A New Hypnotherapeutic Treatment For PTSD

David H. Clayton Ph.D.

Memory plays a key role in the theory, the neurobiological consequences and the treatment of PTSD. A successful treatment for PTSD requires an alteration and/or a reorganization of all or some of the associations between the various stimuli that constitute the traumatic memory. Neurobiological and clinical research distinguishes two PSTD subtypes: (a) re-experiencing/hyperarousal (under modulated affect) and (b) dissociative (over modulated affect), each requiring different treatment approaches. These two subtypes can be seen as polar opposites on a continuum of emotional dysregulation (Lanius et al., 2010).

This article focuses on the treatment of acute forms of trauma resulting in subtype (a) PTSD. Treatment approaches for chronic trauma resulting from psychological, sexual and physical trauma leading to subtype “b” PTSD, have been reported by Clotre, et al. (2002).

Acute trauma is often comprised of a sudden, single-event-exposure to a disorganized jumble of stimuli and somatosensory information including visual, auditory, olfactory, kinesthetic, emotional and intellectual components, etc., all held together by an intense and often disabling dissociated emotional memory, fragmentally encoded and stored in the amygdala. The dissociated and fragmented character of PTSD memories in general, results in impairments in retrieval and a persistent discontinuity between the various components of the memory, particularly the emotional and cognitive components (Spiegel, 1997; Spiegel and Cardena, 1991). Subsequent stimulation of the amygdala by any one of the original stimuli provokes a cascade of fear-triggering neuronal activity which constitutes the original trauma (Canli, et al., 2000). Furthermore, long term hyperarousal in PTSD sufferers results in an enlarged amygdala as well as hippocampal atrophy, severely debilitating those with PTSD. As a result of this new neuro-imaging research, PTSD is now properly identified as an organic disorder rather than a neurotic disorder (Sapolsky, 2017: 34, 78).

To date, the development of treatments for the more common re-experiencing/hyperarousal PTSD subtype (a) include: pharmacological, drug enhanced psychotherapy and psychologically based treatments. Currently, only two drugs are approved for the treatment of PTSD: sertraline and paroxetine (Jeffereys, 2011). However, neither has been shown to be effective with male military-related PTSD (Kamendi, et al, 2016). More recently, two older drugs are showing promise in treating PTSD. Cyclobenzaprine, originally prescribed for muscle spasm, when administered at higher doses, has shown promise in a small dose-related study of military-related PTSD in reducing symptoms of PTSD (Brooks, 2016). Just recently, Tetracycline antibiotic doxycycline was found to reduce the recall of threat memory by 60% in a small well controlled study (Bach, Tzovara and Vunder, 2017). MDMA (3, 4 methylenedioxymethamphetamine), also known as “ecstasy”, has been tested in small-scale studies to augment psychotherapy in patients with treatment resistant PTSD. MDMA was associated with reduced responses in the amygdala to angry and fearful expressions and subsequent memory allowing the patient to examine their traumatic experiences without disabling emotions. The authors suggested that the limitations of MDMA augmented approaches are primarily both legal and political (Curran, 2016).

 The most common psychologically based treatments currently being used in the treatment of subtype (a) PTSD are TFCBT (trauma-focused cognitive-behavioral therapy) and EMDR (eye movement desensitization and reprocessing). They were compared in a meta-analytic study and neither found to be more efficacious (Seidler G & Wagner F, 2006). When compared to a third common treatment approach, Exposure Therapy, which has the strongest empirical support, (Berg, et al., 2008) Exposure Therapy yielded the greatest reduction in PTSD symptoms (Taylor, et.al. 2003). Another treatment, Mindfulness Therapy was found to have a modest effect on the decrease of PTSD symptoms (Polusny et. al 2015).

Finally, of the psychologically based treatments for subtype “a”, hypnotherapy has been successfully used in the treatment of PTSD with Viet Nam veterans (Spiegel, 1992). Spiegel found that hypnosis is particularly well suited for the treatment of PTSD, not only because of its utility in treatment but also because of the similarity between hypnotic phenomena and the symptoms of PTSD, in particular, dissociation, which he found predicted later PTSD when appearing soon after traumatic experiences. Furthermore, Spiegel found that Viet Nam veterans with PTSD had higher than normal hypnotizability scores on standardized tests and consequently, responded well to hypnosis in general. Spiegel’s hypnotherapeutic strategy involved coupling access to dissociated traumatic memories with positive restructuring of those memories into a broader perspective (Spiegel, 1992).

The relationship between hypnotizability and PTSD, as well as the specific usefulness of hypnotherapy as a treatment modality, particularly among combat veterans, has also been corroborated by other studies (Bryant, et. al., 2003; Stutman, & Bliss, 1985; Spiegel D, et. al, 1988). These studies and others suggest that hypnosis can be helpful in both the assessment and the treatment of PTSD and as an add-on in the treatment of chronic type (b) PTSD (Abramowitz, et al, 2008). Overall, there is considerable empirical support for the use of hypnosis in treating a variety of conditions in addition to PTSD (Lynn, et al 2012). At present, however, there are no controlled systematic studies on the effectiveness of hypnotic treatments for PTSD. Not unlike other psychologically based treatment approaches, hypnotherapy requires professional training (Foa, et. al., 2008).

Dropout rates for psychotherapy based PTSD treatments has been estimated to be 18% and as high as 30% for pharmacotherapy. New research shows that when PTSD patients were given a choice between sertraline (Zoloft) and prolonged exposure therapy, they were significantly more likely to adhere to their choice of treatments. Patients not given a choice had a dropout rate three times higher than the patients who “bought into” their treatment preference. (Melville, 2017) This research points to the importance expectation plays in successful treatment outcomes. Of the psychologically based treatments, hypnotherapy can be more easily tailored to meet the patients’ needs and as a result, can significantly improve the patient’s expectations leading to a successful outcome.

Alteration of Traumatic Memories

As previously stated, if a treatment for PTSD is to be effective, it needs to help reorganize and alter, in some way, the traumatic memory. In pursuit of that goal, researchers at the University of Amsterdam (Soeter and Kindt, 2015) used a beta-blocker drug with arachnophobics. The action of the beta-blocker inhibited the release of norepinephrine resulting in an alteration of the long term emotional memories associated with the phobia. After taking the drug, the arachnophobia subjects could almost immediately touch spiders and their repeated exposure to spiders didn’t include a release of adrenaline. Three months later they were able to hold spiders. The researchers concluded that without the release of norepinephrine, the original disabling emotional reaction was disrupted or altered in some way when it was reconsolidated in long term memory. This finding is supported by research into the neurobiology of learning and memory which supports the concept that each time a memory is retrieved and then restored again, new biochemistry replaces the old during the reconsolidation of a long-term memory, resulting in an alteration (to one degree or another) in the original distressing memory itself (Izquierdo and Medina, 1997).

Hypnotic Phenomena and Hypnotherapy

A recent study conducted at Stanford University School of Medicine, led by David Spiegel MD, identified distinct areas in the brain of hypnotized subjects showing altered activity and connectivity (Jiang et al., 2016). The changes in neural activity during hypnosis, indicating both increased and decreased connectivity between various neural networks (using functional MRI imaging), for the first time documents how heightened focused attentiveness, enhanced somatic and emotional control, lack of self-consciousness and dissociative states (all recognized characteristics or phenomena of hypnosis) neurologically manifest during hypnotic trance. Once elicited and combined, these hypnotic phenomena, among others, allow for the crafting of hypnotherapeutic approaches particularly well suited to the treatment of deeply imbedded, dissociated and emotionally disabling memories associated with both subtypes of PTSD. One of the distinct advantages of using hypnosis in PTSD cases is the hypnotic operator’s ability to protect his/her subject when dealing with highly charged emotional memories. In that same vein, hypnosis also greatly accelerates rapport between subject and operator thereby contributing to positive treatment outcomes. Strategically, hypnotic trance offers a unique kind of altered psychological state in which the subject’s awareness can be directed in whichever way necessary to bring about their therapy.

 A good example of the creative use of hypnotic phenomena and mental mechanisms can be found in an approach developed by Spiegel (Spiegel & Spiegel, 2004). They refer to their approach as the “split-screen technique”. Using the mental mechanism of projection and the hypnotic phenomenon of positive hallucination, hypnotized subjects are taught to project their negative images, sensations and thoughts away from the self onto a screen or onto one half of an imagined or hallucinated split-screen while positive, constructive and opposing images, etc. are projected onto another screen or the other side of a split-screen. Using the hypnotic phenomenon of dissociation, memories can be separated and disconnected from any physically painful component of the trauma. The utility of this technique allows for the manipulation of any one of the components comprising the trauma, including the affect and its intensity and the speeding up or slowing down of the review using the hypnotic phenomenon of time distortion. In the process, the subject is taught control of their experience while remaining safe during their therapy. The split-screen provides a way of restructuring and reorganization the trauma resulting in the original memories moderated and made more bearable.

New Hypnotherapeutic Treatment Approach

Hypnotic phenomena are central to both the induction of trance and as a vehicle for the therapy. As in the author’s approach described below, the induction of trance utilizes the hypnotic phenomena of catalepsy and ideomotor behavior while the therapy utilizes the hypnotic phenomena of hypermnesia, dissociation, regression and post-hypnotic suggestion. The primary methodology utilized in this approach revolves around disassembling the components of the trauma using multiple trance events. Each component (stimuli) of the trauma is separately experienced in trance and then briefly reviewed in a waking state immediately following each trance. After all the components of the trauma have been brought into consciousness, briefly experienced and described, a final trance is elicited during which the subject is given a post hypnotic suggestion that, upon wakening, they will reassemble the components of their trauma to form a new organization of their experience that is much more acceptable and tolerable.

Training Subjects for Procedure

The author has found that in using this hypnotic approach as well as others, preparation and training of the subject is essential for a good outcome. For the majority of individuals who might benefit from this procedure, most have not previously experienced hypnotic trance. Therefore, training the subject to enter and exit trances easily constitutes the first step in preparation for the treatment process.

Eliciting Hypnotherapeutic Trances

 As previously stated, hypnotic trance develops in relationship to the emergence of one or more hypnotic phenomena. Hypnotic phenomena, to one degree or another, constitute latent experiential learnings or underdeveloped resources most individuals unknowingly possess as well as mental mechanisms such as projection. As previously mentioned, the author prefers to facilitate trance development in his hypnotic subjects by eliciting the hypnotic phenomenon of catalepsy and/or ideomotor behavior (although the elicitation of other hypnotic phenomena would also result in the development of trance). Both of these phenomena, while unfamiliar to the majority of subjects, can be elicited in most naïve subjects using some well-developed approaches. As these phenomena begin manifesting in the subject, the subject, unknowingly, begins to develop a hypnotic trance. The experience of going into trance for the subject can be one of intense absorption with a deepening concentration, awareness and relaxation- resulting in a slowing of breathing and heart rate. As the subject goes deeper in the trance, their capacity to become receptive and responsive to ideas and suggestions greatly increases along with a significantly enhanced access to unconscious memories, feelings and understandings. A series of hypnotic experiences can be suggested which can lead to a trance level suitable for therapy, particularly one in which the subject can respond easily to post-hypnotic suggestions-another hypnotic phenomenon.

Treatment Process

Once the hypnotic subject has demonstrated their ability to achieve trances suitable for therapy, the first step of the treatment involves eliciting a trance and, in that first trance, the hypnotic subject is taught to remain in trances comfortably while reviewing, in an emotionally detached fashion, the source and circumstances of emotionally significant events (positive and negative) from their past- other than the trauma they are being treated for. In response to these suggestions, subjects most often develop a partial regression (as opposed to a complete regression) and dissociation. In this altered state, they can be instructed to use their adult intellect to view themselves, in an emotionally detached manner, during emotionally significant events at earlier stages of their life development. Once they have demonstrated their ability to remain detached and contemplate events from their own lives, they are then taught to rapidly retreat from emotionally charged memories via a post hypnotic suggestion such as:

“…when you feel me lifting your left hand and arm that will be your signal to do something. It might be to withdraw immediately from whatever you were looking at or feeling or it might be to make your mind blank and feel calm and relaxed or it might mean to go into another trance. But whenever you feel me give you the signal, you’ll be prepared to carry out the task. Do you understand?”

Using Ideomotor signaling for security

In addition to training the subject to respond to the operator’s signal to withdraw, it is also very important to train the subject to develop their own ideomotor signals so they can communicate non-verbally with the operator and, most importantly, let the operator know, (while they are in a trance), when or if they need help in withdrawing from any experience they find overwhelming. In the author’s experience, the operator should not assign ideomotor signals for their subjects. Doing so contradicts the authenticity of this hypnotic phenomenon. Training subjects to develop genuine ideomotor signals-signaling originating at the unconscious level can be done in the following manner. The subject is told to sit comfortably with their feet flat on the floor with their arms resting on, either their lap or, preferably, on the arms of the chair with their hands comfortably hanging over the arms of the chair. They are instructed to pick a spot out on the wall across from them, to fix their gaze on it and, once they find a spot, they are told to fix their eyes on that spot and not move their focus off that spot. They are then told a variation on the following:

“…the first way we learn to communicate is non-verbally. We learn body language before we learn to use words. For example, we learn to nod our heads for “yes” before we learn the word “yes” and we learn to shake our heads for “no” before we learn the word “no”. We also learn to signal “stop” by lifting one of our arms to mid-level, bending our hand upward at the wrist and then pushing our palm and arm away from our body. We learn to signal “I don’t know” by lifting both shoulders while bending our elbows and, at the same time, lifting our arms and shoulders with our palms turned upwards. We learn to signal “come here” by moving one of our index fingers towards us. In other words, the first way we learn to communicate is non-verbally and then when we learn to speak those words, we continue to use our non-verbal communication, often without knowing it, even as we’re speaking those words. And, as we all know, some people “speak” with their hands a lot. Now I’m going to ask your unconscious mind a question and you’re going to hear the question with your conscious mind but I don’t want you to answer it with your conscious mind. Just let your unconscious answer on its own. I’ll ask the question in such a way that your unconscious can answer my question non-verbally. You may or may not be aware of how your unconscious is answering but neither you nor I, not even my unconscious, knows how your unconscious is going to answer. Let’s both wait. There’s nothing you need to do. Just let your unconscious answer on its own. Now here’s the question and then let’s both wait: (spoken more slowly with emphasis) How does (subject’s first name) unconscious mind think it will signal me? Will it lift a finger on one of the hands, lift one of the hands and arms together, or lift one of the hands alone or will it nod or shake the head? Now let’s wait and give your unconscious mind a chance to think about how it will answer me."[[1]](#footnote-1)

Unconscious muscle movements have a number of distinguishing characteristics including: a lag time between when the question is asked and when the response is given; the muscle movements are hesitating, halting, jerking, ratcheting; and they are executed in a perseverated manner, generally with the presence of catalepsy. A smooth, continuous muscle movement has a conscious origin. When the first movements manifest they are often tentative and minimal, usually operating outside the subject’s conscious awareness. There is also a paradox of sorts regarding authentic ideomotor movements: the subject must enter a trance, at minimum, if only temporarily, in order to signal.[[2]](#footnote-2) Once a muscle movement is detected, the operator can then say:

“…good…nice job…now I’m going to ask your unconscious another question. (Spoken slower with emphasis). How does (subject’s name) think it will signal a “yes” signal? With a finger, a hand, an arm or the head?”

Again, the operator should wait until a movement is detected and any movement should then be accepted. Next, a “no” signal is requested in the same manner. Once both a “yes” and “no” signal have been established, testing those signals becomes the next important step. The operator can explain in the following way:

 “…now let’s give your unconscious a chance to practice signaling “yes” and “no” to some unimportant questions. Are you sitting down? (waiting for the “yes” signal assuming the subject is seated and if it comes), Are you standing up? (again, waiting for the “no” signal and if it comes) Do you mind standing up? Do you mind sitting down? Do you mind me asking you this question: what is your name?

While these latter questions may appear innocent enough, if the subject’s signals are authentic, the answer to any of these questions should be either a “yes” or a “no” signal, either of which indicates the presence of trance. This is due to the tendency of the hypnotized subject to hear the literal meaning of a question. Literally speaking, the question: “Do you mind standing up?” requires a “yes” or “no” question. “Yes, I mind (standing up), or “no, I don’t mind (standing up). Also, the answer to the question: “do you mind me asking you what your name is”, should be “yes” or “no”. If the subject provides their name, they are responding to the behavioral implications of the question which is a consciously learned response. In such an instance, the operator can say the following:

“…that was your conscious mind answering. Let me ask the question again and, this time, just let your unconscious answer it. Right now, I just want to know your unconscious mind’s answer… what your unconscious thinks. Let it answer by itself. It can do it all by itself.”

If after a reasonable period of time passes without an unconscious type muscle movement, the operator can then say:

“…now… just let your head nod or shake in response to the following question. Are you now in a trance?”

For individuals who have difficulty in signaling with their fingers, hands and/or arms, nodding the head is very basic and, with a little encouragement, subjects can usually be successful in manifesting some kind of unconscious neck muscle movements. It is immaterial whether the subject’s head nods or shakes. What’s important is the nature of the muscle movement. Again, is it a smooth, continuous movement that initiates quickly after the question is asked? Or, is there a pause and then the movement begins hesitatingly and in a halting and/or jerking movement? If it’s tentative and halting, the operator can encourage by saying:” good! Just let it nod all by itself. That’s right. All by its self. Let it keep nodding”. The later type of response is more likely unconscious in origin and the former more likely to have a conscious origin. If the operator is satisfied that the movement(s) are unconscious, she/he can proceed to the next task.

Once authentic ideomotor signals have been tested and authenticated, the operator can then ask the subject:

“…how does (subject’s first name) think it will signal “I want/need your help to feel safe and calm” or “I want your help in coming out of a trance”?

Over the years, the author has witnessed a range of signals in response to the above question. “I want your help” signals are invariably more pronounced than the “yes” and “no” signals the subject had previously established. The “I need help” signal is more distinguishable. For example, if the “yes” or “no” signals involve slight (yet consistent) finger movements (twitching from side to side or ratcheting up and down) on one or both hands, the “I need help” signal might involve an entire hand lift or an entire arm/hand levitation. The author wishes to emphasize the meaningfulness of genuine ideomotor signals for the subject during hypnotherapy. For the subject, ideomotor movements can be compared to an expression of “individuality”. In the author’s experience, it’s not a stretch to say the subject feels a certain “pride” in manifesting their own unique signals.

To recap: before initiating the treatment for PTSD, the subject needs to demonstrated (to themselves and the operator) their ability to respond to: (1) the operator’s initiating the posthypnotic suggestion of the arm lift and, in response, quickly withdraw from emotionally charged situations and experience calm, and (2) improvise their own unique ideomotor signal for: “I need help”.

A new trance is then elicited in which the subject is directed to begin exploring their traumatic experience while remaining emotionally detached and calm. Once they begin to identify the various components and events of their trauma via the hypnotic phenomenon of hypermnesia (vivid recall), they are encouraged to relate to the operator what they are learning about their trauma without awakening. Subjects usually need some help in learning to talk in a trance. The author has found that giving the following suggestion is often helpful.

“I want you to learn that you can awaken from the neck up only…just let your face begin to awaken. First your neck and then you can begin to feel your face slowly awakening…all the muscles, nerves and organs associated with speech awakening..…just enough so that you can talk to me without disturbing your calm and relaxed body beneath you.”

Once they have identified some, but not necessarily all the essential components of their trauma, they are given the following multi-part post-hypnotic suggestion:

“…soon I will begin counting back from 20-1 and as the counting proceeds you can find yourself awakening 1/20th of the way with each count. When I reach “one”, you can awaken fully. Shortly after you awaken I will ask you: ‘are you awake?’ And, you will say “yes” or “ya”. Suddenly, but not immediately after you say “yes” or “ya”, just the emotion(s) associated with your trauma and no other parts, will hit you hard”. I want you to hold onto those emotions just long enough to tell me a little about them and, after you do, I will start counting from 1-20 and the higher I count the more comfortable you will become and when I reach 20 all the distressing feelings will have faded. I will make sure you can handle whatever you experience and ‘take you away’ immediately, if necessary, as you learned to do earlier.”

Upon the subject’s awakening from this first treatment trance, the operator greets them with “hello”, as if they’ve just returned from somewhere. A small conversation may ensue regarding how they feel and what they’ve been thinking about. Shortly, however, the operator casually interjects the post-hypnotic cue, “are you awake”. Generally speaking, when subjects respond to post-hypnotic suggestions they spontaneously and unknowingly reenter another trance. As the operator recognizes the development of this spontaneously developed trance, the statement is made: “get ahold of that feeling and tell me about it”. The subject usually responds to this suggestion by showing physiological arousal of some kind as they begin experiencing the distressing emotion(s) again. Their breathing rate and heart beats may increase suddenly and markedly; some part of their body may begin shaking or moving or their body might become completely still. At this point the operator can ask: “tell me about it. What are you feeling: scared, angry, sad?” As soon as the subject begins to describe the feeling(s) they are experiencing, the operator begins counting again from 1-20. At the count of 10, the operator can say: “half way asleep…the feeling almost gone now”. Once the count reaches 20, the suggestion is given to the subject to make their mind blank and to feel their body relaxing deeply and comfortably. Once the subject begins to respond with a slowing of their breathing rate, heart rate and a relaxation in part or all of their body, the operator states that he/she now has another task for them. The subject is told that in a little while the operator is going to start counting back from 20-1 and:

“…this time when you awaken, you will see only pictures or movies of the distressing event. You will not feel any of the emotions. You will see only the picture(s) associated with your distressing emotion. I want you to tell me about the pictures or movies you are seeing and after you do, I will start counting again from 1-20 and again, you will go into yet another trance and all the pictures or images will fade from view. Once you’re in a new trance, I’ll have another task for you to do. Do you understand?”

If the subject responds with a non-verbal nodding or a verbal “yes”, then the operator begins counting back from 20-1. If not, the operator repeats the instructions until the subject demonstrates an understanding. (Depending on the number of components comprising the subject’s traumatic experience, other trances can be utilized to experience an auditory component or an olfactory or a kinesthetic component; each brought out separately and briefly discussed.) As the subject awakens, again the operator can say “hello” and ask how they are feeling or where they’ve been and then, as before, the post-hypnotic cue: “Are you awake”, is given and again the subject spontaneously redevelops a trance. As the new trance begins to progress, the operator asks: “tell me about the pictures you’re seeing…the movies you’re seeing, the scenes you’re seeing.” After the subject finishes describing the pictures or “scenes” related to their traumatic experience the operator repeats the pattern and begins counting again from 1-20. When the subject develops yet another trance, the operator can make suggestions to the subject to clear their mind of all pictures and scenes.

In the final step, the operator initiates another post-hypnotic suggestion:

“…in a moment, I’m going to ask you to awaken again after I finish counting back from 20-1. After you open your eyes, I’m going ask you if you are awake and you will say “yes” or “ya”. Then, suddenly but not immediately, you will put the emotions and the pictures (as well as any other components of the trauma, i.e. olfactory, kinesthetic, etc.) from your distressing experience together, but this time, you’ll do it with an adult perspective…a new perspective that allows you to think back upon your experience without the same kind of fear or distress you felt before. You will be able to handle the whole experience in a much better manner and you will feel as though you’ve accomplished something very important.”

Once the subject indicates they understand the task, the operator begins counting back from 20-1. After the subject awakens, again the post hypnotic cue, “are you awake”, is given. Once the subject says “yes” or “ya” and begins to redevelop another trance, the operator asks the subject: “tell me about your distressing experience again. How do you feel about it now?” As the subject responds, careful attention is paid to how the subject talks about their experience. Usually little encouragement is needed for the subject to elaborate upon the event at length, even mentioning previously unrelated parts of the experience. If, however, the subject hesitates to elaborate or talk at all, the operator can state:

“…the important thing is what you think now and how you feel now about what happened to you and not what you relate to me. If you’d rather keep it to yourself for now and let it all sink in, I think that’s a good idea. If you ever feel like talking about it sometime in the future, I would appreciate you teaching me all about it.”

Finally, if the subject appears to still remain in a trance, the operator begins counting back from 20-1 and when the subject awakens, no post-hypnotic suggestion is given. At this point, the subject can be asked to talk a little about what they have learned and how they feel. A follow-up session can be offered days or weeks later in which the operator can judge the effects of the hypnotherapy.

 The hypnotic approach described above was developed by the author while teaching clinical psychology graduate students in Guatemala over the last ten years. These students are challenged by a patient population exposed to multiple traumas, often associated with the 36-year-old Guatemalan civil war. Through trial and error, this approach evolved in response to a need to provide a more effective and briefer trauma therapy. Based on the neurobiological and clinical research cited earlier, e.g. Sapolsky (2017: 129, 149), the author hypothesizes that by extracting the components (stimuli) of a given traumatic memory separately, in a piecemeal fashion, hypnotized PTSD patients, by means of their detached/dissociated state and perspective, were able to more effectively regulate and reorganize the amygdaloid stress responses associated with their trauma. It is further hypothesized that they were able to accomplish this, in part, by utilizing their prefrontal cortex to initiate and accelerate “pattern separation” through hippocampal neurogenesis with its resulting neuronal integration into other circuits associated with the trauma. The author suggests that this “relearning process” is considerably enhanced during the altered state of hypnotic trance. This process allowed them to relearn, revise and reassemble their traumatic memories both in and out of hypnotic trance resulting in a significant reduction in hyperarousal and re-experiencing symptoms. The trauma wasn’t repressed or deleted. Rather, it reemerged reordered, less distressing and better tolerated.

While researching the hypnotherapy literature on PTSD, the author found that Spiegel’s (2004) split-screen and restructuring approach shared much in common with the author’s approach.[[3]](#footnote-3) Like Spiegel’s split-screen approach, the author has also found that his approach has also been effective in treating a variety of difficult cases where intense emotional memories create significant treatment challenges, including phobias.

Conclusion

Research into the neurobiology of learning and memory supports the concept that each time a memory is retrieved and explored and then restored again, new biochemistry replaces the old during the reconsolidation of a long-term memory, resulting in an alteration (to one degree or another) in the original distressing memory itself. Of the psychological approaches currently being used in the treatment of PTSD, hypnotherapy is particularly well suited to the recollection, modulation, integration and reorganization of traumatic memories. This is due, in part, to the similarity between hypnotic phenomena and the symptoms of PTSD, in particular, dissociation, but also because of the flexibility and dynamics of hypnotic phenomena in creating a therapy through which the painful and disabling nature of the trauma can be better tolerated via the process of reorganizing the original traumatic memory. In this article, the author describes a hypnotherapeutic approach in which the various stimuli and somatosensory information comprising the traumatic memory are deconstructed into their various components (stimuli) using multiple trance events. After each component is accessed and experienced separately, both in trance and in a brief post-waking state, a final trance is elicited during which the memory components are reconsolidated to form a newly organized memory resulting in a marked reduction in re-experiencing and hyperarousal symptoms thus making it more tolerable and acceptable to the patient.

The history of hypnosis as a treatment for traumatic conditions spans 200 years, yet, to date, no systematic studies of its efficacy as a post traumatic treatment have been conducted. (Carden~ a, 2000). The author suggests that well designed and controlled studies, (including neuro-imaging), demonstrating its efficacy as a trauma treatment, will be needed before hypnotherapy becomes a generally recognized, taught and utilized treatment option in today’s “scientific” clinical culture. Until then, hypnotherapy will remain an effective, yet underutilized short-term post trauma treatment option.

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1. For a more complete explanation of establishing ideomotor signaling see: Erickson, M. H. (1964). An hypnotic technique for resistant patients: The patient, the technique and its rationale and field experiments. *American Journal of Clinical Hypnosis*, *7*(1), 8-32. [↑](#footnote-ref-1)
2. Eliciting ideomotor signals constitutes a trance induction technique. See previous footnote for reference. [↑](#footnote-ref-2)
3. Personal email with D. Spiegel Oct. 12, 2016. [↑](#footnote-ref-3)