POST-TRAUMATIC
STRESS DISORDER
AND THE
WAR VETERAN PATIENT

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CHAPTER

11

The Use of Hypnosis in Post-Traumatic Conditions

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The survivors of traumatic events frequently possess lasting and emotionally distressing post-traumatic symptoms. These include symptom complexes of intrusive traumatic memories, emotions, and imagery alternating with amnesia, denial, and emotional numbing—the latter symptom complex representing the attempt "to forget" (Horowitz, 1976). Yet therapists have long recognized that a survivor cannot truly forget a traumatic experience without first remembering it and making "possible its integration into the structure of the present personality" (Reiff & Scheerer, 1959 p. 41).

"REHEARSING" THE PAST

The "rehearsal" of the past is a common experience in everyone's life. Its importance is based not only on the need to relive and master a previously traumatic situation but to have access to one's own previous life experiences, which is necessary for a sense of identity and continuity with the past (Reiff & Scheerer, 1959). However, persons suffering from the post-traumatic symptoms of amnesia and hypermnesia (Horowitz, 1976) lack such continuity.

Historically, the loss of memory has been described as symptomatic of hysteria, believed caused by sexually traumatic events (Ellenberger, 1970; Veith, 1977). In fact, Breuer & Freud (1893) conceptualized the presence of "hypnoid" or altered states of consciousness taking place in association with traumatic events which provided emotional amnesia for persons with hysteria. Lifton (1979) has suggested that "hypnoid states" are forms of post-traumatic "psychic numbing" which keep traumatic memories from conscious recall, similar to the "over-control—under-control" phenomenon of denial vs. intrusion of traumatic memories (Horowitz, 1976). These seemingly protective "hypnoid" states prevent conscious "rehearsal" of the past from occurring and thereby interfere with resolution of post-traumatic symptoms since they perpetuate a condition of intrapsychic "splitting" (Shapiro, 1965).

As each group of post-traumatic symptom complexes remains separated or "split" from one another, the resulting intrapsychic instability gives rise to repetitive reenactments of traumatic experiences which are unconscious and potentially "uncontrollable" attempts to achieve resolution of the intrapsychic "split". Thus, reenactments are behavioral ways of rehearsing the past in order ". . . to restore an earlier state of things, (by creating) a bondage to the past, and . . . in repeating, past and present are merged" (Sedler (1983); ". . . by experiencing again and again what once had to be gone through in the trauma . . . (so that) . . . control may slowly be regained" (Fenichel, 1945).

HYPNOSIS AND ABREACTION

Achieving resolution of the internal psychic split through "rehearsal" and abreaction of past traumatic experiences is one of the important therapeutic goals of hypnotic age regression. It is not surprising, then, that hypnosis has been a primary treatment for post-traumatic conditions, particularly hysteria, dating back to before the 20th century (Janet, 1887, 1889, 1907; Ellenberger, 1970). For example, Breuer & Freud (1893) successfully applied the standard hypnotic technique of that time by inducing an abreaction and re-enactment of a past traumatic experience in their patient, Anna O.

Hypnotic treatment thus had as its primary focus the facilitation of abreaction. The benefits of which have been described by Jung (1954) as follows:

> (a) . . . Abreaction . . . the dramatic rehearsal of the traumatic moment, (is) emotional recapitulation in the waking or in the hypnotic state (and) often has a beneficial therapeutic effect. We all know that a man feels a compelling need to recount a vivid experience again and again until it has lost its affective value. . . . (p. 131-132)
>
> (b) . . . Abreaction is . . . an attempt to reintegrate the autonomous (traumatic) complex, to incorporate it gradually into the conscious mind as an accepted content, by living the traumatic situation over and over again, once or repeatedly. (p. 132)

Abreaction has been the commonly used term for an hypnotically induced reexperience of a traumatic event. The word revivification has also been used (Erickson & Kubie, 1941) to describe this reexperience. Abreactions and revivifications have usually been associated with formal hypnotic trance induction but they may occur spontaneously during therapy or a hypnotic session, even without formal age regression (Gill, 1948). An abreaction or revivification is most likely to promote improvement in a patient's functioning when he can maintain awareness of the revivification experience, while simultaneously maintaining awareness of the present time and of the therapist's presence (Gill, 1948; Weitzenhoffer, 1955).

Jung (1954) also used abreaction during hypnotic treatment, but gave new recognition to the power of the therapeutic relationship, which he described as follows:

> The rehearsal of the traumatic moment is able to integrate the neurotic dissociation only when the conscious personality of the patient is so far reinforced by his relationship to the doctor that he can consciously bring the autonomous complex under the control of his will. . . . The mere rehearsal of the experience does not itself possess a curative effect: the experience must be rehearsed in the presence of the doctor . . . the intervention of the doctor is absolutely necessary. (The patient's) conscious mind finds in the doctor a moral support against the unmanageable effect of his traumatic complex. No longer does he stand alone in his battle with these elemental powers, but someone whom he trusts reaches out a hand, lending him moral strength to combat the tyranny of uncontrolled emotion. In this way, the integrative powers of his conscious mind are reinforced until he is able once more to bring the rebellious affect under control. . . . (pp. 132-133)

In spite of the fact that hypnosis and abreaction were often successfully used, permanent cures were infrequent. At times, the hypnotic induc-

)n merely reproduced the hysterical condition. Charcot reportedly re-roduced hysterical symptoms using hypnotic trance induction llenberger, 1970). Lifton (1979) has referred to Breuer & Freud who und that hypnosis reproduced the intrapsychic splitting found in hys-ria:

> . . . the various kinds of hypnoid states in hysteria share with one another and with hypnosis, namely the ideas which emerge in them are very intense but are cut off from associative communication with the rest of the content of consciousness. (p. 201)

Freud used hypnosis for a number of years in his treatment of hysteria, it eventually concluded after 1895 that his patients' hypnotically in-ced reenactments and emotional catharses did little more than tem-rarily alleviate post-traumatic symptoms. Furthermore he suspected at these reenactments were likely contaminated by exaggerated fears, brications, or even wishful fantasies. Freud's disillusionment with hyp-sis led him to discontinue its use. He consequently abandoned abreac-e treatment in favor of free association, creating an "anti-hypnosis" mate which appeared to bias all those who followed him.

YPNOSIS AND PSYCHOANALYSIS

Although Freud concluded that hypnosis was an ineffective treatment, appeared to be influenced by his years of experience as a hypno-erapist to realize that there was a therapeutic quality to the patient's ered state of consciousness. It is not surprising then that he incor-rated this knowledge into his psychoanalytic technique which he did a very creative way. Freud began to instruct his patients in his newly veloped technique of *free association*. The patient was instructed to lie wn and relax mentally with the therapist behind and out of view. He s told that he would soon note an ability to talk freely about any idea, ydream or thought that might enter his mind. The choice of subject tter was immaterial and left entirely up to the patient. He would note t as he related things, various ideas would occur to him which he uld feel inclined to put aside for certain criticisms, but he was to rbally express whatever was going through his mind. The patient was imagine and act as if he were sitting at the window of a railway car, ating to someone behind him the changing views he might see outside window (Freud, 1913, p. 135).

Freud's movement away from hypnotic abreaction as a treatment was enhanced by the development of psychoanalytic theory which rested heavily on the concept of tripartite mind—id, ego, and super-ego—bisected by conscious and unconscious components which were separated by the boundary of "repression." It was believed that repression was an important ego defense which prevented intrusive noxious ideas and emotions from entering consciousness. Anna Freud (1946) described the detrimental effects of bypassing this repressive barrier with hypnosis:

> . . . Hypnosis was a means of getting rid of (the noxious experience) temporarily. (The ego) tolerated the intruder only so long as it was itself under the influence of the physician who had induced hypnosis. Then it revolted and began a new struggle to defend itself against the . . . id which had been forced upon it, and so the laboriously achieved therapeutic success was vitiated. Thus it came about that the greatest triumph of hypnotic technique—the complete elimination of the ego during the period of investigation—proved prejudicial to permanent results and disillusionment as to the value of the technique set in. (p. 12)

Freud also realized the burden upon the hypnotherapist who was placed in the position of breaking through this repressive barrier through hypnotic suggestion, discussed by Sedler (1983): ". . . by means of my psychical work I had to overcome a psychical force in the patients which was opposed to the pathogenic ideas becoming conscious. . . ." (Freud, 1895, p. 268).

Freud came to realize that the patient should be responsible for his own recovery and developed a technique, which he called the "working through" process, that would be partially separate from the responsibility of the therapist. With this concept, he departed even further from the traditional use of the hypnotist's suggestion as a primary treatment: ". . . the doctor has nothing else to do than to wait and let things take their course. . . ." (Freud, 1914, p. 155).

Thus, in emphasizing this departure from hypnotic treatment, he defined working through as ". . . that part of the work which effects the greatest changes in the patient and which distinguishes analytic treatment from any kind of treatment by suggestion" (Freud, 1914, p. 155-156).

Sedler (1983), in an article about Freud's concept of working through, has referred to Fenichel's (1945) definition as primarily interpretive and educational, partly involving the framework of the therapeutic transference, and extending beyond ". . . a single operation resulting in a

single act of abreaction; it is, rather, a chronic process of working through, which shows the patient again and again the same conflicts and his usual way of reacting to them, but from new angles and in new connections. . . . (This systematic) and consistent interpretive work . . . can be described as educating the patient to produce continually less distorted derivatives until his fundamental instinctual conflicts are recognizable" (p. 31).

PSYCHOTHERAPY AND ABREACTION IN WORLD WAR II COMBATANTS

Although the use of hypnotic abreactive treatment lost favor within the psychoanalytic movement, attempts were subsequently made to combine psychoanalytic principles with hypnosis for the treatment of post-traumatic symptoms in war combatants. For example, Grinker & Spiegel (1945) have reported treating combat-related symptoms with abreactive techniques as well as with individual and group psychotherapy for World War II combatants, described as follows:

> 1) Establishment of doctor-patient relationship (transference).
> 2) Support, and gratification of the patient's weakened and regressed ego by means of tenderness . . . attentive interest . . . and identification with the therapist's strength.
> 3) Release and uncovering of isolated, repressed and suppressed emotions, memories and conflicts (ABREACTION). (p. 373)

They described seven additional treatment concepts, including the following recollection and desensitization technique:

> Desensitization from the memories of the anxiety-producing situations (can be achieved) by repetitive recounting of traumatic experiences, as the therapist helps the dependent ego to discriminate between past danger and present safety, and between the world of reality and inner anxieties. (p. 374)

Their treatment approach included a type of working through which they have described as follows:

> After the abreaction has been started and the patient has come out of his narcosis, he is forced to review the material in a conscious state. However, this is not always necessary, for insight may be reached and learning established by the unconscious ego. Conscious verbalizations are not always necessary to indicate therapeutic benefits. . . . (p. 279)

Watkin's (1949) treatment of World War II combatants also involved the use of psychotherapy with a hypnotic approach to achieve abreaction, which he has reported (1971) as follows:

> a)The reaction is indicated only in neurotic and not in psychotic or prepsychotic personalities.
> b) Cathartic abreactions should enlist the total personality.
> c) The released material must be interpreted and integrated. (Watkins, 1980, p. 102)

OTHER ABREACTIVE AND REGRESSIVE TECHNIQUES

Drug-induced abreactions, developed during and after the Second World War (Grinker & Spiefel, 1945), have been referred to as an effective uncovering technique for the treatment of combat veterans. In reviewing the use of Amytal interviews, Perry & Jacobs (1982) called them preferable uncovering techniques in acute traumatic conditions: "Amytal frees up a highly defended traumatic experience and aids in reintegration of dissociated ideas and affects. It provides a pharmacological cushion that allows exploration and a lowering of defenses against the anxiety-provoking recollection of trauma" (p. 556).

Reports have also been published of Amytal interviews being excessively intrusive. Klein (1945), for example, expressed his concern about "forced" abreactions on World War II combatants, suggesting instead that the therapist's reassurance and verbal support were more important:

> At first an attempt was made . . . to use the method . . . described as narcosynthesis . . . but it was given up and found to have no advantage over adequate sedation. . . . Indeed, in many of the patients it was felt to be detrimental to (their) early recovery. What these men wanted most was not to be reminded of their grievous ordeal or horrifying experiences but rather to be permitted the healing . . . of merciful forgetfulness. . . . The so-called "abreaction" is a neat term implying an analogy of draining off disturbing emotional states . . . but was found to be poorly founded. (pp. 39-40)

Grinker and Spiegel (1945) emphasized a positive transference and permissive interview techniques as a means of avoiding such intrusive-

single act of abreaction; it is, rather, a chronic process of working through, which shows the patient again and again the same conflicts and his usual way of reacting to them, but from new angles and in new connections. . . . (This systematic) and consistent interpretive work . . . can be described as educating the patient to produce continually less distorted derivatives until his fundamental instinctual conflicts are recognizable" (p. 31).

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ness with Pentothal induced abreactions: "No patient is given pentothal treatment without adequate preliminary interviews, until a good grasp is obtained of the factual material regarding combat and past life, or until a good transference relationship has been established by the physician" (p. 392).

However, the authors emphasized a free association style of interview as a means of cutting through resistence, while omitting questions prompted by the interviewer's personal needs and curiosity, described as follows:

> . . . resistances occur under pentothal as well as in the conscious state and the therapist must put the patient under pressure to overcome them. Psychiatrists accustomed to the method of free association, and not disturbed by silences, have no difficulty in following this method. (p. 391)

Amytal interviews have also been reported as useful in the treatment of Vietnam veterans with post-traumatic symptoms. Yet abreaction alone has usually been insufficient. Recognizing the need for ego integration of abreacted material, Perry & Jacobs suggested psychotherapy following Amytal induced abreactions while Maoz & Pincus (1979) recommended concomitant group therapy for patients who had Amytal interviews. Similarly, other authors (Cavenar & Nash, 1976) have used videotaped reviews by patient and therapist to facilitate ego integration of chemically induced abreacted traumatic experiences.

NON-CHEMICAL ABREACTIVE TECHNIQUES

Non-chemical means have often been preferred for achieving "adaptive regressions" (Fromm, 1977), including affective recollections, abreactions, and revivifications of traumatic experiences during treatment of combat veterans. Such experiences have been referred to as "healing recapitulations" (Figley, 1978) and "integrative regressions" wherein the patient has the opportunity for "psychic growth, recovery, or renewal . . . (and can) temporarily 'let go' of defenses against past memories or archaic images within the unconscious (and face) memories and images directly (may) . . . progress to higher levels of psychic functioning" (Brende & McCann, 1984).

Although such experiences have commonly been associated with hypnotic age regression, some authors have preferred other therapeutic

modalities to achieve the same purpose believing them to be less likely to intrude upon ego autonomy. Thus, the supportive milieu of "Rap group therapy" has been found to facilitate "therapeutic revivifications" (Brende & Benedict, 1980). A sensitive therapist can help a patient reexperience a sensation—particularly imagery—which may subsequently evoke an affective recollection or even revivification of traumatic experiences. For example, Brende & McCann (1984) have reported an example of a therapist asking a patient to recall detailed imagery of a past traumatic event and, in so doing, evoking the patient's vivid affective recollections.

The author has had other patients with similar experiences. For instance, during treatment of a veteran who had been unable to recall the details of a man being shot and killed in a hotel room, the patient was asked to describe the situation in the context of current reality: "Let yourself be there as if it were taking place now. What do you see?" The patient responded to that question by pausing and spontaneously achieving a trance-like state without further suggestions. Then he began to describe the emotionally charged details of seeing the man being killed.

In a similar therapeutic situation, a depressed and obviously disabled Vietnam veteran was observed during his first therapeutic session. He was asked by the therapist to describe how he had come to suffer amputations of two of his extremities. As the patient began to talk about it unemotionally and abstractly, the therapist focused on recreating the details of the event, as follows:

> Th: Describe what happened to you. Can you see it?
> Pt: Yeah, I can still see it.

He then began to revivify and abreact his experience of being blown into the air by a rocket, losing his arm and leg and nearly dying when shot by an enemy soldier in Vietnam.

Eisenhart (1977) remembered his own personal reliving of a combat experience and found it to be an essential component of the healing process. He described it as occurring during psychotherapy without the use of hypnosis and with only a suggestion that he reexperience the olfactory sensation:

> For four or five years after Vietnam, a specific intrusive image kept recurring. The image was that of a very badly dismembered man that I had seen. He had been shot, burned, blown wide open

with his guts hanging out, and he stank something fierce. The image recurred continually and triggered affective responses. During therapy I was asked to remember the smell. To remember it vividly and to relive the experience in the present tense. I saw the image and smelled that stink once again. I was told to go further into the image and assume the posture of the dead man. As I was doing this, I came in touch with my fears of emasculation. The individual had been shot and burned in the groin and I had blocked the image. . . . (pp. 3-4)

HYPNOSIS AND POST-TRAUMATIC STRESS DISORDER IN VIETNAM VETERANS

There have been occasional reports of hypnotherapy being used successfully for the treatment of PTSD in Vietnam veterans. Balson & Dempster (1980) used a psychodynamically oriented treatment process for Vietnam veterans lasting 6-9 months which included several hypnotically induced abreactive sessions. Spiegel (1981) has written about his use of hypnosis with Vietnam combat veterans, finding it particularly helpful in resolving traumatic grief experiences by facilitating recollection of not only the death trauma but also a positive memory of the grieved comrade:

> . . . the intensification of memory and the emotion which surrounds it in hypnosis can be used as part of the process of doing grief work. The trance state provides a structured intensification of memory which becomes the setting for repeating and working through, or putting into perspective painful memories and experiences. . . . (p. 35)

Brende and Benedict (1980), in their report of successful hypnotherapy of a Vietnam veteran, used hypnosis in different ways: a) as a supportive technique when the patient required help to control anxiety; b) as an uncovering technique when he was amnestic for important events; c) as an abreactive technique when symptomatic; and d) as an integrative technique.

Differentiating between these varied uses of hypnosis is dependent on the quality of the therapeutic relationship and follows to some extent the hypnotherapist's understanding of the patient's ego strength, character defenses, phase of treatment and the therapeutic goal at the time. The following examples will illustrate these different applications of hypnotic treatment in survivors of trauma.

Hypnosis as a Supportive Technique

Parson (1981) has described the use of hypnosis and relaxation techniques during the first phase of therapy when patients suffer from considerable anxiety. Fairbank et al. (1981) have found that relaxation is an effective treatment for reducing frequency of post-traumatic startle reactions. Brende & McCann (1984) give accounts of using therapeutic techniques during early phases of therapy which would promote "regression in the service of the ego" rather than a dis-integrative regression. Similarly, Brende & Benedict (1980) have reported their use of hypnosis in the treatment of a Vietnam veteran during the initial phase of psychotherapy for controlling anxiety and target symptoms. His improvement with supportive hypnotic techniques was enhanced by his learning self-hypnotic and meditative techniques as well.

In addition to its initial value in relieving specific target symptoms, hypnosis can also be useful as a means for building trust. For example, the following hypnotic suggestions were used during a session six months after the beginning of combined group and individual psychotherapy with a Vietnam veteran who had significant character pathology and suffered from chronic, severe shoulder and back pain:

> I would like to have you relax and imagine that I and the other veterans in your therapy group are all helping you with the burden that you are carrying. It's been there ever since you've returned from Vietnam and has contributed to all the pain that you are feeling in your back and shoulders. Imagine that we are right here with you now, helping you hold up the burden. As you let us share that burden with you, it will be easier for you in the future to talk about what is bothering you and to share your feelings with us.

Following this session, the veteran temporarily experienced relief from pain, but more importantly felt increased support from his therapist and fellow group members. It also became easier for him to talk about emotionally charged combat experiences and, within a short time during one of the group therapy sessions, he was able to grieve the loss of buddies who had died in Vietnam.

Hypnosis as an Uncovering Technique

Following an initial supportive phase of therapy, a patient may gain control over his most severe target symptoms and be amenable to "open-

ing up". Parson (1981) has characterized the therapist's task during this time as being able to "gently crack the shell with which the vet has surrounded himself." Hypnotic techniques can be used for this purpose.

In the previously described case (Brende & Benedict, 1980), the patient's continuing use of self-hypnosis and meditation was soon associated with recollections of war-related experiences, for which he had been amnestic. This use of meditation as an "opening-up" process has been described by Carrington & Ephron (1979) as facilitating psychotherapy. The patient's recalled war memories were important and provided information which enabled the therapist to understand the nature of his combat experiences. However, within a few weeks, the opening-up process became excessive due to the lifting of repressive barriers over traumatic memories. He began to have disturbing symptoms similar to what has previously been described in some borderline patients who use meditation or biofeedback training excessively (Brende & Rinsley, 1979; Glueck & Stroebel, 1975).

Thus, within a few weeks, the patient ". . . began to be flooded with feelings of guilt about combat deaths for which he felt responsible. . . . The flooding of consciousness with such material interfered with effective concentration . . . (and) he began to feel increasingly guilt-ridden about having killed civilians . . . and (about) feelings of guilt related to his emerging rage. . . . He began to feel like a 'bomb' that could explode at any time and which he was unable to defuse" (p. 36).

Because the patient could not tolerate this influx of traumatic memories, hypnosis and meditation were discontinued in favor of supportive psychotherapy for the remainder of the first phase of his treatment. He was subsequently able to gain considerable relief from guilt feelings, stabilize his life situation, and establish a trusting therapeutic alliance. The initial phase of therapy thus provided him a sense of self-control and trust in the therapist.

Hypnosis as an Abreactive Technique

The value of abreaction is contingent upon the degree of symptom reduction following the procedure as described earlier. Among those factors related to success is the therapeutic rapport, capable of allowing an "integrative regression" (Brende & McCann, 1984). While the goal of abreaction is usually to facilitate an emotional discharge, Watkins (1980) has encouraged a "silent abreaction" for patients who need to discharge anger.

Parson (1981) has also described this phase of therapy as the "in vivo

affective revival phase" during which time treatment facilitates "a controlled regressive pathway to the traumatic experience . . . possible (when) the veteran (can) withstand the possible 'fragmenting' effects of uncontrolled regressive ego activity in response to the ego-lulling impact of meditation, relaxation, and hypnotherapy" (p. 35).

To facilitate an abreaction, the hypnotherapist is frequently permissive in his approach, utilizing the "affect-bridge" technique (Watkins, 1971), described as follows: This is a method "wherein the patient is regressed over a bridge of common emotion to the earlier situation rather than over a 'cognitive bridge,' such as is generally employed in the free associations of traditional analytic therapy. That is feelings, and not thoughts, serve as the associative links from present to past" (Watkins 1980, p. 103).

Abreaction is generally considered to be most effective when used during a later phase in the treatment of Vietnam veterans whose traumatic experiences occurred many years earlier. On the other hand, the treatment of acute combat reactions in war combatants has frequently involved hypnotic abreaction early in the treatment process. For example, Moses et al. (1976) have described their treatment of combat reactions in Israeli soldiers, including "abreaction as a means—not as an end in itself—by encouraging the soldier to experience his feelings and to reconstruct the hours or days of combat, together with the therapist and in direct contact with him."

In another example of hypnosis being used immediately following a traumatic experience, the author previously reported a case (Brende, 1982) of a hospital employee nearly killed by a patient. He suffered from nightmares, startle reactions, and fear of returning to work. The use of hypnotic abreaction four weeks after the trauma resulted in his control of these symptoms and return to work.

As an exception to the concept that abreaction is primarily effective during the immediate post-traumatic period. Godfrey (1983) has described using hypnotic abreactive therapy in a Second World War Veteran nearly 40 years after his traumatic experience. After two sessions which included "working through" the meaning of repressed guilt feelings which were abreacted, his repeated nightmares ceased recurring. During the treatment of the Vietnam veteran previously discussed (Brende & Benedict, 1980), hypnotic abreactive techniques were used during a second therapeutic phase nine months after therapy had begun and lasted five months. This phase of the treatment was prompted by the veteran's increased target symptoms in the form of nightmares and physical symptoms, evidence of the presence of a hidden "victim iden-

fication" (Brende, 1983). The veteran's abreactions, occurring several mes over a period of five months, were characterized by the emergence f traumatic memories, the details and emotional impact of which had ot been expressed previously. The content of the memories were "vic- m" related, i.e., persons being killed and his own near-death experi- nce.

Victim Identification

The presence of a "victim identification" as well as an "identification vith the aggressor" is commonplace in survivors of trauma (Brende, 983; Brende & McCann, 1984; Shatan, 1974; Moses, 1978; Moses et al., 976). This identification results from witnessing or being responsible or the death or killing of others and becomes "split-off" from conscious wareness. The manifestation of the hidden identification becomes ap- arent primarily in the form of self-destructive dreams, behaviors, and hysical symptoms. As an example, Moses (1978) found that soldiers vith combat reactions frequently had physical symptoms: "Soldiers with ombat reactions showed many more vegetative disturbances, consid- rably more regression . . . (and) a deeper, more extensive type of epression . . . (and) . . . more marked, deeper, longer-lasting resist- nce to talking about the details of their battle experiences" (p. 358).

The presence of the victim identification in the veteran whose case as been described previously (Brende & Benedict, 1980) was evoked uring the hypnotic abreactions occurring during the second phase of herapy. During these sessions, the patient spontaneously relived sev- ral different traumatic war experiences. During the first session, he elived an event which took place in Vietnam in 1966, and began to hake and tremble out of fear during the revivification of ". . . a surprise ttack when he experienced fear of an enemy tank which appeared on he verge of running over him" (p. 37).

This evoked the emergence ". . . of somatic accompaniments, i.e. gen- ralized tremulousness and a delayed feeling of pain in his leg which ad been injured during the battle" (p. 37), further evidence of the resence of the victim identification described earlier. "The theme of the econd hypnotic session, three weeks later, was abandonment and be- rayal. During this session he revealed feelings of vulnerability as he felt nsupported by his military superiors and . . . (later) his fear of being bandoned in the hospital. . . ." (p. 37).

During the posthypnotic follow-up session, this same patient de- cribed his feelings of rage which emerged to cover up his helplessness.

As part of the process of "working through" the content of the previously abreacted experiences, he began to describe guilt-related memories of accidently killing innocent civilians. Further use of hypnosis was curtailed for a month until he developed a resurgence of victim related nightmares. Hypnotic abreaction then uncovered the first experience of killing and the emergence of guilt and grief.

Hypnotic Abreaction as an Integrative Technique

When the goal of treatment includes the integration of "split-off" aspects of the self, i.e., part-identities linked to traumatic events, it is often facilitated by hypnotic age regression and abreaction. For example, in the previously described case, hypnotherapy had eventually exposed not only a "victim identification" but also an identity split between "killer-self" and "protective-self" (Brende, 1983), as follows:

> He (had) suppressed his prior value system and slipped into the role of a "killer." He . . . had come to get pleasure out of killing so that he had come close to accepting a job as a "hit man". . . . The evolving change in his identity had led him into an identity "split" between the "killer" and the healthy, protective "leader," both of which had been idealized by his peers. Ultimately, the "killer" part came into direct conflict with the protective part . . . (and) he developed serious problems, including at least one dissociative episode when it was reported by a friend who had observed him . . . killing Viet Cong soldiers and laughing hysterically, although having complete amnesia for that episode at a later time. (Brende & Benedict, 1980, p. 38)

The final hypnotic session was useful in the process of integrating the patient's split-off identifications involving not only the "killer-self" but also the "victim-self." This occurred in the process of abreacting and revivifying a final battle wherein he was nearly killed, and in the process, he became "aware of his dissociated helpless and aggressive feelings. After each revivification of the experience of being shot, he was able to reexperience the components of the original occurrence which consisted of . . . (being wounded, reliving the fear, reliving the absence of pain, experiencing the grief of expecting to die, and finally) . . . "experiencing being rescued by his friends. The hypnotic age regression and revivification of the final battle with (the therapist's help) and the memory of the suppport of his peers, enabled him to integrate the different painful components of the experience that had been dissociated by feelings of

guilt and shame" (pp. 38-39), and find meaning in his own survival. Thus, the veteran integrated dissociated aspects of himself linked to fear, dehumanization, killing, guilt, grief, through an abreaction and revivification of traumatic events, including his own experience of nearly being killed; first through hypnotic abreactions and revivifications and second by "working through" these memories between each of the hypnotic sessions.

DISCUSSION

Vietnam veterans, particularly those with anti-social or borderline traits (Brende, 1983), are often not amenable to personality integration via abreaction alone but require concomitant and lengthy psychotherapy, including the confrontation of resistance in the form of character traits. The previously described hypnotic techniques of support, uncovering, abreaction, and integration can be used for specific purposes during different treatment phases. It is particularly important that a period of stabilization precedes uncovering or abreactive hypnosis.

Furthermore, it is important to be aware that a poorly timed hypnotic intervention may be ineffective and precipitate increased resistance or a disintegrative regression (Brende & McCann, 1984), particularly if the patient displays omnipotent character traits and unstable ego boundaries (Brende & McCann, 1984). As an example, a Vietnam veteran with narcissistic character traits and symptoms of dissociated aggressive outbursts and flashbacks experienced hallucinated frightening images while hypnotized one and a half years after the onset of psychotherapy. In another Vietnam veteran with longstanding character pathology, age regression and revivification of combat-related betrayal and abandonment experiences were followed by symptoms of aggressive outbursts a week later.

The need for hypnotic intervention can be ascertained in various ways. Veterans requiring stabilization and support during early phases of treatment need hypnotic techniques which accomplish that purpose. During later phases of the treatment process, hypnosis can be useful to uncover traumatic experiences. Specific target symptoms indicate when the use of hypnosis is appropriate. These may consist of neurological symptoms, pain or destructive dreams, and suggest the presence of hidden victim and aggressor related identifications. The therapeutic task is thus hypnotic revivification of victim and aggressor related events and the expression of fear, guilt, and grief. In this way, victim and aggressor identifications can be successfully integrated into the self.

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