Hypnotherapy for Traumatic Grief: Janetian and Modern Approaches Integrated

Onno van der Hart
Utrecht, Netherlands

Paul Brown
Melbourne, Victoria, Australia

Ronald N. Turco
Portland, Oregon

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Traumatic grief occurs when psychological trauma obstructs mourning. Nosologically, it is related to pathological grief and posttraumatic stress disorder (PTSD). Therapeutic advances from both fields make it clear that the trauma per se must be accessed before mourning can proceed. The gamut of psychotherapies has been employed, but hypnosis appears to be the most specific. Pierre Janet provided a remarkably modern conceptual basis for diagnosis and treatment based on a dissociation model. His approach is combined with contemporary innovations to present a systematic and integrated account of hypnotherapy for traumatic grief.

Hypnosis is widely used in the treatment of pathological grief but is much underreported. It speeds and facilitates mourning and makes possible a personal reorientation to the future (Fromm & Eisen, 1982; Yager, 1988). Hypnosis is specifically indicated in the resolution of traumatic grief. Grief is traumatic when it follows objective and severe subjective trauma and when posttraumatic reactions inhibit mourning.

In recent years, reports of traumatic grief in both children and adults have begun to appear, describing the reactions of survivors of those lost as a result of lethal accidents (Lundin, 1984; Lehman, Wortman, & Williams, 1987); disasters (Raphael, 1986); homicide (Rynearson, 1984; Amick-McMullan, Kilpatrick, Veronen, & Smith, 1989); and battle combat (Spiegel, 1981). Traumatic grief reactions do not occur only when the event is witnessed directly. Death of loved ones can also be seen on television, read in news reports, reconstructed in fantasy from court proceedings, or even *experienced in* cells adjacent to torture chambers (0. Brozky, personal communication).

As yet, there have been few reports on treatment of traumatic grief. Singh and Raphael (1981) describe marked neglect of psychological trauma in bereavement counseling. The earliest reports of successful use of hypnosis for traumatic grief were from the early and middle nineteenth century (Bakker, Wolthers, & Hendriksz, 1814; Hoek, 1868). At the end of the nineteenth and beginning of the current century Pierre Janet systematized the hypnotic treatment of posttraumatic stress disorder (PTSD), including traumatic grief (Janet, 1889, 1898a, 1898b, 1904, 1911, 1919/25). Recently, the hypnotic treatment of traumatic grief has been taken up again, especially within the context of advances in hypnotherapy of PTSD. However, further development has been hampered by the absence of an adequate conceptual basis for diagnosis and treatment.

Pathological Grief and PTSD

Traumatic grief straddles two diagnostic fields: pathological grief and PTSD. Neither one describes the symptomatology completely, and because neglect to accommodate both aspects may lead to therapeutic failure, the clinical focus must include both (cf. Amick et al., 1989; Burgess, 1974; Eth & Pynoos, 1985; Furman, 1974; Lehman et al., 1987; Lindy, Green, Grace, & Tichener, 1983).

According to Horowitz, Wilner, Marmar, and Krupnick (1980), pathological grief involves intensification of mourning without progression to completion. Parkes and Weiss (1983) subdivided pathological grief into three distinct syndromes: chronic grief occurring from the onset in dependent relationships, ambivalent grief where relationships are conflicted, and unexpected grief. Parkes (1985) recognized that sudden and untimely grief was also often horrifying, painful, and mismanaged. 1n fact, the symptoms of traumatic loss center on recurrent terrifying images of the victim's death (Eth &

Pynoos, 1985; Rivers, 1918; Rynearson, 1981, 1987). These "traumatic memories" intrude into waking life as flashbacks and disturb sleep with nightmares. They are accompanied by fears of death and dying and by feelings of helplessness and shame (Lindy et al., 1983). Survivors generally avoid reminders of the loss and of death in general (Terr, 1984). They become withdrawn, hypervigilant, and given to startle reactions. Survivors of the victims of homicide also report feelings of rage and vengefulness (Amick-McMullan et al., 1989; Rynearson, 1984).

These posttraumatic reactions, which can be subsumed under the diagnostic category of PTSD (American Psychiatric Association, 1987), prevent grief work; they mask, inhibit, and delay the mourning process (Burgess, 1974; Eth & Pynoos, 1985; Furman, 1974; Rivers, 1918; Rynearson, 1986; Wolfenstein, 1969).

Thus, traumatic grief is not only a subset of pathological grief but also of PTSD and exhibits the same biphasic symptom-swings from symptoms of arousal, intrusive traumatic imagery, and anxiety to defensive numbing and avoidance (cf. Horowitz, 1986; Brom, Kleber, & Defares, 1989). As with PTSD, there are many *formes frustes* (cf. Brown & Fromm, 1986). Not all cases of traumatic grief overtly present with posttraumatic symptomatology. Survivors are frequently silent about their traumatic loss. In some this is a conscious suppression, but in others it reflects psychogenic amnesia. Diagnosis is further complicated by disorders which overlap, mimic, or mask the posttraumatic grief response. Cases sometimes present with antisocial behavior and substance abuse, as has particularly been noted in Vietnam veterans (Jellinek & Williams, 1987). Traumatic imagery presenting in the form of pseudo-hallucinations may even be managed as functional psychoses. Kardiner and Spiegel (1947) recognized that the adaptive failure in posttraumatic states, including traumatic grief, can actually give rise to the symptom picture of any known mental illness.

It was Pierre Janet who first presented many cases of traumatic grief and emphasized its dissociative nature (Janet, 1889, 1898, 1904, 1911). Janet observed that many persons exposed to the sudden or violent death of a loved one were completely unable to adjust to it. Instead, they were overwhelmed by vehement emotions, which exerted a disintegrative effect on the mind. The traumatic experience became dissociated from ordinary consciousness and continued as "traumatic memories," described by Janet as subconscious fixed ideas (cf. van der Hart & Friedman, 1989). Ordinary consciousness became restricted, and affect and interest also became restricted. Traumatic memories, evoked by associations and reminders, manifested as vivid and terrifying flashbacks, nightmares, and behavioral reenactments in the form of "somnambulistic crises." The vehement emotions which accompanied these traumatic manifestations, and the related sleeping disorders in many of these patients, caused fatigue and emotional exhaustion (cf. van der Kolk, Brown, & van der Hart, 1989). Thus the capacity to assimilate the traumatic memories was further reduced; patients became even less able to transform their traumatic imagery into narrative memory and to perform their grief work, that is, to accomplish the necessary adaptation to the loss of their beloved one (cf. van der Hart, 1988a).

Hypnotic Approaches to Traumatic Grief

Hypnosis played a key role in Janet's treatment of traumatic grief and related posttraumatic syndromes (Janet, 1889, 1898a & b, 1904, 1911, 1919/25). His view of the relationship between hypnosis and posttraumatic stress is remarkably similar to modern thinking as exemplified by Kingsbury (1988): ". . . hypnosis may be an isomorphic intervention for PTSD because both involve related dissociative shifts in the state of consciousness" (p. 84). Hypnosis was incorporated into a three-stage treatment model (van der Hart, Brown, & van der Kolk, 1989). Initially hypnosis was employed to induce relaxation, relieve life-threatening symptoms such as anorexia, mobilize energy, and focus attention on the therapeutic task. In stage two, it was required to access and modify dissociated mental states. Janet called this process "liquidation" and employed three hypnotic approaches: uncovering, neutralization, and substitution. The former was often incorporated in the latter two. Neutralization consisted of progressive uncovering and dissolution of traumatic memories. It enabled the patient to move from experiential (symptomatic) recall to neutral, verbal recollection. Substitution was a method of therapeutic revision in which traumatic memories were substituted by positive or emotionally inert images. Liquidation of traumatic memories enabled mourning to proceed, often with the aid of hypnosis in stage three. In general, this stage consisted of prevention of the tendency to dissociate and relapse, consolidation of therapeutic gains, and rehabilitation.

Uncovering and liquidation of traumatic memories also form the basis of modern hypnotherapy for traumatic grief. Methods are drawn from contemporary treatment approaches to PTSD. They are usually not grounded in theoretical models of psychological dissociation. We have tried to restore this conceptual basis, and below we attempt to systematically describe the hypnotic techniques of both Janet and modern authors.

Hypnotic Approach 1: Uncovering Traumatic Memories in Traumatic Grief

Patients with complicated traumatic grief are amnestic for the traumatic memories of the death of their loved ones. Instead, traumatic imagery emerges in dissociative symptomatology or is disguised and replaced by conversion symptoms, antisocial behavior, or psychotic phenomena. Traumatic memories can be uncovered by a variety of direct and indirect methods. Janet employed hypnosis, automatic writing, and guided fantasy. Janet's case of Zy (Janet, 1898a) is complemented by a

contemporary example of hypnotic uncovering from Turco (1981).

Case 1. At the age of 39, the female patient Zy was admitted to the Salpêtrière with a 2-year history of insomnia. She had lost her son 3 years earlier. Her mourning process, which was originally within the normal range, was interrupted after 3 months by a prolonged typhoid fever. She became obsessed with her son's demise and developed visual hallucinations of his traumatic death and burial. These symptoms disappeared 2 months later and were replaced by insomnia and psychogenic amnesia. Janet first induced hypnotic sleep and then uncovered the dissociated traumatic memories in the form of hypnotic dreams. Subsequently he modified these dreams and made them disappear altogether.

Case 2. Turco reported a case of pathological grief which presented following a sequence of serious road traffic accidents. The patient's daughter had been a motor fatality victim 2 years earlier. Using hypnotic age regression Turco uncovered traumatic factors which blocked mourning of her daughter and also factors impeding mourning of her father many years earlier.

Hypnotic Approach 2: The Neutralization Technique

In this approach Janet used hypnosis to elicit experiential recall and then facilitate more "neutral" description of the trauma in words, i.e., without the vehement emotions which accompany reexperiencing of unassimilated traumatic memories. He achieved neutralization first under hypnosis and later in the waking state. Assimilation of the traumatic memories subsequently enabled mourning to proceed. Janet's complex hypnotic treatment of Irène took over 2 years to complete (Janet, 1904/11). Follow-up was for a further 14 years. MacHovec's current example demonstrates how hypnosis can enable more rapid and spontaneous neutralization (MacHovec, 1985). It is an important case, because it is one of the few that draw attention to the need to deal with trauma before mourning can proceed.

Case 3. Irène, a girl of 20, had been a timid, sickly, and dependent child. She nursed her tubercular mother through 60 consecutive sleepless nights. When her mother died, Irène dragged her body back onto the bed. Irène wandered in a fugue state and subsequently showed no awareness of the death and burial. She alternated between somnambulistic crises in which she reenacted her mother's demise and her states of indifference. Irène twice attempted suicide and was hospitalized in the Salpêtrière. Janet first uncovered Irène's dissociated traumatic memories and facilitated reexperiencing within the therapeutic arena. As their emotional tone diminished, Irène was eventually able to reconstruct a verbal memory of her mother's death without suffering dissociative symptoms. Irène proceeded with her mourning, set her life in order, and became independent.

Case 4. MacHovec's patient, a 42-year old divorcee, celebrated her forthcoming wedding with her new fiancé at a gourmet restaurant. They both immediately became ill with food poisoning, from which the man died. She survived but experienced posttraumatic anxieties, anorexia, and insomnia. Medication gave a troubled sleep from which she awoke in terror. She denied her fiancé's death and was offered hypnotherapy. Prolonged induction and suggestion for relaxation facilitated spontaneous recall of the entire restaurant episode. Once the dissociated traumatic memories had been elicited and put into words, the patient was able to start grieving. Five more hypnotic sessions were required, and at one-year follow-up the positive outcome was maintained.

Hypnotic Approach 3: Therapeutic Revision

Janet based his hypnotic revision on his substitution technique. It was addressed to severely disturbed patients who were unable to neutralize their traumatic memories and transform them into a personal narrative. Instead Janet assisted them in substituting alternative emotional, inert, or even positive imagery. In the case of Cam, Janet hypnotically substituted positive images for scenes of death (Raymond & Janet, 1898). Spiegel (1981) reported the case of a Vietnam veteran in which positive imagery was combined with traumatic memories rather than substituted for them. The content of the trauma remained unchanged but its impact was lessened so that mourning could proceed.

Case 5 Cam lost her two infants and mother in close succession. She was in constant despair and suffered gastrointestinal cramps and vomiting. Cam was admitted to the Salpêtrière, emaciated, preoccupied with reminders of her children, and regularly hallucinating realistic scenes of their deaths. Janet initiated treatment by having her give up the reminders for safekeeping. Using hypnotic suggestion, he substituted her traumatic death images with those of flowers. Then he made them fade away altogether. Subsequently Janet focused Cam's attention on the future and in particular on her training in midwifery. At one-year follow-up she was working again and considered to be cured.

Case 6. Spiegel's patient, G.R., was a career officer whose psychiatric history of psychopathy, psychosis, and depression commenced after a 3-year tour of duty in Vietnam (Spiegel, 1981). There he witnessed a rocket attack on an orphanage in which his adopted son was burnt to death. Spiegel had the patient hypnotically regress to the time of death and burial. Traumatic images were combined with happy memories of the child's birthday party. He instructed the patient in selfhypnosis so that he could visualize a mental split-screen image of the grave alongside memories of a birthday cake. He was also instructed to relinquish the experience if it became too painful. The patient was able to remember without retraumatization and was discharged from treatment.

Modern hypnotic revision goes beyond substitution or addition of neutral or positive images. Therapists explore and revise a broad range of traumatic factors impeding grief. Thus, failure to assimilate traumatic memories is frequently associated with the haunting idea that something more could have been done. It is often retrospective and loaded with feelings of guilt. The tendency to act may have arisen during the traumatic episode itself, when its implementation was impossible to achieve. This tendency was dissociated and persisted at a subconscious level beyond the subject's control. In the following two contemporary cases, hypnotic revision was used to have the patients perform the desired action in imagination. It facilitated assimilation of the psychological trauma and enabled grieving of the loss to occur.

Case 7. Scott Jennings (1979) described a woman who lost her 18-yearold daughter in a jeep accident 3 years earlier. She had been forbidden by a nurse to hold her dead daughter in her arms. The patient suffered severe arm pains, nightmares, and guilt feelings. Hypnotic age regression to the scene of the trauma allowed her to bug her deceased daughter in fantasy. The patient experienced immediate relief, laying the way open to completion of the grief.

Case 8. Lamb (1982) reported a case in which posttraumatic grief followed courtroom revelations concerning the murder of the patient's niece. He was obsessed with the question of whether he could have prevented the death. Hypnosis facilitated exploration of this issue and expression of unspoken positive feelings towards the deceased.

Mourning can he impeded by subconscious fixed ideas or traumatic memories in which promises or disturbing thoughts towards the deceased predominate. These occult, pathogenic ideas provoke a range of neurotic and psychotic posttraumatic reactions. Hypnosis provides an opportunity for their revision and for sympto-matic resolution (cf. Mutter, 1986). Sexton and Maddock (1979) reported a case of traumatic grief in which pathogenic promises were corrected.

Case 9. The patient was a 52-year-old woman who presented catatonic after a suicide attempt. There was no obvious precipitant or past history of mental illness. Hypnosis uncovered the unexpected and traumatic losses of her brother (when she was 12), father (at 16), and mother (at 24). When hypnotically regressed to -age 16, she remembered promising beside her father's coffin, "I will be with you sometime." A combination of deep hypnotic relaxation and concentration enabled her to "reunite" with her loving father in heaven and return to her husband on earth who also loved her. She recovered completely, experiencing no further death wish. Grief may be hindered by recurring dreams and fantasies whose symbolic content reflects a traumatic loss. Hypnosis can be aimed to revise their traumatic contents and allow them to grieve.

Case 10. Van der Hart (1988a) described the case of a 32-year-old woman in which traumatic imagery was revised when the patient returned for hypnosis a second time. Initially, treatment had focused on the patient's fears and traumatic memories of her violent father. Following his sudden and unexpected death she returned for resolution of pathological grief. This time she was able to overcome the threatening images of her father and bury him symbolically in fantasy. At 6 months the patient had made a good recovery.

Conclusions

Janet and a number of contemporary authors recognized that the experience of psychological trauma may complicate and inhibit mourning and must first be resolved before grief can be completed. Using a model of dissociation, Janet showed how traumatic memories remain unassimilated and prevent grief work. Based on this dissociation model, he developed hypnotic techniques for retrieving, neutralizing, and revising them. Modern approaches are akin to these. Neutralization involves decatlhexis of traumatic memories, in which vivid traumatic imagery is transformed into neutral, personal narrative. Resulting verbal recall both stimulates and reflects acceptance of the loss and adaptation to life without the deceased. MacHovec's patient (case 4) achieved this rapidly and spontaneously, but Janet's case of Irene (case 3) was much more arduous. However, for severely traumatized and complex cases and in states of chronic emotional exhaustion, neutralization often proves impossible. Here, Janet recommended substitution with neutral or positive images (case 1, 5), and Spiegel used linkage of traumatic memories with positive imagery (case 6). Janet's substitution technique is complementary with modern approaches of hypnotic revision, which encourage patients to develop and pursue their own modifications. Scott Jennings reported hugging the deceased in hypnotic fantasy (case 7), Sexton and Maddock correcting pathogenic promises (case 9), and van der Hart completing fantasies related to traumatic grief (case 10).

Almost all reports of hypnotherapy with traumatic grief also mentioned working with the loss itself. In various forms the patients took symbolic leave from the deceased, for example, by saying an imaginary goodbye, covering the dead body, and burying the body with mementos alongside it. Mourning also involves a total personal reorientation towards the future. Janet, for instance, realized this when he focused Cam's attention on her training in midwifery (case 5).

Hypnosis can also complement other treatment techniques which are part of more global strategies of mourning therapy. This is especially the case in dealing with material reminders of the deceased. Both Janet (cf. case 5) and modern clinicians have recognized the pathogenicity of fostering these so-called "linking objects" (Volkan, 1981) or "key symbols" (van der Hart, 1983, 1988b). The therapist may keep them for the duration of the therapy or the patient may "depart" from them in a therapeutic leave-taking ritual.

Trauma complicating grief has thus been recognized and treated specifically with hypnosis for nearly 200 years. Janet based his diagnosis and treatment on a dissociation model which integrates well with modern treatment approaches. All of these methods aim to assimilate traumatic memories, reduce traumatic effects, and enable mourning to proceed.

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