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GETTING STARTED: PREPARING THE PATIENT FOR HYPNOTHERAPY

When two strangers meet to discuss the possibility of their making a difficult journey together into unknown lands, it is important that they make a clear agreement about how the tasks of the journey will be shared, being sure that compass and map are readily at hand. Thus, the initial phase of treatment involves the preparation of both therapist and patient for an agreed-upon experience that will include various uses of formal and informal hypnotic states.

There are three main goals in this initial stage of hypnotherapeutic treatment:

1. *To assess the appropriateness of hypnosis* and other modalities of treatment and determine the types of hypnotic approaches that will be most effective.
2. *To build the therapeutic alliance and the hypnotic relationship*. During this beginning stage of therapy, the therapist works to build rapport and a positive working alliance and explores the various possibilities of hypnotic treatment with the patient. We inform our patients that hypnosis is a valuable tool that can amplify and deepen psychotherapy and will only be used within that context. Direct hypnotic approaches are deferred with patients who are fearful of them; the therapist may elect to use indirect approaches with subsequent re-evaluation of readiness for formal trance experiences.
3. *To create a viable treatment plan*. This may include a contract for

change, agreements about such issues as frequency of appointments and fees, and clarification of therapist policies about emergencies.

Efforts toward these three goals are made simultaneously. They will be presented in this chapter as separate but interconnected processes.

Assessment

The therapist begins to determine whether formal hypnosis is an appropriate therapeutic modality for a given individual during the first interviews and even during preliminary telephone screening. Caution must be exercised with patients who exhibit active suicidal symptoms, psychotic conditions, impairment with alcohol and other drugs, borderline personality disorder, and other conditions that present with extreme dependency and emotional liability (Crasilneck & Hall, 1975; Wester, 1984). Though many such patients can benefit from the use of direct and indirect hypnosis, the therapist must decide how hypnosis can best be introduced in these cases.

An important contraindication for using hypnosis exists when the patient is currently involved in, or plans to be involved in, legal proceedings related to difficulties for which he seeks therapy. The patient must be informed that in many states memory material obtained or explored with the use of hypnosis is inadmissible in courts of law. Using hypnosis in such situations may contaminate even unrelated information, including memories held before the initiation of therapy or hypnosis, so that the patient's testimony becomes disallowed. To avoid these damaging consequences, we recommend the use of an informed consent form, which includes this information as well as other data related to the therapist's policies, provisions for privacy and confidentiality, fee structure, and other pertinent details related to the conduct of psychotherapy. Written consent indicating understanding of the above should follow extensive discussion of the issues involved as they relate to each individual patient.

If presenting symptoms are seen to impair the individual's full involvement in establishing a positive hypnotherapeutic context, the therapist may decide to postpone formal hypnosis until daily functioning is more stable and a solid therapeutic alliance has been established. Brenda, a 36-year-old patient who had a compulsive overeating problem, was referred to me (MP) for hypnotherapy to help control her weight and manage her eating difficulties. In taking a careful history, I discovered that I was the tenth therapist she had seen in a period of five years, that she was depressed and had intermittent suicidal feelings, that she had few memories of her childhood before the age of 10, and that she used marijuana and alcohol to medicate panic attacks

and other anxiety symptoms, including episodes of depersonalization and derealization. In addition, she reported severe financial problems with her freelance computer business, which was on the verge of folding. I told Brenda that our contract would consist of several parts, with our first efforts focused on helping her stabilize her daily life, with special attention to suicidal feelings and thoughts. This might include evaluation for medication. When she was stable, we would evaluate together whether and when to begin the use of hypnosis for her eating disorder and other symptoms.

Two real dangers are the use of hypnosis by an inadequately trained hypnotherapist and its use for inappropriate purposes (Carich, 1986; Rosen & Bartemeier, 1961). Risks in the first category are posed by hypnotists who do not have adequate training in psychodynamics and therefore do not anticipate or work effectively with the powerful reactions that subjects may have to the hypnotherapist (Kleinhauz & Beran, 1981) or to powerful hypnotic techniques such as regression (Carich, 1986; Hammond, 1990b).

One important inappropriate use of hypnosis is its employment to determine whether or not a particular traumatic event, such as physical or sexual abuse, actually occurred. Hypnosis is *not* a lie detector test or a truth serum. We *do not* accept such referrals and suggest that our readers avoid such unethical situations. Other improper uses of hypnosis include inappropriate suggestions and the creation of excessive dependency. Inappropriate suggestions might include focus on pain relief without proper evaluation of the psychophysiological condition; such an approach risks reliving superficial symptoms without regard for underlying organicity. An example might be suggestions to relieve back pain that result in increased activity and further damage to undiagnosed disc problems. Hypnotherapists who imply that their role is one of "expert" risk making their subjects dependent on hypnotic interventions rather than on mutual, cooperative experience.

Assessment Interview

The hypnotherapist will want to interview the patient in terms of presenting symptoms and difficulties, family background, health and medical history, employment and educational situation, current lifestyle and personal interests, and previous experiences and beliefs about therapy and hypnosis. Several other factors (Crasilneck & Hall, 1975; Wester, 1984) may need to be considered and evaluated during the interview process:

- Why is this individual seeking therapy at this time?
- Who referred the patient? How did the patient decide on treatment?

- What are the motivations for this individual to seek help for current symptoms?
- Are current symptoms/difficulties being used to get needs met by others?

Hypnotic Communication Style

During the assessment interview process, the hypnotherapist may want to use a slightly different style of communication oriented to eliciting unconscious responses. For example, in talking with a 37-year-old woman with the post-traumatic symptoms of disorientation and inability to concentrate, which she believed were related to early childhood sexual abuse, I (MP) suggested: "Just go back in your mind to a recent time when you felt unable to concentrate. That's right; just explore that for a moment. What else comes to mind now about that? Does this remind you of similar experiences? What are they?" In another assessment interview, I (CF) suggested to a 15-year-old boy whose severe memory problems had begun at age four, "Just close your eyes for a moment, if that's okay with you, and go back to the time before you were in kindergarten, when memory was no problem, to see if you can recall what things were like for you then." This simple age regression provided a basic assessment of hypnotic responsiveness, while introducing him informally to an ego-strengthening hypnotic experience of "good memory."

These types of inner explorations, which can occur even in the first interview, set the stage for more extensive inner-directed work throughout the course of therapy. For the dissociative patient, this approach introduces the importance of accessing information outside of consciousness in a naturalistic and comfortable way.

If the patient is uncomfortable with this type of approach, quickly moves into a more regressed state with disoriented responses, or loses contact with the therapy situation, the therapist has received important diagnostic information. The therapist may hypothesize that the individual has a lack of internal boundaries for containment, so that hypnotherapy will need to proceed cautiously, and only after careful preparation.

For example, during an assessment interview, Mary, a 23-year-old woman who believed that she had been sexually abused by her grandfather, began to dissociate dramatically while attempting to respond to inner-directed questions about her difficulties. Her breathing intensified, her legs began to shake violently, and she began to lose contact. I (MP) immediately began to describe my observations of Mary's reactions and helped Mary to reorient again to the outside room, the feeling of her body in the chair, and the sound of my voice, which she was able to do with a great deal of effort.

As soon as the patient is reoriented to current time and place, it is important to discuss the implications of temporary loss of here-and-now focus. Usually the individual has experienced this kind of dissociated state in other situations. In Mary's case, she recalled similar reactions while attending seminars or watching TV programs on child abuse, when awaking from nightmares, or when listening to others describe abuse experiences. Noting the intensity of her responses, Mary and I agreed on a therapy plan that emphasized externally focused changes, such as strengthening her coping skills at work and in her communication with significant others, before reassessing her readiness for hypnotic work.

In another instance, I (CF) discovered during the first few interviews that the patient greatly feared hypnosis and wanted nothing to do with it. I responded, "That's fine. I would not want you to do something you objected to that strongly. Who knows, maybe someday we'll find out more about what it is exactly about hypnosis that is so frightening for you."

When individuals are generally uncomfortable with a more "hypnotic" approach to interviewing (e.g., "Why are you asking me these kinds of questions?" "This doesn't make sense"), their reactions must also be explored and the information utilized in treatment planning.

Assessment of Beliefs about Hypnosis

Another important aspect of the assessment process is the examination of the potential hypnotic subject's beliefs and misconceptions about hypnosis. Any previous experiences with formal hypnosis, whether with an individual practitioner, in a group setting, or with autohypnosis training, should be thoroughly explored. Several myths should also be examined at this time, whether or not the individual expresses specific concerns about them. They include the beliefs that hypnosis is the same as sleep (Wester, 1984), that the hypnotherapist has complete control over the subject (Gilligan, 1987), that hypnosis is an unusual and abnormal experience and therefore may be harmful to subjects (Udolf, 1981), that the patient may begin talking spontaneously and divulge information against his will (Wester, 1984), and that the subject will lose all conscious awareness of surroundings and have no memory of the hypnotic experience (Kroger, 1977).

These issues are especially important to explore with dissociative patients, since many of them have intense fears of going to sleep, because of the disturbing nightmares that occur, or about placing themselves in any situation where their conscious decision-making processes and vigilant defenses may be overcome. These patients need to be told directly that hypnosis is quite different from sleep, with more ego involvement and control over the pro-

cess, and that hypnotic states are more like different forms of communication within the self and with the therapist than like sleep. We further differentiate hypnosis from sleep by pointing out that eye closure is not essential (Mann, 1986). It is important to emphasize that the subject and the hypnotherapist are in a cooperative endeavor and that control of the trance state is in the hands of the subject, who may accept, reject, or modify any suggestions from the therapist.

We also explain that hypnosis is simply a focused use of naturally occurring states of relaxation and inner attention and that the individual always has a choice about whether and when to talk with the therapist during hypnotic sessions. The therapist can point out that it is common for individuals to have some amount of dissociation during formal hypnosis and that some also experience complete or partial amnesia for hypnotic experiences. If a given patient wants to stay consciously aware of the hypnotic process, however, he should be reassured that this need will be addressed and worked with until comfort is achieved.

Spiegel (1986, 1993) has suggested that the experience of involuntariness may be the common denominator among hypnosis, dissociation, and trauma. He and others (Kluft, 1985a; Putnam, 1985) have pointed out that the kinds of traumatic events that mobilize dissociation as a defense seem to be those in which the individual's voluntary will is physically overridden. Thus, the natural involuntary responses of hypnosis may be viewed by dissociative patients as a repetition of a traumatic experience, where involuntariness was imposed upon them. This is why it is so important for the hypnotherapist to emphasize the patient's control during initial experiences with hypnosis.

Cooperative Approach during Interviewing

We endorse a cooperative approach to hypnosis (Gilligan, 1987), rather than an authoritarian one. This means that in addition to *obtaining* information from the patient during the assessment interview, the hypnotherapist must be open to *sharing* important information. For example, the therapist can discuss various aspects of the hypnotherapeutic process, including what the patient can expect from sessions and in between sessions, his own particular beliefs about the value of hypnosis, and the therapist's training background and professional orientation to the field of hypnosis.

This step is particularly important for dissociative patients, who are often reassured by explicit information about the therapist's beliefs about pacing and control of hypnotherapy. What we often tell patients is, "Your responses to hypnosis will help us to create an approach that is safe for you. All we have to do is to pay careful attention to what your conscious and unconscious reactions tell us." We reassure them that they will have input into decisions

made at every step of treatment, but also that we fully expect that they will be empowered by the therapy process and experience more effective control over relevant areas of their outside lives. If this is not happening, we explain that the direction of therapy will be adjusted immediately.

Evaluating Hypnotic Responsiveness

Another important aspect of assessment is the evaluation of the individual's responses to hypnosis. Experimental hypnotherapists have developed a number of assessment instruments, including the Hypnotic Induction Profile developed by Herbert Spiegel (1972), the Stanford Hypnotic Susceptibility Scale (Weitzenhoffer & Hilgard, 1959), and the Barber Suggestibility Scale (Barber & Wilson, 1978/79). Uses of standardized scales of hypnotizability may provide information about an individual's likely responses to certain types of hypnotic tasks. In addition, psychological tests, if indicated, can be useful in diagnosing mania, attention deficit disorder, and other psychological and organic conditions that may accompany, mimic, or appear as part of the dissociative patient's clinical profile. As Cohen (1982) points out, however, there is no study indicating that the use of these tests is superior to the clinician's evaluation obtained through more subjective and informal assessment procedures.

Experts agree that not all subjects are equally hypnotizable, since some respond immediately and significantly to direct hypnotic techniques, while others do not respond, even after extensive specialized training. The important clinical issue here is whether an individual who does not respond well to standardized hypnotic assessment may be responsive to more flexible hypnotic approaches used within the interpersonal context of a developing therapeutic alliance. From an Ericksonian perspective (Erickson, 1952; Gilligan, 1987), each individual is considered to have the capacity to respond experientially within the hypnotic relationship; the task of the hypnotherapist, then, becomes one of identifying and creating a context favorable for hypnotic development.

Clinical Assessment of Hypnotic Responsiveness

Many experienced hypnotherapists develop their own approaches to hypnotic assessment, which feature the flexible use of a variety of hypnotic approaches to determine the types of suggestions most likely to elicit positive responses.

We often schedule several sessions for the introduction of hypnosis and include progressive body relaxation, the use of imagery for creation of safety and further relaxation, and suggestions that include opportunities for visual, kinesthetic, and auditory responses. If the patient has already developed use-

ful, positive approaches to inner focusing through previous experiences in hypnosis or meditation, those are carefully utilized and enhanced in order to develop an atmosphere of mastery and self-control. As part of hypnotic assessment, we may also introduce ideomotor signals (Cheek & LeCron, 1968); these enable the patient to indicate when inner experiences are satisfying and to signal readiness to make the transition from one strategy to the next. Such signals can be used throughout treatment as an effective way of communicating nonverbally with the therapist (Putnam, 1989).

Regardless of the types of hypnotic approaches included in this early assessment phase, it is important that the trance state be formally concluded by the therapist before the session ends and that time be reserved for reorientation and processing of the experience. This is important *whenever* hypnosis is used, but is particularly crucial for dissociative patients, since this structure helps them with the process of boundaries and can prevent "hangover" effects (Braun, 1984), which occur when formal trance states become associated or blurred with the patient's own naturally occurring states of anxiety and disorientation.

Cautions in Using Hypnosis with Dissociative Conditions

Even with careful preparation, some dissociative patients tend to respond to the introduction of hypnosis by rapidly dissociating more intensively. In this case, we reorient the individual to current time and place, explain that there are many kinds of "trance" states, and observe that he seems to be entering a trance that will not easily permit interaction and communication with the therapist. We then describe the possibility of a more "interactive" trance that involves staying in greater contact with the therapist and having a greater sense of control over inner experiences. Here the hypnotic principle of fractionation (Haberman, 1990) can be utilized to help the patient learn to move into and out of internally focused states at will, responding to suggestions first with eyes open, and then carefully comparing that experience with responses to similar suggestions with eyes closed. Such an approach promotes mastery and deepening of the hypnotic experience, rather than precipitating decompensation and further internal chaos.

Premature Exploration of Traumatic Material

A common mistake made by many inexperienced hypnotherapists, particularly ones with little formal training in the treatment of dissociative spectrum patients, is to begin exploration of traumatic material in hypnosis before adequate assessment and preparation of the patient have been conducted. This is particularly likely to occur with patients who appear "driven" by anxiety and who are already flooded with memory material and flashbacks when they begin therapy.

There is clear consensus among experts that exploratory work, such as attempting to access traumatic memories or contact alter personalities, should *not* be initiated during this initial phase of treatment (Braun, 1980; Herzog, 1984; Horevitz, 1983; Kluft, 1982, 1994; Putnam, 1989). Therapists who fail to heed this proviso may find themselves in the position of unintentionally retraumatizing their patients and jeopardizing the therapeutic alliance.

The Hypnotherapeutic Relationship

From our point of view, the most powerful hypnotic tool in the treatment of *any* individual is the hypnotherapeutic relationship. Because hypnosis is a *cooperative* experience (Gilligan, 1987; Hammond, 1990a) rather than something done *to* an individual, it is crucial to devote time and effort to developing a positive relationship rather than concentrating solely on developing technical expertise with hypnosis. According to Erickson (1952), "hypnosis should primarily be the outcome of a situation in which interpersonal and intrapersonal relationships are developed constructively to serve the purpose of both the hypnotist and subject" (p. 166).

Although building a good hypnotherapeutic relationship is basically no different from building a therapeutic alliance when any other clinical approach is to be used, there are some additional considerations. These include creation of positive expectancies toward the hypnotic process, attention to certain boundary issues between therapist and client, and focus on important transference and countertransference phenomena which can be intensified and complicated by the use of hypnosis.

Creation of Positive Expectancy

During the preparatory phase of developing the hypnotherapeutic relationship—in fact, throughout treatment—one of the therapist's major tasks is to help patients create an optimal attitude to maximize therapeutic effectiveness, particularly one of expecting that change is possible (Erickson & Rossi, 1980). A key issue with dissociative patients in developing positive expectancy involves establishing an atmosphere of trust and safety (Braun, 1986; Kluft, 1984a; Putnam, 1989; Ross, 1989). With MPD patients and severely dissociated patients, issues of trust and safety must be worked through with each alter or ego state as it appears in the therapy process.

Trust and Safety

Methods for creating trust and safety within the hypnotherapeutic relationship are numerous and include: communication skills that convey warmth, unconditional positive regard, and empathy for the patient's current experi-

ences and beliefs; information and education about hypnosis that corrects misconceptions and addresses fears; reassurance and permission to both keep one's current level of functioning and also to change when ready; reframing, which helps to utilize attitudes and beliefs in positive ways that can be immediately accepted by the patient; and a permissive style that does not attempt to control or manipulate the patient's responses to hypnosis and minimizes resistance (Levitan & Jevne, 1987).

"Yes" set

Many experts in the field of hypnosis (Erickson & Rossi, 1980; Gilligan, 1987; Hammond, 1990a) have also emphasized the importance of creating an attitude of acceptance, or a "yes-set." As Erickson and Rossi (1980) describe it, a yes-set involves the simple association of a "certain and obviously good notion with the suggestion of a desirable possibility" (p. 32). Gilligan (1987) has discussed pacing and leading as one of the main strategies for creating a cooperative frame or yes-set. This involves making statements that acknowledge and accept both external and internal experiences of the subject (i.e., pacing) and linking them to "desirable possibilities" (i.e., leading). For example, in talking with a dissociative patient during the first assessment interview, I (MP) commented: "I don't know and you don't know just how you will respond to hypnosis when we begin that process; you've told me that you are curious about it, and you seem willing to learn more about it (*pacing statements*), but I wonder just how the part of you that is most concerned about your safety and well-being will help you respond to any suggestions that I might give so that you feel very comfortable and deeply relaxed from the very beginning" (*leading statement*).

The therapist's attitude toward the patient has also been cited as an important variable in developing positive expectancy. Hammond (1990a) has addressed the importance of a confident attitude on the part of the hypnotherapist in inspiring confidence in hypnotized individuals through a permissive yet authoritative style, rather than through an authoritarian, controlling, or overly permissive one. Gilligan (1987) has stressed the value of the therapist's integrity in the hypnotic relationship, which involves setting aside various personal biases and needs and creating a context that fully accepts and utilizes, while not necessarily agreeing with, the client's experience.

Boundary Issues

Treatment of dissociative spectrum patients must be based on good general principles of psychotherapy, including carefully defining, protecting, and maintaining the boundaries that form the parameters of the therapy context. Among those parameters are frequency of sessions, length of sessions, fees,

therapeutic tasks, roles of patient and therapist, and the therapeutic contract, which will be discussed in a separate section below. Consistent management of these boundaries is particularly important for dissociative patients, who often suffer from blurred intrapersonal and interpersonal boundaries and the chaos this engenders (Beahrs, 1990).

Therapy Sessions

There is no uniform prescription for the frequency and length of therapy sessions that will best address the needs of dissociative patients (Putnam, 1989). We have found that sometimes even severely ritually abused MPD/DID patients respond well to weekly or even biweekly sessions, while certain less severely dissociated patients seem to require two or three sessions per week. Thus, decisions about length and timing of sessions should not be made on the basis of diagnosis but on optimal patient response. Sometimes fees will determine session frequency. As general policy, we see patients often enough so that therapeutic progress is continuous, yet not so frequently (e.g., more than two or three times per week) that therapy becomes enmeshed and chaotic. Putnam (1989) points out that certain aspects of treatment, such as the "development of trust and metabolism of trauma, have intrinsic rates of their own that cannot be significantly increased by more frequent sessions" (pp. 167–168).

Since treatment of this type of patient may take several years to reach positive resolution (Kluft, 1985b; Putnam, 1989; Ross, 1989), sessions should be paced according to need, with more frequent sessions, only if indicated, during times of crisis or intense uncovering and abreactive work.

Generally, we schedule sessions as 50-minute hours. Although there are some circumstances that require longer sessions, for example, patients who drive from long distances or who work more productively during 75-minute or double sessions, others cannot easily tolerate more than the standard therapy hour. Whatever the arrangement, once made, appointment length and frequency should be consistently maintained (Langs, 1988), since unplanned deviations, including running over the time allotted, can evoke boundary confusion, encourage abuse of the therapist's time schedule, and derail the therapy.

Because MPD and dissociative patients tend to overstay time boundaries (Putnam, 1989), we operate by Kluft's (1990b) "rule of thirds," and train our patients to take responsibility for beginning any hypnotic work during the first 10–15 minutes of the session. This allows time for intensive inner work, including trauma retrieval and abreaction, and for reorientation, processing of the material, and closure.

Failure to insist on adequate time (roughly 5–10 minutes) for restabiliza-

tion after hypnotic experiences can result in post-session dissociation, which can disrupt future therapy experiences (Putnam, 1989). When a patient says near the end of the hour, "Oh, I think a new part wants to talk with you" or expresses the imminent emergence of a new "memory," we say firmly, "Since our time is almost up, I'll be very glad to talk with him or to explore that experience at the next session."

Fees

As with other therapeutic parameters, fees for dissociative patients should be set at the beginning of therapy and consistently maintained. In general, these patients should be treated the same as other patients in the therapist's practice. Unfortunately, with many severely impaired patients, the therapist may be tempted to suspend the regular fee structure and agree to a lower fee. We have supervised numerous cases where therapeutic progress was obstructed because the therapy fee was lower than the therapist was comfortable with.

Only in cases of extreme hardship, and with the therapist's full understanding of future implications, should fees be lowered. Otherwise, holding the patient to standards set for other patients may be part of the therapy work. With Stella, a ritually abused MPD patient on SSI income, for example, I (MP) refused to lower her fee during several initial phone requests. After several months Stella was able to mobilize resources to meet this standard, initiated therapy on this basis, and has since made excellent progress. In other cases, the therapist can give out a list of lower-fee referrals or encourage the prospective patient to pursue other community resources, such as programs for victims of violent crimes.

Therapy Tasks and Roles

As we have discussed above, the tasks of the therapist during the initial preparatory phase of hypnotherapy are to establish rapport, assess abilities to be utilized, facilitate therapeutic frames of reference, and create expectancy (Erickson & Rossi, 1980).

Therapy work with dissociative patients always involves a mixture of present-day focus (support, ego-strengthening, and life management) and past-oriented work (access of memories, abreaction, renegotiation, and integration of trauma material) (Calof, 1991). The therapist must be especially responsible in making sure that the patient can manage the demands and stresses of current everyday life before engaging in hypnotherapy aimed at exploring the depths of the past.

Another important task of the therapist at this stage, then, is to educate the patient about the various uses of hypnosis and the necessary pacing of different activities throughout treatment. For example, we often tell dissocia-

tive patients at this stage that if their lives seem unmanageable now, this quality may even intensify during work that is oriented toward reassociating past experiences. Therefore, our role as therapists will be to balance treatment, using hypnosis to help strengthen internal processes to manage the interpersonal field of daily life as well as the intrapersonal field of experiences from early childhood (Calof, 1991).

The Treatment Plan

The creation of a viable treatment plan for a dissociative patient should include:

1. Agreements about the parameters of therapy, including frequency of appointments and length of appointments.
2. Clarification about the therapist's policies for canceled or missed appointments, emergency phone calls and sessions, confidentiality, medication, and hospitalization.
3. A therapy contract with specific goals for change and the maintenance of safety.

Clarifying Therapist Policies

It is quite helpful during the first sessions of therapy to discuss and clarify various policies that help to set the boundaries of therapy. We often tell patients during the first session that we charge for appointments not canceled 24 hours and 48 hours in advance, respectively, for ***any*** reason—no exceptions. The first author explains that she charges for phone calls in between sessions beyond 5–10 minutes, while the second author holds open telephone hours each morning before 9:00 a.m. We state clear expectations that they will develop and make use of a good outside support system so that emergency phone and office visits are rare. Since we also travel frequently, we make it a point to tell dissociative patients of travel plans for the next four-to-six months and ask them what their plans will be to support themselves in our absences.

Additionally, we spell out the provisions of confidentiality, stating explicitly that we will not give or receive information about them to anyone without a written release. Since some dissociative patients are concerned about medication and hospitalization, we also explain that we rarely hospitalize patients, and will only do so if they are at risk of hurting themselves or someone else, or if we come to a mutual decision that the hospital will provide the best form of treatment during a particular stage of therapy. We also state our belief that medications can be quite helpful with dissociative

conditions, particularly if there is a secondary diagnosis indicating this type of intervention, such as severe depression or bipolar disorder, but that the decision to use medication will be made only with careful consideration of patients' concerns and in such a way that every part of them can cooperate.

Therapy Contracts

As in any therapeutic situation, we do not believe that it is possible to provide good hypnotherapeutic treatment without an adequate treatment contract. After assessing the appropriateness of hypnosis as a treatment modality, obtaining relevant historical and current information in the assessment interview, and securing the therapeutic framework by clarifying ground rules, boundaries, and policies, the therapist can begin the process of constructing a contract that will contain the goals of the treatment process. Often, when complex situations present themselves, it is helpful to outline all relevant treatment possibilities, with and without the use of formal hypnosis, and to identify the possible benefits, risks, and side effects of each (Ross, 1989).

For example, after the first two interviews, I (MP) began constructing a treatment plan with Nick, a dissociative disorder patient with a history of severe sexual and physical abuse, limited financial resources, and active suicidal feelings in response to disturbing flashbacks. Identifying suicidal feelings as a priority, I suggested an evaluation for medication, more effective use of Nick's existing support system, and therapy focused on daily coping and maintenance of safety. Nick was told that he could learn to use self-hypnosis and relaxation techniques to help center himself and contain the flashbacks. He was further informed that recovering traumatic memories related to the flashbacks was a long-term project, that the work would likely uncover painful experiences difficult to come to terms with, and that such a process might affect his functioning at work and in his marriage. Based on this information, Nick agreed to a two-part contract consisting of immediate medical, social, and self-hypnotic interventions for his suicidality. Once we agreed that his condition was stabilized, we would evaluate the possibility of focusing on the underlying traumatic experiences that might be contributing to his symptomatology in the second part of the contract.

When individuals present in a crisis state, have a past history of abuse, or are diagnosed on the dissociative continuum, it is often important to assess the incidence and likelihood of self-harm and other acting-out behaviors. Therapist assessment should include underlying motivation for self-injurious behaviors such as cutting or mutilation. If these dangerous behaviors are suicidal, contracts for their control must be not only very specific and concrete but also agreed to by all parts of the personality: "I will not hurt myself

or kill myself or anyone else, external or internal, accidentally or on purpose, at any time" (Braun, 1984, p. 36). If not suicidal, self-injurious behavior may be approached by obtaining further data about motivation and working toward mastery or symptom substitution. Attempting to control or stop self-injury that is not related to suicide may result in ineffective power struggles (Gil, personal communication, 1994).

Contracts can be initiated at any time during the therapy process and put in written form to prevent confusion. Ideally, these agreements should also specify consequences, such as hospitalization or increased frequency in therapy sessions for extreme self-abusive behavior. As Thames (1984) suggests, in addition to providing consistent attention to contract violations, the therapist must also acknowledge and affirm the honoring of contracts.

Language of Cooperation

In making the therapy contract, we adhere to the principle of creating a context of cooperation where "the therapist aligns with client, thereby enabling both parties to become increasingly receptive to each other" (Gilligan, 1987, p. 11). A related concept is that of utilization, which implies that every part of the client's behavior, personality, beliefs, and current situation is potentially a valuable and useful resource in attaining desirable change (Dolan, 1985).

Therefore, we attempt to use the language of cooperation (Phillips, 1993a) when composing the therapy contract. This involves the creation of a mutual "yes-set" (Erickson, Rossi, & Rossi, 1976), in which both therapist and client agree to work together toward desired changes. Thus, the therapist can identify and utilize the patient's own words and frames of reference to facilitate the transformation of seemingly uncooperative reactions into cooperation, "a feeling of being understood, and an attitude of hopeful expectancy of successfully achieving the goals being sought" (Erickson, Rossi, & Rossi, 1976, p. 59). Language patterns useful in creating cooperation and yes-set responses include the use of truisms, implication, therapeutic binds, open-ended suggestions, and suggestions that cover all possibilities (Dolan, 1985; Erickson, Rossi, & Rossi, 1976; Gilligan, 1987).

Goals for Change

We agree with Erickson's conceptualization of therapeutic trance as a means of helping patients learn to use inner potentials to achieve their own therapeutic goals by providing a "special psychological state in which [they] can reassociate and reorganize their inner experience" (Erickson & Rossi, 1980, p. 15).

Some patients, however, need help in formulating goals that are realistically attainable. In certain cases, presenting difficulties are viewed as insurmountable. When this occurs, it is often necessary to change the context or meaning of the presenting problem so that it can be viewed as a possible resource instead of a liability. This model of reframing (Watzlawick, Weakland, & Fisch, 1974) is employed in many different therapy approaches and can often be central to the contracting process in hypnotherapy.

For example, in a goal-setting session with a PTSD patient who complained about intrusive images of self-mutilation, I (MP) pointed out to him that, although I understood his complete distaste for these images and his unwavering desire to eliminate them forever, I could not help but be curious about what these images could teach us about the inner workings of his personality. When he seemed intrigued by what I meant, I further suggested that there must be a part of him that was involved in formulating these images. If he insisted on just finding a way to eliminate them, instead of attempting to locate the "image maker," he might lose an opportunity to learn some ways of cooperating with this part of him to create images that were more to his liking. Since he was interested in discovering ways of generating relaxing, enjoyable imagery, he agreed to change his initial goal to one of self-discovery.

The importance of adequate preparation for hypnotherapy cannot be overemphasized. For most dissociative patients, control is a central issue. The more effective the therapist's efforts at assessing the individual's clinical situation, in establishing a solid hypnotherapeutic relationship, and in creating a practical and comprehensive treatment plan, the more easily the "divided" patient can feel in charge of clear choices in the treatment process. Such an atmosphere of cooperation and teamwork can set the stage for healing the divided self.