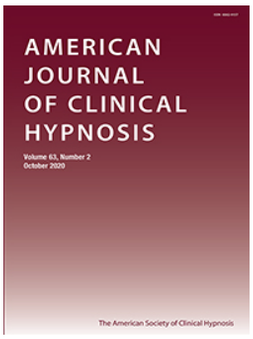

American Journal of Clinical Hypnosis

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/ujhy20

Applicability of hypnosis to the treatment of Complex PTSD and dissociation

Steven N. Gold & Michael Quiñones

To cite this article: Steven N. Gold & Michael Quiñones (2020) Applicability of hypnosis to the treatment of Complex PTSD and dissociation, American Journal of Clinical Hypnosis, 63:2, 78-94, DOI: 10.1080/00029157.2020.1789546

To link to this article: https://doi.org/10.1080/00029157.2020.1789546

Published online: 29 Oct 2020.

AMERICAN JOURNAL OF CLINICAL HYPNOSIS
2021, VOL. 63, NO. 2, 78–94
https://doi.org/10.1080/00029157.2020.1789546

Applicability of hypnosis to the treatment of Complex PTSD and dissociation

Steven N. Gold[1] and Michael Quiñones[2]

[1]Nova Southeastern University, Fort Lauderdale, FL, USA; [2]Independent Practice

ABSTRACT

In considering the applicability of hypnosis to treating Complex PTSD (C-PTSD) we examine the relationship between trauma, hypnosis, and dissociation, the latter being a common response to traumatization that is particularly salient in C-PTSD. We then provide an overview of the nature of C-PTSD, which research is beginning to demonstrate is considerably more prevalent than the more circumscribed PTSD syndrome depicted in the DSM. Building on this foundation, we discuss the reasons why hypnotically structured treatment is particularly well suited for C-PTSD, explaining how each of the major aspects of this syndrome can be addressed within a hypnotic framework.

KEYWORDS

Complex PTSD; contextual Trauma Therapy; dissociation; hypnosis

It has long been proposed that there is a special connection between hypnosis and trauma (Putnam & Carlson, 1998; Spiegel, 2003) and between hypnosis and dissociation (Irwin, 1999; Whalen & Nash, 1996). The precise nature of the relevance of hypnosis to trauma and dissociation, however, is far from settled, nor is it even universally endorsed. For quite some time it was believed that the previously presumed correspondence between hypnosis and dissociation was contradicted by research findings. This belief was derived from a number of studies that showed a near-zero correlation between hypnotizability as measured by the Harvard Group Scale of Hypnotic Susceptibility (HGSHS) and the Dissociative Experiences Scale (DES) (Angelini, Kumar, & Chandler, 1999; Faith & Ray, 1994; Frischholz et al., 1992; Nadon, Hoyt, Register, & Kihlstrom, 1991). However, more recent studies have challenged the conclusions of investigations using those instruments (Cleveland, Korman, & Gold, 2015; Facco et al., 2017; Vanhaudenhuyse et al., 2019).

Very recently, Dell (2019) has offered a detailed thesis on the relationship of trauma and dissociation to hypnosis. Over time, others have posited a special relationship between hypnosis and traumatization (Cardeña, 2000; Spiegel, 2016), hypnosis and dissociation (Dienes et al., 2009; Sapp, 2015), or all three (Cardeña, Maldonado, Hart, & Spiegel, 2009; Spiegel, 2001). Although the notion that these three phenomena are intimately connected dates back to the earliest days of trauma psychology (Haule, 1986; Steele & van der Hart, 2019; Whalen & Nash, 1996), identification of the precise nature of the relationship remains in many ways elusive (Putnam & Carlson, 1998). Several theorists have suggested, for example, that dissociative processes lie at the very root of hypnotic responding and hypnotic phenomena (Gruzelier, 2000; Hilgard, 1992; Kirsch & Lynn, 1998).

CONTACT Michael Quiñones mquinon03@gmail.com 7501 NW 4th St, Suite 215, Plantation, FL 33317, USA.

Regardless of lingering ambiguity in the empirical literature about the nature of the relationship of hypnotic states to traumatization and dissociative experiences, we contend that clinical observation is strongly supportive of a formidable link between the three phenomena. In our own clinical work with severely traumatized clients, the ease with which members of this cohort can enter hypnotic states, access hypnotic phenomena, and effectively apply their hypnotic capacities to the attainment of treatment goals has made a strong impression on us and appears to strongly correspond to their proclivity for dissociation. The increasing awareness of the prevalence of dissociative experiences among traumatized individuals is attested to by the inclusion in the DSM-5 (American Psychiatric Association [APA], 2013) of the designation "Posttraumatic Stress Disorder, Dissociative Subtype." Although in the DSM-5 this term specifically pertains to dissociation in the domains of depersonalization and derealization, there is considerable reason to believe that other forms of dissociation, especially dissociative amnesia and identity fragmentation, are at least as prevalent and very likely more common among trauma survivors (Cardeña & Gleaves, 2007; Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006; Sar, 2011; Şar, Akyüz, & Doğan, 2007).

What is fairly well established in the research literature is that several types of problematic dissociative reactions and states are related to a history of trauma (Powers, Cross, Fani, & Bradley, 2015; Stein et al., 2013). Partly due to this observed correspondence, various authors have suggested that hypnotherapy is either the treatment of choice for posttraumatic stress disorder (PTSD) and other trauma-related disorders, or a tool that is a useful adjunct to other forms of trauma-informed treatment (Lynn & Cardeña, 2007; Rotaru & Rusu, 2016; Spiegel, 2003, 2016).

Complex PTSD

Despite an explosion in research papers and scholarly literature in general pertaining to psychological trauma since the PTSD diagnosis was formally legitimized with its introduction into the DSM-III in 1980 (APA, 1980; Scott, 1990), and the high prevalence of trauma in the general population (Gradus, 2007; Kilpatrick et al., 2013; Perkonigg, Kessler, Storz, & Wittchen, 2000), too many practitioners do not receive adequate training in how to effectively treat traumatization (Courtois & Gold, 2009). One major gap in the knowledge of many practitioners is an understanding of Complex PTSD (C-PTSD), a diagnosis first proposed almost thirty years ago by Herman (1992). Probably in large part because C-PTSD has never been incorporated into the DSM, few practitioners acquire sufficient familiarity with it to know how to treat it (Kumar, Brand, & Courtois, 2019). However, on the basis of extensive research (Hyland et al., 2017; Karatzias et al., 2017) C-PTSD has recently been included in the most recent version of the *International Classification of Diseases*, ICD-11 (World Health Organization, 2018), which, in contrast to the DSM, is the standard diagnostic manual employed in most of Europe and other parts of the world.[1]

C-PTSD consists of the entire range of symptom patterns that characterize PTSD, plus an additional set of difficulties referred to as "disturbances of self-organization" (DSO) (Karatzias et al., 2017). PTSD consists of four major categories of symptoms: (1) persistent, unwanted and disturbing reminders (e.g., thoughts, memories, physiological reactions) of

[1]The World Health Organization (WHO), an agency of the United Nations, encourages all its member nations to use the ICD.

instances of trauma; (2) attempts not to be reminded of traumatic events; (3) enduring cognitive and affective changes shaped by incidents of trauma; and (4) heightened emotional and physiological reactivity. In contrast, C-PTSD encompasses these four symptom areas plus three additional categories of difficulties that together comprise the DSO component of C-PTSD: (1) persistent difficulty relating to others; (2) problems with emotion regulation; and (3) a negative self-image (Brewin et al., 2017).

Recent research confirms what a substantial proportion of front-line trauma therapists have long suspected based on their clinical experience: C-PTSD is appreciably more prevalent than PTSD as framed in the DSM (Cloitre et al., 2019). Although dissociation is sufficiently common in PTSD to warrant the inclusion of a dissociative subtype in the DSM-5 (APA, 2013), dissociation appears to be even more emblematic of C-PTSD (Powers et al., 2017; Van Dijke, Hopman, & Ford, 2018). Herman (1992) originally posited that C-PTSD arises in response to extended interpersonal violence trauma in general. However, empirical evidence is accumulating that suggests it is specifically related to prolonged child abuse (PCA) trauma (Cloitre et al., 2019; Hyland et al., 2017; Van Dijke et al., 2018).

The contextual trauma model of C-PTSD

Our own perspective on C-PTSD has largely been informed by 30 years of clinical and supervisory experience at a university-based outpatient trauma clinic staffed by doctoral level psychology trainees, the Trauma Resolution & Integration Program (TRIP). Although TRIP treats adults ages 18 and up presenting with all types of trauma histories, by far the largest proportion of clients seen there report an extensive PCA history. Clinical and research work with this cohort over many years in an academic setting has underscored the following observations, consistent with the empirical findings cited above:

- C-PTSD is much more prevalent in the general population than PTSD.
- Therapy clients who present with C-PTSD overwhelmingly report histories of PCA as opposed to other types of ongoing trauma.
- A proclivity for dissociative reactions to trauma-related cues and for dissociative modes of experience is extremely common in clients with C-PTSD.
- Due largely to the prevalence of dissociation among PCA survivors with C-PTSD, this is a cohort that tends to exhibit the capacity to quickly and easily respond to hypnotic inductions, master the capacity for self-hypnosis, and access a variety of hypnotic phenomena that can be employed to facilitate the attainment of treatment goals.

Our experiences at TRIP as well as our clinical observations in independent practice have led to a model for conceptualizing and treating C-PTSD that we have come to refer to as Contextual Trauma Therapy (CTT) (Gold, 2020). The core tenet of CTT is that the difficulties experienced by individuals with C-PTSD stem as much from growing up in an interpersonal environment that fails to adequately provide for their developmental needs as from explicit child abuse trauma. In other words, the forms of impairment manifested by PCA survivors, largely captured by the diagnostic criteria of C-PTSD, are as much a reflection of the absence of salutary forces in their formative years as of the presence of traumatizing experiences. Very simply, the CTT model proposes that while their PTSD symptoms can primarily be accounted for by their PCA history, for the most part their DSO difficulties are attributable to having

grown up in circumstances that did not sufficiently transmit to them the developmental capacities needed to successfully navigate the complexities of gratifying and productive adult functioning. These restrictive characteristics of their upbringing represent the context of PCA from which CTT derives its name, a context that CTT suggests creates gaps and warps in psychological development. These developmental limitations, in turn, are posited by CTT to render children especially vulnerable to the manipulation and exploitation of ongoing abuse in childhood, to being enduringly traumatized by their experiences of maltreatment, and to continued susceptibility to victimization later in life.

The CTT model emphasizes that the distinction between trauma-related PTSD symptoms and developmental limitations that foster DSO difficulties carries crucial implications for treatment (Gold, 2020). The manifestations of PTSD are largely *performance deficits*, i.e., they interfere with the expression of behaviors that lie within the person's repertory. In contrast, the constituents of DSO represent *skills deficits*, abilities that, due to developmental deprivation, have never been mastered. Consequently, resolving the difficulties comprising these two areas of impairment require appreciably different therapeutic strategies.

Although many clinicians equate therapy for traumatized individuals with an intense focus on the traumatic events themselves, from Herman (1992) onward most experts on C-PTSD advocate that therapy proceed in a way that *does not* initially focus on the processing of these experiences. Often referred to as "phase-oriented treatment," this approach begins with a period, often protracted, of stabilization. The major task of this first phase of therapy is to equip the traumatized client with the coping abilities and adaptive capacities needed so that confrontation of traumatic material in the second phase leads to the resolution and mastery of past traumatic experiences rather than exacerbation of their traumatizing effects due to being overwhelmed by them. The third and final phase centers on helping the survivor, who is now no longer "haunted" by their trauma, to make sense of those experiences in a way that allows them to effectively reconcile them with their overarching philosophy of life. Doing so enables them to engage in the routines of daily living while retaining a sense of direction, purpose, and meaning.

CTT is a phase-oriented treatment, but differs in at least two appreciable ways from other similar models such as the one delineated by Herman (1992). The first phase of treatment is framed not merely as fostering stabilization, but as working toward enhancing the survivor's coping ability and overall quality of life in the present by identifying and ameliorating developmental gaps and warps stemming from the deficits in their formative environment. In addition, although trauma processing is the focus of the second phase when it is indicated, what we have observed is that after thorough phase one work aimed at remediating areas of developmental deficiency, symptoms associated with the PTSD component of C-PTSD sometimes have reduced or been eliminated to the point where extensive trauma work is no longer necessary.[2]

Why hypnosis?

Dissociation literally means disconnection (Gold & Seibel, 2009). It signifies a relative lack of awareness and/or experiential distance from: (1) the subjective realm (i.e. one's own

[2]In fact, Brown and Elliott (2016) have similarly proposed that with extensive and intensive attachment-focused therapy, trauma-focused intervention may not be necessary in order to successfully treat traumatization. The decisive impact of the therapeutic relationship in the treatment of C-PTSD is addressed in the following section.

thoughts, emotions, beliefs, memories, sensations); (2) the external environment; and (3) the interpersonal sphere (i.e., a sense of closeness, intimacy, joining with others). Colloquially, the subjective aspect of dissociation is frequently captured by terms such as "fogginess," "spaciness," and "zoning out." Although research suggests that dissociation and hypnosis are not completely identical (Cleveland, Reuther & Gold, this issue; Dell, 2017; Spiegel, 2001), they certainly share key elements of overlap (Cleveland et al., 2015; Dell, 2017; Spiegel, 2001).

Among survivors of complex traumatization dissociation is not merely manifested as discrete episodes, say, of amnesia or depersonalization, although those certainly do commonly occur. It is, rather, a pervasively detached state of consciousness marked by profoundly constricted attention and awareness that is so fundamental to the survivor's subjective orientation that they may not be cognizant that other people's experience of life is substantially different from their own. Although this deviation from the norm is highly unlikely to be apparent to the casual observer, when the practitioner does encounter indicators of these modes of experience, they can be stunning. For example, in response to successful therapy a highly dissociative individual may discover that for the first time they are experiencing themselves as located within their body rather than "floating" at a point outside of their physical being. Or they may be so detached from their own tactile sensations that when they purchase new shoes the only way they recognize that they fit too tightly is by noticing several days later that their feet are bleeding. Or, more commonly, sometimes in relation to people outside of therapy but often in interaction with the clinician, they may feel sufficiently "present in the present" to discover what it means to experience a sense of connection to another person.

In keeping with the central construct at the core of CTT – that PCA survivors with C-PTSD suffer not only from the effects of trauma but also from restricted development resulting from deprivation during their formative years – we see this subjective detachment as stemming from both of these factors. From this vantage point a major contributor to a generally dissociative orientation beyond traumatization per se is having grown up with a relative paucity of the interpersonal resources that are indispensable to arriving at adulthood with the capacities needed to manage the complexities of daily living: reliable and caring attachment figures; emotional responsiveness and support; and the modeling of effective coping and adaptive skills. Growing up with these types of deficiencies in one's interpersonal environment carries with it insufficient stimulation of psychological and brain functions to adequately potentiate development (Siegel, 2012). This principle highlights that problematic dissociation in complex trauma survivors is not only as a response to trauma, but also a consequence of truncated development. Being reared under insufficiently stimulating conditions fosters limitations in the capacities for attention, concentration, and awareness that form a foundation for the converse of dissociation: experiential connectedness.

Like dissociation, hypnosis is an altered state of consciousness, and although they may not be identical, they certainly share experiential qualities reflected in terms such as "fogginess," "spacing out," and "zoning out." Moreover, both phenomena involve a relinquishment of conscious (i.e., prefrontal cortical) control (Gruzelier, 2006). A major distinction between the two, however, is that hypnosis is entered into volitionally, while problematic dissociation[3]

[3]Although there is not universal agreement on this point, several specialists in dissociation, including the senior author, contend that dissociation has normal and normative variants, and therefore does not always indicate the presence of a disorder (Seligman & Kirmayer, 2008).

creates difficulties precisely because and to the degree that it is automatic, not volitionally evoked, and therefore has a high potential to interfere with adaptive functioning (McLeod, Byrne, & Aitken, 2004; Seligman & Kirmayer, 2008; Spitzer, Barnow, Freyberger, & Grabe, 2006). What hypnosis is especially well-suited to accomplish is to help the complexly traumatized client to harness their dissociative state of mind in the service of directed (albeit not consciously), goal-oriented efforts. The effect is, frankly, paradoxical: by hypnotically accessing the state of detachment and lack of awareness of the dissociative mind-set, the therapist is able to employ hypnotic modes of communication to incrementally help the survivor client develop the capacities for connectedness and augmented awareness. Execution of this principle can readily be conceived of in terms of Erickson's notion of "meeting the client where they are at" in the initiation of a process of change (Erickson & Rossi, 1981) or of dialectical behavior therapy's core dialectic of acceptance of current limitations and the need to move beyond them (Linehan, Miller, & Addis, 1989). In the next section we delineate strategies for achieving this end in relation to each of the main features that comprise C-PTSD.

Although others have independently constructed similar interventions (Kluft, 1989), we routinely draw upon a strategy for helping dissociative clients acquire the ability to modulate their degree of detachment based on the Ericksonian principle that people can rarely directly diminish a problematic experience, but when prompted to can easily intensify it (O'Connell, 1983). We call this method, described in detail in Gold (2020), the "Dissociative Dial." Briefly described, the client is asked to rate their level of dissociation on a hundred-point scale (pictured by them as a dial) from zero (none at all) to 100 (complete or maximal). Under the direction of the therapist, they then picture an indicator on the dial moving gradually, point by point, up the scale in the direction of *greater* (sic) dissociation. After they have pictured the indicator moving a distance up the scale, they then incrementally view the indicator moving in the opposite direction, until the number is at a level of dissociation considerably lower than that at which they began. An entire session is devoted to this procedure so that the "movement" can take place just a little bit at a time. By the end of the session the client has learned how to modulate their level of dissociation via a procedure they can now practice on a daily basis until they are confident they have mastered it. An added benefit of this capacity to modulate their level of dissociation is that essentially the same strategy can now be applied to regulate other experiences, such as anger, anxiety, or physical pain.

Beyond this generic approach to provide C-PTSD survivors with a greater measure of choice over whether and to what degree they dissociate, a number of qualities that dissociation and hypnosis have in common can be exploited for therapeutic purposes. Consider, for example, the following characteristics of both of these phenomena:

- Depersonalization and Derealization – the experience, respectively, or one's subjective sense of self or one's surroundings being distant or unreal, allows for a sense of experiential detachment in addressing difficult material, thereby examining it in a relatively dispassionate, objective fashion;
- Amnesia – disconnection in the form of compartmentalization, "sealing off" content from consciousness so that new perspectives are not "disrupted" by skepticism, disturbing material does not interfere with routine functioning, and traumatic experiences can be processed without seeping into awareness outside of hypnosis;
- Vivid Imagery – a dimension of both dissociation and hypnosis that renders metaphor, real life examples, and storytelling more impactful and therefore more convincing;

- Intensified Emotionality and Reduced Critical Thinking – increase the potential for interventions to have more experiential impact;
- Easier Access to Compartmentalized Senses of Self – so that awareness, communication, and internal cooperation between sectors of self-identity can be facilitated.

We now turn our attention to the relevance of hypnotic therapeutic strategies to the treatment of C-PTSD.

Dimensions of hypnotic applicability to treating complex traumatization

Phase-oriented treatment for C-PTSD dictates, in effect, that the DSO aspects of the disorder be the primary focus of the first phase of treatment. If, following thorough phase one work, appreciable PTSD symptoms persist, these are the focus of attention in the second phase. The guiding rationale for this approach is that once an individual with C-PTSD has attained sufficient ability to form and maintain supportive interpersonal relationships, manage emotional reactions well enough to resist being overwhelmed, and establish a reasonably positive self-image, they are well positioned to productively face the extraordinary stress associated with past traumatic experiences. As framed by Herman (1992), these capacities represent a foundation for a sense of safety and the attainment of psychological stability. From a CTT vantage point, these are simultaneously developmental capacities that the survivor with C-PTSD was unable to establish because they were not adequately modeled and cultivated during their formative years. Consequently, assisting the survivor in attaining these abilities equips them in essential ways that extend far beyond merely being able to tolerate the challenges of resolving traumatic material; it simultaneously enables them to more fully assume the status of adult functioning (Gold, 2000, 2020)

Phase one: hypnotic strategies for stabilization and developmental remediation

The first and highest priority in treating C-PTSD is helping the survivor to function better in the present. This attainment obviously has tremendous value as an end in itself in addition to preparing the survivors to tolerate facing their traumatic past in the subsequent phase of treatment. Helping the survivor improve their current level of adjustment is accomplished largely by addressing each of the three major components of the DSO sector of C-PTSD.

The relational component of DSO: fostering rapport and promoting secure attachment

Most students of hypnosis learned in their first introductory course on the topic that the use of the word "rapport," now often used to refer to the resonant relationship between client and therapist, originated in the time of Anton Mesmer to denote the deep sense of connection that characterizes the interaction between hypnotist and respondent (Gravitz, 2004). Having been betrayed in the form of abuse trauma and deprived of many of the interpersonal resources that foster psychological development, PCA survivors are prone to feeling acutely isolated and alone. Promoting and capitalizing on the profound experience of interpersonal connectedness that can be stimulated in the hypnotic situation can

therefore be an invaluable tool. Rapport can easily be employed to help the complex trauma survivor develop the capacity for secure attachment. It can also be a foundation for self-soothing (i.e., distress reduction) through the experience of safety and tranquility that can arise from a sense of connection with a trusted and trustworthy other.

As with other aspects of hypnotic approaches to resolving C-PTSD, addressing this component of DSO requires nuanced hypnotic inductions and interventions. In order to accomplish this objective, the practitioner needs to base hypnotic approaches on close observation and careful conceptualization of the individual survivor's unique life circumstances, perspective, and needs to intricately construct highly individualized hypnotic experiences. Approaching hypnosis in this way arouses in the survivor a palpable sense of being attended to, understood, and cared for. Especially in regard to the relational component of DSO, it is largely through this attunement, reminiscent of Erickson's (Erickson & Rossi, 1976) concept of "the microdynamics of trance," (p. 171), that rapport is facilitated and secure attachment attained.

The traditional three-phase approach to trauma-informed treatment utilizes a focus on "safety and stabilization" at the onset of therapy (i.e. "Phase one"). The emphasis on safety and stabilization is due to a commonality for many PCA survivors: chronic distress, heightened reactivity, and pervasive interpersonal difficulties due to fear and distrust. For many survivors of prolonged abuse and maltreatment, the circumstances of an inconsistent and maladaptive upbringing led to the development of insecure attachment types. These insecure attachment types consist of anxious, avoidant, and/or disorganized patterns of self-concept and relating that underlie respective disruptions in capacities for self-soothing, emotional regulation, and interpersonal relationships. The characteristic difficulties associated with the DSO component of C-PTSD (i.e. negative self-concept, affective dysregulation, and interpersonal difficulties) share a commonality among the range of insecure attachment-types (Karatzias et al., 2018; Powers et al., 2017). Taking into consideration the likelihood of PTSD-related difficulties (i.e. increased vigilance, distrust of interpersonal relationships, and heightened reactivity), along with the previously mentioned difficulties, lends to trauma survivors being at an increased risk of experiencing distress, dysregulation, and dissociative episodes at the onset of treatment. These factors altogether can be a substantial barrier to establishing therapeutic rapport and developing the foundation for a trusting collaborative relationship in the beginning phases of trauma-informed treatment.

Hypnosis, either as a "stand-alone" therapeutic approach or as an adjunct to trauma-informed treatment, can provide a range of clinical utility in the early phase of therapy with PCA survivors presenting with C-PTSD symptomology. The beginning-phase of therapeutic applications of hypnosis focus on a therapist's capacity to, 1) "tune in" – "meeting a person where they are at" in terms of recognizing and communicating effectively with them based on their current emotional and cognitive state, 2) reflecting on the internal subjective experience of the client that underlies their current emotional and cognitive state, and 3) utilizing verbal and non-verbal responses to therapeutically communicate "recognition" of the client's "state of being". These capacities that promote "mirroring" to the client, are the precursor to instruction and practice of relaxation-based techniques underlying the hypnotherapeutic approach, and are congruent with the precursors for the development of secure attachment (Spiegel, 2016; Zelinka, Cojan, & Desseilles, 2014). When considering the deficient and disruptive developmental circumstances experienced by PCA survivors, utilization of these capacities can facilitate reductions in distress and reactivity and cultivate more favorable conditions for developing therapeutic rapport in the early phase of treatment.

The affective dysregulation component of DSO: equipping survivors with distress-reduction capacities

As previously discussed, the developmental context of PCA survivors impedes the acquisition of effective capacities for tolerating, managing, and reducing distress. Inadequate development of the capacity for emotion regulation and self-soothing can lead to persistent and chronic experiences of distress, dysphoria, and dissociative reactions. CTT theory emphasizes that these response patterns stem from being overwhelmed not only by trauma-related triggers, but also, due to limited developmental capacities, to the ordinary, expectable stresses and strains of daily living. The combination of severely restricted developmental opportunities and trauma-related symptomatology, underlie the affective dysregulation component of DSO and its corresponding deficits related to emotion regulation and self-soothing. The treatment approach taken in the first phase of CTT, therefore, corresponds to the development and improvement of capacities for emotion regulation. Consequently, the establishment of rapport and formation of a collaborative relationship in the first phase of treatment also incorporates a focus on improving the capacities related to emotion regulation (i.e. distress tolerance, modulating emotional intensity and expression, communicating effectively about emotions). Per the CTT model, PCA survivors are capable of utilizing the interpersonal benefits of therapeutic rapport in "phase one" to, 1) reflect upon and conceptualize past experiences of abuse and deprivation, 2) the consequent difficulties associated with affective dysregulation, and 3) their role in chronically disruptive emotional states, intense and/or overwhelming affect, and correspondence with dissociative reactions. Clinicians can also utilize emotional experiences in session to facilitate experiential learning about the client's emotional reactions, collaborative practice with emotion regulation techniques, and incorporate communication skills to explore affective responses. In doing so, PCA survivors are capable of remediating deficits in emotion regulation skills within a safe and stable therapeutic relationship, potentiating the possibility for growth and healing that initially began with the development of therapeutic rapport.

Hypnotherapeutic approaches can meld seamlessly with the emphasis on emotion regulation skills that are necessary to address the chronic affect dysregulation component of DSO. Early focus on hypnotic approaches to reduce distress and reactivity can reduce the risk of dissociative experiences in the early phase of treatment and promote therapeutic rapport by engaging in instruction and practice of relaxation techniques. Hypnotherapy typically incorporates a range of relaxation practices (e.g. relaxed breathing, body scanning, tension reduction, guided-imagery, etc.) to improve a client's capacity to reduce stress, modulate attention and awareness, focus on and modulate emotional experiences, and to recognize and regulate dissociative experiences. The objective is not primarily for the practitioner to help the survivor obtain relief in session, but to simultaneously instruct the client in the requisite skills so that they can be employed outside of sessions. Hypnosis utilizes the transmission of relaxation practices as an extension of the rapport building. In doing so, the clinician "stays in tune" with the PCA survivor as they improve their capacity for regulating and modulating their emotional experiences, dissociative reactions, and experience "states of being" in the safety of a therapeutic relationship. This lends to a "synergistic" effect with the focus on "safety and stabilization" in the first phase of trauma-informed treatment, providing the PCA survivor with the safety of a trusting and collaborative relationship, and the necessary skills to promote stability and strengthen autonomy for continued therapeutic progress.

The negative self-concept component of DSO: building a positive self-image

For PCA survivors with C-PTSD, experiences of chronic dissociative reactions, interpersonal difficulties, and affective dysregulation compounds and sustains a pervasive sense of negative self-concept and impoverished self-esteem. In addition to the humiliating impact of overt abuse, PCA survivors are faced with a developmental context riddled with inconsistent nurturing and responsiveness, unpredictable and chaotic household dysfunction, and inadequate modeling of adaptive capacities for daily living. Taking this into consideration, along with the survivor's experience of pervasive physical, sexual, and/or emotional abuse and neglect, it is not difficult to imagine the desert-like conditions in which the PCA survivor's sense-of-self must develop and endure. These harsh conditions underlie the negative self-concept component of DSO among survivors with C-PTSD. Chronic difficulties associated with negative self-concept can include diminished sense of self-worth, low self-esteem, and pervasive feelings of guilt and shame. The underlying factors associated with DSO share a circular exacerbation, in which chronic interpersonal difficulties and affective dysregulation potentiate a negative feedback loop that sustains the characteristics of negative self-concept that contributes back to the other two factors. PCA survivors are prone to experience chronic cycles of negative and overwhelming affect (i.e. dysphoria, fearfulness, paranoia, angry outbursts, dissociative reactions), interpersonal difficulties (i.e. fears of abandonment, labile and/or abusive relationships, ineffective communication skills) and a sense of self defined by chronic feelings of loneliness, worthlessness, distrust, and disconnection from others.

From a CTT perspective, a focus on improving self esteem and self-concept is a logical progression within the "Phase one" approach to trauma-informed treatment. With the establishment of rapport and continued focus on distress tolerance and emotion regulation, a foundation of trust, collaboration, and skills-based development create fertile ground for ameliorating a client's impoverished self-concept. This can be addressed through methods such as cognitive reframing, emphasis on positive self-talk, and therapeutic self-reflection and introspection among many others. Recent empirical research provides support for the inclusion of hypnosis to potentiate the efficacy of these approaches (Alladin, 2012; Bryant, Moulds, Guthrie, & Nixon, 2005; Green, Laurence, & Lynn, 2014; Milburn, 2011). Not only can hypnosis be utilized to assist survivors in developing the capacity to modulate dissociative reactions, hypnosis can also be utilized to develop non-pathological dissociative states that can foster introspective attention and awareness to therapeutically focus on emotional experiences, self-concept, and conceptual reframing and restructuring. Facilitating a non-pathological dissociated state through hypnosis can orient the client towards a deeper personal experience with their attention and focus directed away from external stimuli and distractions. Hypnotic approaches such as age-progression (i.e., envisioning a more adaptive future), ego-strengthening, and guided-imagery for the cultivation of positive affect, and metaphorical dialogue can be blended with traditional cognitive approaches for the purpose of developing a positive self-image and improved self-esteem. Age-progression is a technique where the client carefully envisions various aspects of their future life-trajectory based on choices and assumptions from their current state of mind and circumstances. The client and therapist can collaborate from a hypnotherapeutic approach, allowing the client to utilize a hypnotic state to deepen the introspective experience of envisioning and reframing their future circumstances based on the therapeutic work they are currently engaging in. For the PCA survivor with C-PTSD who has acclimated to chronic dysphoria and a negative self-concept, pathological

dissociative reactions may only serve as a reminder of feelings of helplessness and loneliness. With hypnosis, the client can learn to enter a non-pathological dissociative state while under conditions of trust, safety, and a sense of comfort. This facilitates positive introspective experiences that were previously unimaginable due to chronic pathological dissociative reactions originating from a development under threat and deficit. This kind of experience alone can potentiate a positive and dramatic shift in clients therapeutic progress, due to the newfound possibility that dissociative states can provide an internal space to experience positive possibilities and perspectives. Therapeutic utilization of dissociative states further supports the importance and value from the inclusion of a hypnosis-oriented approach to strengthen rapport and foster the development of emotion regulation skills. A hypnosis-oriented approach can augment the progression of the therapeutic relationship, capacities and skills for regulating emotional experiences, and improve the capacity for creativity and choice with dissociative states and reaction, while therapeutically targeting the underlying factors associated with DSO.

Phase two: the utility of hypnosis for trauma processing

The second phase of trauma-informed treatments traditionally consists of a "trauma processing" component. Treatments usually proceed to trauma processing once a sufficient capacity for safety and stabilization has been achieved by the client. There are a plethora of variable treatment approaches for trauma processing that vary in their theory, modality, and mechanisms of action (Gutermann et al., 2016; Imel, Laska, Jakupcak, & Simpson, 2013). A basis for the three-phase approach is for the first phase to focus on the capacities and skills for self-soothing, emotion regulation, and cognitive functioning that are prerequisites for the daunting effort of trauma processing (i.e. "Phase Two"). This is due to the considerable work needed for a survivor to confront traumatic content, maintain the capacity to tolerate and modulate intense affect and physiological responses, and cognitively appraise and conceptually integrate the traumatic experience and its impact.

For PCA survivors with C-PTSD, this phase of treatment can present a risk for decompensation, dissociative reactions, and short-term instability in daily functioning. Trauma-informed treatments that heavily focus on trauma processing have been shown to be contraindicated for PCA survivors due to inadequate focus on the prerequisite capacities needed to tolerate treatment (Cloitre et al., 2011; Hagenaars, van Minnen, & Hoogduin, 2010). This further supports the importance and emphasis on the first phase of treatment to provide survivors with the foundation necessary to shift treatment to trauma processing.[4] As discussed in previous sections, hypnosis has a multifaceted utility throughout the first phase of treatment (e.g. strengthening rapport, emotion regulation, modulating dissociative states, and improving self-concept). The benefits of a hypnosis-oriented approach to trauma treatment extends beyond those relevant to the first phase of treatment. The hypnotic skills cultivated in phase one provide another dimension of applicability for the trauma processing of phase two. Through hypnosis, non-pathological dissociative states can be utilized for 1) beneficial

[4]From a CTT approach, it is not mandated to move to trauma processing during the course of treatment. Survivors who develop the foundational capacities emphasized in phase one, are able to achieve gratifying and functional lives without the necessity of trauma processing. Survivors are capable of achieving a level of functioning in phase one that permits them to independently focus on the third phase of treatment in order to further develop a more gratifying and functional life.

"compartmentalization" to reduce the likelihood of disruptions in daily functioning, and 2) as a "surgical anesthetic" to effectively manage PTSD symptoms from trauma processing. Hypnotic states can orient an individual's attention and focus inward toward increasingly introspective experiences. Deeper introspective experiences can reduce conscious awareness of distractions from external stimuli and permit greater attention and focus toward introspection. Doing so can facilitate the client's "compartmentalization" of the trauma processing sessions in order to keep them contained within a specific depth of the psyche that can be reached with hypnotic practices and kept distinct from otherwise daily functioning.

Hypnotic states can also be employed by clients to alter and modulate the quality of introspective experiences. As discussed previously, hypnotic states can both potentiate the experience of positive affect and imagery, and reduce the intensity of negative affect and physiological arousal. For PCA survivors engaging in trauma processing, the utilization of hypnotic states can alter the quality of PTSD symptoms associated with trauma processing. For example, hypnotic states can allow for introspective processing of traumatic content from various degrees of "experiential distance" to observe and reflect upon with corresponding reductions in arousal and reactivity. This approach can be combined with hypnotic practices to reduce affective and physiological arousal prior to confrontation with traumatic content, so as to allow gradual recollection without possible disruption from PTSD symptoms. PCA survivors can embark on the arduous process of trauma processing in gradations of experiential awareness and introspection, while reducing the risk of being overwhelmed and flooded through exposure to traumatic content and possibly destabilizing the progress established in the first phase of treatment. The inclusion of hypnosis in the formation of rapport, fostering capacities and skills for emotion regulation, and development of a positive self-image and concept, can strengthen the PCA survivors sense of control and autonomy to effectively navigate and integrate aspects of trauma processing.

Phase three: integrating trauma resolution with adaptive/developmental gains

The third phase of treatment marks a transition in therapeutic focus directed toward the client's continued formation of a successful and gratifying life-structure. With a CTT approach, it is not always necessary to engage in protracted, immersive trauma processing during the course of treatment. In fact, our clinical evidence supports that PCA survivors who develop the foundational capacities emphasized in phase one (i.e., emotion regulation, distress tolerance, effective interpersonal and communication skills, and critical thinking skills and sound reasoning and judgment), are able to achieve a marked diminution in PTSD symptomatology without extensive trauma processing. Survivors are capable of achieving a level of functioning in phase one that permits them to independently focus on the third phase of treatment in order to further develop the functional capacities to live a life worth living for (i.e forming healthy attachments, positive self-esteem and self-concept, modulating distress, maintaining employment, and satisfying connectedness and relationships with others).

The hypnosis-oriented approaches reviewed in prior sections provide extensive contribution to the client's progress in the third phase of treatment. Hypnotic approaches to rapport building and its role throughout the therapeutic process, can provide clients with experiential continuity of a supportive, caring, and trusting relationship and development of secure attachment. This secure attachment can act as a cornerstone from which clients can develop and maintain healthy

relationship dynamics, while maintaining a positive and adaptive sense-of-self. Hypnotic practices oriented toward relaxation techniques and improving capacities for regulating affect and dissociative reactions, continue to aid the client's progress throughout the third phase of treatment. Experiential continuity is a necessary prerequisite to developing, maintaining, and augmenting the client's therapeutic gains. Clients can draw upon both in-session hypnotic practices and out of session self-hypnosis as stress-reduction strategies to mitigate the inevitable stresses that constitute daily functioning. In-session hypnotic relaxation practices can allow clients to develop a repertoire of self-hypnosis practices and relaxation techniques they can use outside of sessions to mitigate the inevitable and variable stresses that constitute life and daily functioning. Clients can further develop the application and effectiveness of self-hypnosis practices to maintain reductions in baseline stress, mitigate the likelihood of dissociative reactions and episodes, and further strengthen their sense of agency and autonomy. Hypnotic practices such as age-progression and ego-strengthening, used in phase one to cultivate inner resources and develop the capacities underlying safety and stabilization, can also be employed through self-hypnosis to continue developing creativity and choice about their life-trajectory, and the positive self-esteem and self-image necessary to maintain functional momentum in daily living.

Hypnosis, therefore, can be incorporated throughout the three-phase approach, providing compounding benefits over the course of treatment. Hypnosis-oriented principles and practices utilized during the first phase of treatment promote the client's capacities for safety and stabilization, and provide a natural progression through the third-phase of treatment to become a tool in the client's repertoire of skills and practices to maintain a sense of autonomy and functioning as they continue to live a secure, connected, productive, and fulfilling life. Hypnosis provides a wide array of clinical utility and seamlessly threads within the tapestry of the three-phase approach to trauma treatment.

Conclusions

Hypnotic induction and intervention are invaluable resources in the treatment of PCA survivors with C-PTSD. The proclivity for dissociation in this client group positions them to quickly learn how to enter hypnosis, access hypnotic phenomena, and apply these abilities to the resolution of the various areas of difficulty created by both explicit childhood abuse trauma and developmental deprivation. By assisting survivors to learn how to access and modulate the experiential detachment and automaticity of dissociation via hypnosis, therapists can help them learn how to transform and redirect a fraught mode of functioning (problematic dissociation) to one that can be harnessed to bolster adaptation. The various characteristics of hypnosis readily lend themselves to the amelioration of the major problem areas comprising C-PTSD. The interpersonal rapport that is fostered by heterohypnosis can be leveraged to enhance social functioning, equipping the complex trauma survivor to establish and maintain markedly improved interpersonal relationships. The ability to better modulate and manage emotional reactions is readily bolstered by learning to draw upon the quality of automaticity shared by dissociative responding and hypnosis. The intensification of imagery and emotions under hypnosis lend themselves to age progression, story-telling, metaphor and similar forms of intervention that can aid in convincingly improving the survivor's self-image. In the second segment of phase-oriented treatment the experiential detachment shared by dissociation and hypnosis can be employed in various ways to titrate

the intensity of confronting potentially counter-therapeutically overwhelming traumatic content. And in the third and final phase of treatment, having mastered all of these capacities, the survivor is well-positioned to firmly establish a life structure and lifestyle in which they acknowledge their traumatic past while maintaining an existence imbued with a sense of meaning, direction, and gratification. As one of our TRIP clients who entered treatment with complex dissociative traumatization put it after successfully completing therapy:

> I have used the very same imaginal capacities that helped me to mentally escape the horrors of my childhood to build a life in which I am no longer crippled by those horrors. I'm confident, I'm comfortable, I'm aware, and I'm okay. It's like suddenly the lights are on and I don't feel I have to hide somewhere. I've arrived.

References

Alladin, A. (2012). Cognitive hypnotherapy: A new vision and strategy for research and practice. *American Journal of Clinical Hypnosis*, *54*(4), 249–262. doi:10.1080/00029157.2012.654528

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Arlington, VA: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Angelini, F. J., Kumar, V. K., & Chandler, L. (1999). The harvard group scale of hypnotic susceptibility and related instruments: Individual and group administrations. *International Journal of Clinical and Experimental Hypnosis*, *47*(3), 236–250. doi:10.1080/00207149908410035

Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., … Somasundaram, D. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review*, *58*, 1–15. doi:10.1016/j.cpr.2017.09.001

Brown, D. P., & Elliott, D. S. (2016). *Attachment disturbances in adults: Treatment for comprehensive repair*. New York, NY: W W Norton & Co.

Bryant, R. A., Moulds, M. L., Guthrie, R. M., & Nixon, R. D. (2005). The additive benefit of hypnosis and cognitive-behavioral therapy in treating acute stress disorder. *Journal of Consulting and Clinical Psychology*, *73*(2), 334. doi:10.1037/0022-006X.73.2.334

Cardeña, E. (2000). Hypnosis in the treatment of trauma: A promising, but not fully supported, efficacious intervention. *International Journal of Clinical and Experimental Hypnosis*, *48*(2), 225–238. doi:10.1080/00207140008410049

Cardeña, E., & Gleaves, D. H. (2007). Dissociative disorders. In M. Hersen, S. M. Turner, & D. Beidel (Eds.), *Adult psychopathology and diagnosis* (5th ed., pp. 473–503). New York, NY: Wiley.

Cardeña, E., Maldonado, J. R., Hart, O. V. D., & Spiegel, D. (2009). Hypnosis. In E. B. Foa, T. M. Keane, M. J. Friedman, & J. A. Cohen (Eds.), *Effective treatments for PTSD: Practice guidelines from the international society for traumatic stress studies* (2nd ed., pp. 427–457). New York, NY: Guilford Press; 2010.

Cleveland, J. M., Korman, B. M., & Gold, S. N. (2015). Are hypnosis and dissociation related? New evidence for a connection. *International Journal of Clinical and Experimental Hypnosis*, *63*(2), 198–214. doi:10.1080/00207144.2015.1002691

Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey onbest practices. *Journal of Traumatic Stress*, *24*(6), 615–627. doi:10.1002/jts.20697

Cloitre, M., Hyland, P., Bisson, J. I., Brewin, C. R., Roberts, N., Karatzias, T., & Shevlin, M. (2019). ICD-11 PTSD and complex PTSD in the United States: A population-based study. *Journal of Traumatic Stress*, *32*(6), 833–842. doi:10.1002/jts.22454

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy*, *1*(1), 3–23. doi:10.1037/a0015224

Dell, P. F. (2017). Is high hypnotizability a necessary diathesis for pathological dissociation? *Journal of Trauma & Dissociation*, *18*(1), 58–87. doi:10.1080/15299732.2016.1191579

Dell, P. F. (2019). Reconsidering the autohypnotic model of the dissociative disorders. *Journal of Trauma & Dissociation*, *20*(1), 48–78. doi:10.1080/15299732.2018.1451806

Dienes, Z., Brown, E., Hutton, S., Kirsch, I., Mazzoni, G., & Wright, D. B. (2009). Hypnotic suggestibility, cognitive inhibition, and dissociation. *Consciousness and Cognition*, *18*(4), 837–847. doi:10.1016/j.concog.2009.07.009

Erickson, M. H., & Rossi, E. L. (1976). Two level communication and the microdynamics of trance and suggestion. *American Journal of Clinical Hypnosis*, *18*(3), 153–171.

Erickson, M. H., & Rossi, E. L. (1981). *Experiencing hypnosis*. New York, NY: Irvington.

Facco, E., Testoni, I., Ronconi, L., Casiglia, E., Zanette, G., & Spiegel, D. (2017). Psychological features of hypnotizability: A first step towards its empirical definition. *International Journal of Clinical and Experimental Hypnosis*, *65*(1), 98–119. doi:10.1080/00207144.2017.1246881

Faith, M., & Ray, W. J. (1994). Hypnotizability and dissociation in a college age population: Orthogonal individual differences. *Personality and Individual Differences*, *17*(2), 211–216. doi:10.1016/0191-8869(94)90027-2

Foote, B., Smolin, Y., Kaplan, M., Legatt, M. E., & Lipschitz, D. (2006). Prevalence of dissociative disorders in psychiatric outpatients. *American Journal of Psychiatry*, *163*(4), 623–629. doi:10.1176/ajp.2006.163.4.623

Frischholz, E. J., Braun, B. G., Sachs, R. G., Schwartz, D. R., Lewis, J., Shaeffer, D., . . . Pasquotto, J. (1992). Construct validity of the dissociative experiences scale: II. Its relationship to hypnotizability. *American Journal of Clinical Hypnosis*, *35*(2), 145–152. doi:10.1080/00029157.1992.10402997

Gold, S. N. (2000). *Not trauma alone: Therapy for child abuse survivors in family and social context*. New York, NY: Brunner-Routledge.

Gold, S. N. (2020). *Contextual trauma therapy: Overcoming traumatization and reaching full potential*. Washington, DC: American Psychological Association.

Gold, S. N., & Seibel, S. L. (2009). Treating dissociation: A contextual approach. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 625–636, Chapter xxxiv, 864 Pages). New York, NY: Routledge/Taylor & Francis Group.

Gradus, J. L. (2007). Epidemiology of PTSD. *National Center for PTSD (United States Department of Veterans Affairs)*. Retrieved from https://www.mentalhealth.va.gov/coe/cih-visn2/Documents/Provider_Education_Handouts/Epidemiology_of_PTSD_Version_3.pdf

Gravitz, M. A. (2004). The historical role of hypnosis in the theoretical origins of transference. *International Journal of Clinical and Experimental Hypnosis*, *52*(2), 113–131. doi:10.1076/iceh.52.2.113.28096

Green, J. P., Laurence, J. R., & Lynn, S. J. (2014). Hypnosis and psychotherapy: From Mesmer to mindfulness. *Psychology of Consciousness: Theory, Research, and Practice*, *1*(2), 199.

Gruzelier, J. H. (2000). Redefining hypnosis: Theory, methods and integration. *Contemporary Hypnosis*, *17*(2), 51–70. doi:10.1002/ch.193

Gruzelier, J. H. (2006). Frontal functions, connectivity and neural efficiency underpinning hypnosis and hypnotic susceptibility. *Contemporary Hypnosis*, *23*(1), 15–32. doi:10.1002/ch.35

Gutermann, J., Schreiber, F., Matulis, S., Schwartzkopff, L., Deppe, J., & Steil, R. (2016). Psychological treatments for symptoms of posttraumatic stress disorder in children, adolescents, and young adults: A meta-analysis. *Clinical Child and Family Psychology Review*, *19*(2), 77–93. doi:10.1007/s10567-016-0202-5

Hagenaars, M. A., van Minnen, A., & Hoogduin, K. A. (2010). The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD. *Behaviour Research and Therapy*, *48*(1), 19–27. doi:10.1016/j.brat.2009.09.001

Haule, J. R. (1986). Pierre Janet and dissociation: The first transference theory and its origins in hypnosis. *American Journal of Clinical Hypnosis*, *29*(2), 86–94. doi:10.1080/00029157.1986.10402690

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377–391. doi:10.1002/jts.2490050305

Hilgard, E. R. (1992). Dissociation and theories of hypnosis. In E. Fromm & M. R. Nash (Eds.), *Contemporary hypnosis research* (pp. 69–101). New York, NY: Guilford Press.

Hyland, P., Murphy, J., Shevlin, M., Vallières, F., McElroy, E., Elklit, A., … Cloitre, M. (2017). Variation in post-traumatic response: The role of trauma type in predicting ICD-11 PTSD and C-PTSD symptoms. *Social Psychiatry and Psychiatric Epidemiology*, *52*(6), 727–736. doi:10.1007/s00127-017-1350-8

Imel, Z. E., Laska, K., Jakupcak, M., & Simpson, T. L. (2013). Meta-analysis of dropout in treatments for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *81*(3), 394. doi:10.1037/a0031474

Irwin, H. J. (1999). Pathological and nonpathological dissociation: The relevance of childhood trauma. *The Journal of Psychology*, *133*(2), 157–164. doi:10.1080/00223989909599730

Karatzias, T., Cloitre, M., Maercker, A., Kazlauskas, E., Shevlin, M., Hyland, P., … Brewin, C. R. (2017). PTSD and Complex PTSD: ICD-11 updates on concept and measurement in the UK, USA, Germany and Lithuania. *European Journal of Psychotraumatology*, *8*(sup7), 1418103. doi:10.1080/20008198.2017.1418103

Karatzias, T., Shevlin, M., Hyland, P., Brewin, C. R., Cloitre, M., Bradley, A., … Roberts, N. P. (2018). The role of negative cognitions, emotion regulation strategies, and attachment style in complex post-traumatic stress disorder: Implications for new and existing therapies. *British Journal of Clinical Psychology*, *57*(2), 177–185. doi:10.1111/bjc.12172

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress*, *26*(5), 537–547. doi:10.1002/jts.21848

Kirsch, I., & Lynn, S. J. (1998). Dissociation theories of hypnosis. *Psychological Bulletin*, *123*(1), 100. doi:10.1037/0033-2909.123.1.100

Kluft, R. P. (1989). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis*, *32*(2), 90–98. doi:10.1080/00029157.1989.10402806

Kumar, S. A., Brand, B. L., & Courtois, C. A. (2019). The need for trauma training: Clinicians' reactions to training on complex trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*. doi:10.1037/tra0000515

Linehan, M. M., Miller, M. L., & Addis, M. E. (1989). Dialectical behavior therapy for borderline personality disorder: Practical guidelines. *Innovations in Clinical Practice: A Source Book*, *8*, 43–54.

Lynn, S. J., & Cardeña, E. (2007). Hypnosis and the treatment of posttraumatic conditions: An evidence-based approach. *Intl. Journal of Clinical and Experimental Hypnosis*, *55*(2), 167–188. doi:10.1080/00207140601177905

McLeod, H. J., Byrne, M. K., & Aitken, R. (2004). Automatism and dissociation: Disturbances of consciousness and volition from a psychological perspective. *International Journal of Law and Psychiatry*, *27*(5), 471–487. doi:10.1016/j.ijlp.2004.06.007

Milburn, M. C. (2011). Cognitive-behavior therapy and change: Unconditional self acceptance and hypnosis in CBT. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, *29*(3), 177–191. doi:10.1007/s10942-010-0121-1

Nadon, R., Hoyt, I. P., Register, P. A., & Kihlstrom, J. F. (1991). Absorption and hypnotizability: Context effects reexamined. *Journal of Personality and Social Psychology*, *60*(1), 144. doi:10.1037/0022-3514.60.1.144

O'Connell, D. S. (1983). Symptom prescription in psychotherapy. *Psychotherapy: Theory, Research & Practice*, *20*(1), 12. doi:10.1037/h0088472

Perkonigg, A., Kessler, R. C., Storz, S., & Wittchen, H. U. (2000). Traumatic events and post-traumatic stress disorder in the community: Prevalence, risk factors and comorbidity. *Acta Psychiatrica Scandinavica*, *101*(1), 46–59. doi:10.1034/j.1600-0447.2000.101001046.x

Powers, A., Cross, D., Fani, N., & Bradley, B. (2015). PTSD, emotion dysregulation, and dissociative symptoms in a highly traumatized sample. *Journal of Psychiatric Research*, *61*, 174–179. doi:10.1016/j.jpsychires.2014.12.011

Powers, A., Fani, N., Carter, S., Cross, D., Cloitre, M., & Bradley, B. (2017). Differential predictors of DSM-5 PTSD and ICD-11 complex PTSD among african american women. *European Journal of Psychotraumatology*, *8*(1), 11. doi:10.1080/20008198.2017.1338914

Putnam, F. W., & Carlson, E. B. (1998). Hypnosis, dissociation, and trauma: Myths, metaphors, and mechanisms. In J. D. Bremner & C. R. Marmar (Eds.), *Trauma, memory, and dissociation; trauma,*

memory, and dissociation (pp. 27–55, Chapter xv, 429 Pages). Arlington, VA: American Psychiatric Association.

Rotaru, T. Ş., & Rusu, A. (2016). A meta-analysis for the efficacy of hypnotherapy in alleviating PTSD symptoms. *International Journal of Clinical and Experimental Hypnosis*, *64*(1), 116–136. doi:10.1080/00207144.2015.1099406

Sapp, M. (2015). *Hypnosis, dissociation, and absorption: Theories, assessments, and treatment*. Springfield, IL: Charles C Thomas Publisher.

Sar, V. (2011). Epidemiology of dissociative disorders: An overview. *Epidemiology Research International, 2011*, *2011*, 1–8. doi:10.1155/2011/404538

Şar, V., Akyüz, G., & Doğan, O. (2007). Prevalence of dissociative disorders among women in the general population. *Psychiatry Research*, *149*(1–3), 169–176. doi:10.1016/j.psychres.2006.01.005

Scott, W. J. (1990). PTSD in DSM-III: A case in the politics of diagnosis and disease. *Social Problems*, *37*(3), 294–310. doi:10.2307/800744

Seligman, R., & Kirmayer, L. J. (2008). Dissociative experience and cultural neuroscience: Narrative, metaphor and mechanism. *Culture, Medicine and Psychiatry*, *32*(1), 31–64. doi:10.1007/s11013-007-9077-8

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York, NY: Guilford Press.

Spiegel, D. (2001). Hypnosis, dissociation and trauma. *International Handbook of Clinical Hypnosis*. In G. D. Burrows, R. O. Stanley, & P. B. Bloom (Eds.), International handbook of clinical hypnosis (143–159), Chichester, UK: John Wiley & Sons, Ltd.

Spiegel, D. (2003). Hypnosis and traumatic dissociation: Therapeutic opportunities. *Journal of Trauma & Dissociation*, *4*(3), 73–90. doi:10.1300/J229v04n03_05

Spiegel, E. B. (2016). Attachment-focused hypnosis in psychotherapy for complex trauma: Attunement, representation, and mentalization. *International Journal of Clinical and Experimental Hypnosis*, *64*(1), 45–74. doi:10.1080/00207144.2015.1099402

Spitzer, C., Barnow, S., Freyberger, H. J., & Grabe, H. J. (2006). Recent developments in the theory of dissociation. *World Psychiatry*, *5*(2), 82.

Steele, K., & van der Hart, O. (2019). The hypnotherapeutic relationship with traumatized patients: Pierre Janet's contributions to current treatment. In Craparo, G., Ortu, F., & Van der Hart, O. (Eds.), Rediscovering Pierre Janet: Trauma, dissociation, and a new context for psychoanalysis. New York, NY: Routledge. doi:10.4324/9780429201875

Stein, D. J., Koenen, K. C., Friedman, M. J., Hill, E., McLaughlin, K. A., Petukhova, M., … Bunting, B. (2013). Dissociation in posttraumatic stress disorder: Evidence from the world mental health surveys. *Biological Psychiatry*, *73*(4), 302–312. doi:10.1016/j.biopsych.2012.08.022

Van Dijke, A., Hopman, J. A. B., & Ford, J. D. (2018). Affect dysregulation, psychoform dissociation, and adult relational fears mediate the relationship between childhood trauma and complex posttraumatic stress disorder independent of the symptoms of borderline personality disorder. *European Journal of Psychotraumatology*, *9*(1), 13. doi:10.1080/20008198.2017.1400878

Vanhaudenhuyse, A., Ledoux, D., Gosseries, O., Demertzi, A., Laureys, S., & Faymonville, M. E. (2019). Can subjective ratings of absorption, dissociation, and time perception during "neutral hypnosis" predict hypnotizability?: An exploratory study. *International Journal of Clinical and Experimental Hypnosis*, *67*(1), 28–38. doi:10.1080/00207144.2019.1553765

Whalen, J. E., & Nash, M. R. (1996). Hypnosis and dissociation. In L. Michelson and W. Ray (Eds.) Handbook of Dissociation: Theoretical, Empirical, and Clinical Perspectives, New York: Plenum, 191–206. doi:10.1007/978-1-4899-0310-5_9

World Health Organization. (2018). *International classification of diseases for mortality and morbidity statistics* (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en

Zelinka, V., Cojan, Y., & Desseilles, M. (2014). Hypnosis, attachment, and oxytocin: An integrative perspective. *International Journal of Clinical and Experimental Hypnosis*, *62*(1), 29–49. doi:10.1080/00207144.2013.841473