assurance that he would not act out his anger. The occurrence of flashbacks, for example, episodes of Vietnam veterans awaking throttling their wives while thinking they are being attacked on the battle field, makes it clear that this is not just a theoretical problem. Likewise, many rape victims often find themselves isolated from any satisfying intimate experience because, loving and tender as their sexual partners may be, there is a sense in which the very act of making love is tainted with the experience of having been sexually victimized.

Finally, there is the issue of meaninglessness. Victims of trauma often see the event as a meaningless tragedy. As one Vietnam veteran put it, "I think any other war would have been worth my foot, but not this one. One day, someone has got to explain to me why I was there" (U.S. Government Printing Office, No. 5100-0057, 1972). This excerpt from testimony before Congress is typical of many combat veterans who find it especially important that there be a meaning to the loss. Frankl (1965) and others have commented that a human can endure almost anything if it is imbued with meaning. On the other hand, the very essence of trauma is that it is in some sense meaningless, accidental, gratuitous, and this sets victims on a search for some framework in which to give the otherwise meaningless experience some sense of importance in their life. One combat veteran summarized the experience of the persistent preoccupation with Vietnam with two symptoms: he hallucinated faces of friends and a voice asking him, "Why?" and he was pursued by a recurrent dream in which he was deer hunting and came to quiet spot in the woods near a lake. He was attacked by a badger in the dream, "I kept looking at it but I couldn't kill it. It kept tearing me up and I kept stabbing at it, but I kept missing it until finally I shanked it." He described the dream as representing "vicious memories" of experiences in Vietnam which were "badgering" him.

DISSOCIATION AND POST-TRAUMATIC STRESS DISORDER

The Diagnostic and Statistical manual of Mental Disorders (3rd Ed.) (DSM-III) (American Psychiatric Association, 1980) defines post-traumatic stress disorder as consisting of four criteria: (1) the existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone; (2) reexperiencing of the trauma with intrusive recollections, recurrent dreams, or suddenly feeling that the event was recurring; (3) a sense of isolation from others characterized by diminished responsiveness or interest in activities, a feeling of detachment or constricted affect; and, (4) two or more of the following symptoms: hyperalertness, sleep disturbance, survivor guilt, concentration or memory impairment, avoidance of activities that stimulate recollections of the traumatic event, or intensification of symptoms by exposure to such activities.

Many of these symptoms are dissociative in nature. DSM-III points out that the essential feature of a dissociative disorder is "a sudden temporary alteration in the normally integrative functions of consciousness, identity, or motor behavior" (p. 253). Such dramatic alterations in mental state can be understood as well suited to reflect a sudden temporary and often severe alteration in physical state. Indeed, dissociative disorders are characterized by a marked loss of control over mental state, either via psychogenic amnesia, fugue, or, in the exteme, multiple personality disorder. These dissociative symptoms can be conceptualized as a reflection of the profound loss of physical control experienced during the trauma. The sudden reliving of traumatic experiences, sensitivity to stimuli which are reminders of the traumatic event, and the intensification of symptoms by exposure to such stimuli are often accompanied by alterations in self-perception. Indeed, the psychic

numbing described by Lifton (1967, 1973) and characterized by the Diagnostic Manual as a sense of isolation from others is consistent with this dissociated self-image. The self which experienced the trauma is detached from the everyday self but continues to exert a demoralizing influence upon it. Thus, dissociation can be understood as a fundamental mechanism through which individuals experience and suffer from trauma.

Indeed, dissociation has recently been understood as a defense not simply against memories or warded-off unconscious wishes but rather as a defense against the traumatic experience itself (Spiegel, 1984; Putnam, 1985). It is thus not really a retrospective but an immediate defense, protecting patients against the overwhelming pain and fear that accompanies trauma. Many rape victims report out-of-body experiences in which they float above their own bodies, feeling sorry for the person who is being sexually assaulted. It is not uncommon for patients suffering cardiac arrest to picture themselves floating above their bodies, watching the team performing cardiopulmonary resuscitation. One patient (Spiegel, 1984) reported an accidental fall from a third-story balcony as though she were standing on another balcony watching a pink cloud float to the ground. She reported no pain at all and indeed attempted to get up and walk back up to the party despite having suffered a fractured pelvis.

There is increasing evidence of a connection between the experience of trauma and the use of dissociation. A number of studies have now shown that the prevalence of severe physical trauma including beatings, torture, and incest is well above 90% among patients with multiple personality disorder (Spiegel, 1984; Wilbur, 1984; Kluft, 1984; Putnam, 1985). Indeed, these patients report slipping into a dissociated state during episodes of abuse, at first spontaneously and then deliberately. One such patient reported that the first time she experienced an alternative personality was when her father tied her to the bed and raped her. The personality said, "You don't want to be with him. Come be with me now." Another patient tried to endure her father's beatings and sexual assaults while wandering in an imaginary field of wildflowers, an escape which so irritated her father that he, according to the patient, tried to hurt her sufficiently that she could not "leave." A multiple personality patient who was raped by a stranger after her disorder had begun, dissociated to a new personality, which she called "No One," during the rape. This particular name had several interesting defensive purposes. She was made to feel like a "nobody" during the rape and in its aftermath, and yet in retrospect she could look back and say, "No one was raped," the radical discontinuity of selves serving to create the illusion that the rape had not happened to her.

Until recently, there have been no formal measures of dissociation as a phenomenon in itself (Sanders, 1986), but there has long been a link between the frequency of spontaneous episodes of hypnotic-like dissociation and formally measured hypnotizability (Shor, 1960; As, 1962; Tellegen and Atkinson, 1974). Since hypnosis is a form of structured and controlled dissociation (Nemiah, 1985; Spiegel and Spiegel, 1978), an empirical test of the hypothesized relationship would be evidence of high hypnotizability among individuals who have suffered from trauma and its aftereffects. The first such finding is in the work of Josephine Hilgard (1970). In her studies of the early life experiences which were associated with later high hypnotizability, she found that punishment was a predictor variable. This finding was of special interest, since it was against the author's hypothesis that early life experiences which would build trust were likely to result in later high hypnotizability. The other associated variables, a history of imaginative involvements and identification with the opposite-sex parent, were consistent with her hypothesis. She noted that "a possible tie between punishment and hypnotic involvement might come by way of dissociation.... Although we have no direct evidence, some of our case material....suggests that reading or other involvement may sometimes be an escape from the harsh realities of a punitive environment" (p. 221). When these data were reanalyzed by Frischholz (1985), he found that a multiple correlation combining imaginative involvement and punishment yielded a significantly higher correlation with hypnotizability ($r = 0.4$) than did either variable alone, suggesting that each contributes independently to the development or preservation of high hypnotizability. This is of theoretical interest since hypnotizability is at its peak in the later years of childhood (Morgan and Hilgard, 1973; Spiegel and Spiegel, 1978) and declines slowly over adolescence. It may be therefore that traumatic experience early in life impells certain individuals to maintain their high hypnotizability through developmental periods when they would begin to lose this extreme capacity.

Only two studies have addressed the connection between post-traumatic stress disorder and hypnotizability more directly. The first (Stutman and Bliss, 1985) divided 26 Vietnam combat veterans into two groups, one high and one low in post-traumatic symptomatology. They found that the more symptomatic group was more highly hypnotizable on the Stanford Hypnotic Susceptibility Scale, Form C (SHSS:C) (Weitzenhoffer and Hilgard, 1962). The study was important because there was no self-selection involved. These were not patients but rather veterans who responded to a newspaper advertisement.

More recently, we (Spiegel *et al.*, 1987) studied a sample of 65 Vietnam veterans in treatment for post-traumatic stress disorder. Their mean hypnotizability scores on the Hypnotic Induction Profile (HIP) (Spiegel and Spiegel, 1978) were significantly higher than those of a normal comparison sample. Of clinical interest is the fact that these hypnotizability scores were also sig-

nificantly higher than those of three other large patient samples, including those of patients with schizophrenia, unipolar and bipolar depressive disorders, and patients with generalized anxiety disorder. The magnitude of the differences on the HIP's 0-10 Induction Scale were great enough to be of clinical as well as research importance.

These studies are few in number but at least consistent. They do not, however, answer the question of causation. Are highly hypnotizable individuals more vulnerable to the symptoms of PTSD, which, as noted above, include many dissociative features, or do traumatic experiences somehow enhance hypnotizability by imprinting a dissociative experience during the trauma? Do combat veterans who have been traumatized but are incapable of dissociation resort to other defenses and symptoms such as alcoholism and drug abuse? These are important questions for future research. At the least, the few studies available support the relevance of dissociation, and therefore hypnosis, to the phenomenology and treatment of post-traumatic stress disorder.

Thus there is evidence from a variety of populations that the capacity to use dissociation, either spontaneously or under controlled conditions in hypnosis, may be an adaptive response to severe physical trauma. Like most adaptations, however, it has its price, and it may indeed become the problem. While dissociation may help the patient defend against the experience of physical helplessness, it does so at the cost of psychological helplessness, of being taken over by spontaneous episodes of reliving the event, or by dissociated personalities, in the extreme case of multiple personality disorder. Traumatized individuals find it hardest to face their own utter helplessness at the moment of trauma, and instead irrationally blame themselves for their failure to have foreseen the traumatic event or to have surmounted overwhelming odds and changed the outcome. At the same time, they feel irrationally helpless about the course of their present and future life, acting as though in some ways they had died at the moment of trauma (Krystal, 1978). Hypnosis and dissociation are especially suitable vehicles for this problem, since the experience of involuntariness is a major component of hypnosis (Weitzenhoffer, 1980). Ironically, hypnosis can be used at the same time as a means of enhancing patients' sense of control over their mental state despite the expectation that it will be used to deprive them of control; and this is crucial to the therapeutic use of hypnosis.

The defensive phenomenology of victims of trauma can certainly be described using familiar psychoanalytic terms: repression, isolation, displacement, reaction formation, etc. (Freud, 1946). However, there are certain common features in the stress response syndrome. They can be thought of as spatial and temporal fragmentation. During the acute stress, such individuals often respond by saying, "This is not me," and experience it as a dissociation, depersonalization, or out-of-body experience. They often report experiencing the trauma as though it were happening to someone else, occurring in slow motion, or as if they were above their body watching the event happen. This defense results in a fragmented state of mind. The person tries to act as though the event happened to someone else, somewhere else. But this only subtly reinforces the importance of the state of mind in which he or she experienced the trauma. It becomes the hidden truth, the real truth about the person, giving it an exalted importance, a kind of ontological override, in which the way the person was at the time of combat experience or rape comes to seem the most fundamental truth about the person's being, despite a lifetime of totally different performance. One way of determining how badly the person is coping is to assess the degree of fragmentation that he or she experiences. In Horowitz's sense, they experience a relative inability to control their states of mind (Horowitz and Solomon, 1978; Horowitz, 1979). Krystal (1978) describes this condition well in terms of "cognitive constriction." He links it to the helplessness enforced on the victim of overwhelming trauma, which is often accompanied by a mental state of surrender rather than the anxiety associated with the response to preventable danger. From this point of view, the paralysis imposed by a state of fragmentation is both an affective reenactment of the state of helplessness experienced during the trauma and at the same time an atavistic experience linking the traumatic event to much earlier infantile experiences of helplessness. The loss of physical mastery in the trauma is represented symbolically by the loss of emotional mastery in the traumatic reaction.

Many such individuals also experience a sense of temporal fragmentation. Extreme examples are amnesia and fugue states, in which patients literally find themselves in a different periof of time, or dissociating in an absolute sense experience at one time from that of another. They are isolating their present, temporally, from their past or experiencing the events in their past as though they happened to them rather than through them. The same living, acting person who is with the individual now is not the one who experienced the event previously. Such a person is caught in the Aristotelian error of believing that time is merely a succession of events. This defense deprives his experience of the past of his own continuing presence, so there is no connecting thread of continuity to place these traumatic events in the overall perspective of the patient's life. The events thus come to assume even graver importance than is their due.

Horowitz (1979) has conceptualized the process of psychotherapy in terms of a mutual management of states of mind between patient and therapist. This is a useful theoretical framework because it is the very control over states of mind that is lost in the traumatic event, in which the patient struggles to maintain, by manipulating relationships with therapists, by abus-

ing drugs or alcohol, or by fragmenting his experience of himself, viewing the traumatic event as "not me," or as "not now." This phenomenology suggests a therapy aimed at integration, at interweaving the events of the past with the ongoing fabric of the patient's life.

TREATMENT EMPLOYING HYPNOSIS: FROM RELIVING TO RELIEVING

In his classic paper, Freud (1914) conceptualized the process of psychotherapy as "remembering, repeating, and working through." His early use of hypnotic techniques involved abreaction, or catharsis, in which he felt that the mere expression of the affect tied to a conflict would be enough to discharge it and resolve the conflict. He himself became dissatisfied with this and emphasized more the importance of working through rather than merely remembering or repeating the conflict-laden area. This process has been conceptualized in more existential terms by Semrad (personal communication) as that of acknowledging, bearing, and putting in perspective; and there seems to be increasing recognition that it is the latter, the putting in perspective or working through, that is critical. Simply mobilizing and expressing affect may only serve to demoralize the patient further, because the loss of control that was inflicted upon him by the original trauma may be unintentionally reinforced by a therapeutic technique that only reelicits the dysphoric affect. The crucial task in psychotherapy is that of putting the dilemma into perspective. Lindemann's (1944) concept of grief work is helpful. A necessary process of grieving old images of self or pieces of one's past as part of getting on with living is a useful framework for structuring the psychotherapy of stress disorders.

Interest in the use of hypnosis in the treatment of traumatic stress dates at least as far back as Freud, who conceptualized the treatment approach as abreaction or catharsis (Freud, 1914). The cathartic method drew its name from the then common use of purgatives to treat intestinal and other medical disorders. Theoretically, the concept was too simple: discharge an accumulation of unpleasant affect through the hypnotic reliving of the event. The idea was that giving vent to the repressed emotion associated with the trauma would serve to resolve it. Such treatments were particularly effective when conducted in close proximity to the traumatic even both temporally and physically. Other means of bypassing conscious resistance included use of short-acting intravenous barbiturates. Hypnosis interviews have the advantage of being under delicate control, unlike the generalized discontrol seen in barbiturate interviews.

Major interest in the use of hypnosis in the treatment of trauma reoccurred during World War II (Kardiner and Spiegel, 1947). The use of hypnosis posed a stark contrast to the prevailing psychoanalytic interests of American psychiatry, but attention was shifted from pure abreaction, although this was a major component of the treatment, to the use of hypnosis to rework or modify the memories of the traumatic experience. For example, a soldier suffered an hysterical conversion reaction, an inability to walk, after a combat experience in which he was ordered to retreat and abandon a dying buddy. He was hypnotized and asked to relive the experience. He was instructed to note that the soldier's foot was pointed down instead of up, implying that the soldier had already died, and that the patient's wish to remain with him would have been unavailing. He emerged from this hypnotic experience with a sudden "realization" that his friend was already dead, and he quickly regained the ability to walk (Kardiner and Spiegel, 1947).

More recent interest in hypnosis has focused on using the trance state to help the patient restructure his image of the traumatic experience (Spiegel and Spiegel, 1978; Spiegel, 1981) while maintaining a sympathetic and accepting relationship with the therapist (Brende and Benedict, 1980; Haley, 1978). This use of images in hypnosis can be especially vivid and productive, since imagery is a prominent feature of PTSD symptomatology (Brett and Ostroff, 1985). Indeed, Erdelyi and Kleinbard (1978) found that while verbal recall for previous events tends to deteriorate on repeated interrogation, imagistic recall actually improves with repeated trials. Furthermore, work on state dependent memory (Bower, 1981) suggests that the ability to recall mental content is linked to the ability to reexperience the kind of affect occurring at the time the content was acquired. Thus, the ability to recall and process painful memories should be linked to the ability to experience and tolerate the affects associated with them during the process of recall. It makes sense that hypnosis, a state of aroused, focused concentration with a relative suspension of peripheral awareness (Spiegel and Spiegel, 1978), should be especially useful in helping trauma victims mobilize and reexperience images associated with the trauma while at the same time controlling their affective response to them.

Techniques employing hypnosis and hypnotic concentration can be helpful in providing controlled access to these various states of mind while at the same time giving the patient the sense of control and mastery, so that he or she feels able to tap these dysphoric areas but at the same time balance them with other states that are less demoralizing. The intense focused concentration of the hypnotic trance enables the individual to attend to a portion, or a condensation, of the traumatic experience that does not seem so overwhelming, and thereby put it into a different perspective which can include balancing the loss against some victory or achievement.

One technique that has been typically helpful in the use of hypnosis involves the use of a split screen. Patients, if hypnotizable, are put into a trance, instructed to maintain a pleasant sense of floating relaxation in their

body, and to picture in their mind's eye an imaginary screen. They are asked to picture two images, side by side on this screen. The first is drawn from memories of the traumatic experience. They are taught to balance this image with one representing what they did to protect themselves: in combat, what efforts were made to save a buddy's life, even at the risk of their own; in the case of the loss of a friend in combat, remembering those experiences of joy that were shared together and will remain even though the friend is gone; in the case of rape, the efforts that the victim made to defend herself or protect her life. The split screen is, metaphorically, a way of helping patients put the trauma into perspective by seeing it as a part, but not all of themselves. Patients learn to view it this way by seeing the event on the split screen, that is, at some metaphorical distance, accompanied by a sense of physical relaxation and balanced by a sense of any positive aspects of the trauma. This approach helps them to face it as a real but manageable loss rather than as an overwhelming one. In this way, different aspects of the trauma: issues of responsibility, the confrontation with death, feeling of worthlessness, isolation, and meaninglessness, can be addressed in a perspective that does not overwhelm patients. They can be taught to do this exercise as a kind of grief work several times a day, and, by inference, they can thus permit themselves to feel freer from preoccupation with these issues at other times. When this hypnotic grief work is performed regularly, the frequency of spontaneous dissociative symptoms usually diminishes.

The importance of the self-hypnosis aspect of this approach is that it provides patients with a concrete means of enhancing their sense of self through self-care. Krystal (1978) conceptualizes this as a process of expanding the boundaries of the self and thereby diminishing areas perceived by patients as alien or nonself. This process thus counters the regression frequently experienced by patients suffering with traumatic as well as other disturbances.

Case Example 1

A victim of an attempted rape had felt persistently guilty after the assault because her intense physical struggle had resulted in a basilar skull fracture. She underwent hypnosis in an attempt to enhance her visual memory of the assailant for possible identification. The attempt at identification failed, but as she relived the assault she allowed herself to experience something she had previously dissociated, her recognition at the time that the assailant intended not merely to rape her but to kill her, and that he was surprised at the strength of her physical defense. She left with little hope that she would identify the assailant but with the conviction that she had probably saved her life. □

Case Example 2

A combat soldier suffered a two-day fugue episode in Vietnam and became suicidally depressed. He spent the next four years in a variety of VA and state psychiatric hospitals. He was variously diagnosed as schizophrenic, sociopathic, and depressed, but continued to be actively suicidal. He was identified as highly hypnotizable. Hypnotic age regression was used to help him uncover memories of the dissociated episode. It had occurred during the Tet Offensive after he discovered that a Vietnamese child he had adopted had been killed in a rocket attack. Tears came to his eyes as he berated himself for not having taken the boy to a safer place before the attack. I asked him what the boy would have said to him, were he able to talk. "You number one Sargie, number one cook. They shoulda got me instead of Chitown (the boy's name)." It became clear to him that the boy would not have blamed him. "He knew he was going to die." When instructed to remember a party he had given the boy earlier, his affect changed dramatically in a few seconds. He smiled broadly as he relived giving the boy a gift his sister had sent, and watched him enjoy eating ice cream. "Chitown love ice cream, man," he exclaimed. He was instructed to visualize two images on an imaginary screen: the boy's burial and the party. He emerged from an intense 45-minute hypnotic regression, having relived experiences for which he had had no conscious memory in the intervening five years, with only two memories: the images of a grave and a cake.

Memories of this child had been associated only with the overwhelming pain of his loss. This image helped him to associate the loss with memories of his happiness with the child—the very reason the loss was so painful. Subsequent to this intervention he had two brief rehospitalizations in the face of subsequent losses, but the five-year period of constant suicidal ideation and hospitalization ended. Ten years after the intervention he was again rehospitalized briefly with a recurrence of his depression, linked primarily to his sense of social isolation from peers rather than the boy's loss, but other than this episode he functioned well in the community. He felt he had worked through the death, and regretted only that he had been discharged from the Army during his illness. (Spiegel, 1981). □

Such hypnotic images are integrative. They use the intense unitary experience of being in a hypnotic trance to present an image to patients that is at once divided but unified, allowing them to see themselves as frightened, humiliated, or hurt and at the same time as exerting every effort to control or transcend the situation, or at the least, to reaffirm some positive values in their own life by grieving the pain involved in the loss. By facing themselves in the painful situation, they see their worst fears confirmed and yet modify them by linking this image to an image of themselves as struggling

against the adversity, as having cherished what was lost, making both images tolerable as part of a more unified view of self.

The choice of reviewing the event on an imaginary screen as opposed to reliving it as an hypnotic age regression is another step that the therapist can take to help patients manage the intensity of their emotional reaction. Seeing it on a screen gives patients a sense of distance from the material. It has more of an "as if" quality rather than the vividness of the pure regression. Since dissociation is mobilized during episodes of trauma, and since hypnosis is a structured and controlled form of dissociation (Nemiah, 1985), it makes sense that therapy employing hypnosis can be especially effective in allowing patients to tap traumatic memories, tolerate the associated intensely painful affect, and then restructure the memories in a way that allows their incorporation into consciousness.

LIMITATIONS

There is nothing that can be done with hypnosis that could not be done without it. Hypnosis facilitates the access to and control over these dissociated states. Further, hypnotic techniques are of no use if the subject is not hypnotizable. While recent research indicating higher hypnotizability among victims of PTSD suggests that this is not a major problem (Stutman and Bliss, 1985; Spiegel *et al.*, 1987), the number of patients surveyed is still quite small and there must undoubtedly be many patients suffering PTSD symptoms who do not have the requisite hypnotic capacity to use the technique in treatment. Furthermore, the enhanced receptivity characteristic of patients in a trance constitutes a potential vulnerability. The therapeutic strategy must be well thought out, and the sensitivity to transference problems and the fear of being overwhelmed by the dysphoric affect is intensified in hypnosis. Therefore, therapists employing it should primarily be skilled in the basic principles of assessment and psychotherapy. In such circumstances, hypnosis can facilitate the treatment of patients with post-traumatic stress disorder.

TRANSFERENCE CONSIDERATIONS

Therapists can provide a corrective transference experience through their ability to accept the patient as a person despite the patient's participation in destructive events, as Haley (1978) and Brende and Benedict (1980) have pointed out. Clearly, also, therapists' ability to withstand and help the patient control the often extreme affect which emerges can be helpful to patients in developing a greater acceptance of these affects within themselves.

Traumatic Transference

It is not uncommon for rape victims to report that they feel raped again when interrogated by police about the crime. Some of this reaction may be due to insensitivity on the part of the interrogators. On the other hand, the principle of transference would sensibly apply to any situation in which a trauma victim is asked to discuss an emotion-laden event. Inevitably, they will not only remember but also reexperience the event through the relationship, identifying the therapist either with the assailant or with a passive witness of the crime who did nothing to help. Feelings about the assailant will inevitably emerge and be associated with the therapist. These problems can be contained to some extent through active empathic support to patients as they reexperience traumatic moments. At the same time, the therapist must be prepared to be perceived as nonempathic and to discuss openly to patients feelings of frustration, anger, or disappointment.

Hypnotic Transference

Since hypnosis can be conceptualized as a kind of crystallized or intensified transference (Spiegel, 1959), it makes sense that these sorts of reactions may occur more frequently and with more intensity when hypnosis is employed. Patients may have the sense of being reassaulted during the hypnotic work. Such problems can be mitigated by structuring the hypnosis as an exercise to be started and concluded by the patient. It is important that the therapist be sensitive to the time when patients have had enough, and also to structure the exit from the hypnotic regression in such a way that patients feel comfortable remembering consciously as much but no more than they care to. This can enable patients to face their own helplessness during the traumatic episode and yet not feel completely helpless in doing so.

GUIDELINES

This therapeutic approach can be summarized via a series of eight "C's." It is necessary to *confront* the importance of the traumatic event itself in the patient's ensuing dysfunction. This is something which is often only peripherally recognized by the patient. Then the therapist and patient seek a *condensation* of the trauma—a scene, an event, a dream, a memory which comes to represent the horror of the event and which can be faced. There is often a period of *confession,* in which patients test therapists' acceptance and resiliency, and discuss their responsibility, or sense of it, for the

trauma. *Consolation* may follow. Traditional analytic reserve is often not appropriate. Such patients are openly in pain and are testing whether they are acceptable as human beings despite what has transpired. There is, then, an effort to make this material more *conscious,* interweaving it into patients' sense of themselves as persons, to give them a sense of perspective on how this event fits in the overall pattern of their life. Here, focused *concentration* can be very helpful in giving limits to the loss, in helping patients grieve but in manageable doses, focusing so intently on one aspect of the trauma that they are able to put other aspects of it out of consciousness. Along with this, the sense of *control* is critical. Mastering the transition from one state of mind to another and giving the patient a greater overall sense of *congruence,* of being an integrated person who has been able to face and bear a period of tragedy and incorporate it into the flow of life.

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