Overview:

**Somatoform Disorders**
- Hypochondriasis
- Somatization disorder
- Conversion disorder
- Pain disorder
- Body Dysmorphic disorder

**Dissociative Disorders**
- Depersonalization disorder
- Dissociative amnesia
- Dissociate fugue
- Dissociative trance disorder
- Dissociate identity disorder

**Chapter 6**

- **Somatoform Disorders**
  - Som = Body
  - All these disorders at first seem to be physical disorders, but after closer inspection they have no identifiable medical condition causing the physical symptoms

- **Dissociative Disorders**
  - Detachment, feeling like "this isn't really me" or "that doesn't really look like my hand"
    - Known as dissociative experiences
  - For people whose experiences are so intense and extreme that they lose their identity entirely and assume a new one, or they lose their memory or sense of reality and are unable to function, are then diagnosed with a dissociative disorder

- Both somatoform and dissociative disorders are strongly linked historically
- Both used to be categorized under one category, under the general heading of "hysterical neurosis"
  - Hysteria, back to the Greek philosopher Hippocrates - occur primarily in women with a wondering uterus
  - Freud suggested conversion hysteria - unexplained physical symptoms indicating a conversion of unconscious emotional conflicts into a more acceptable form
  - Neurosis as defined in psychoanalytic theory, suggested a specific cause for certain disorders; neurotic disorders resulted from underlying unconscious conflicts, anxiety that resulted from those conflicts and the implementation of ego defense mechanisms
    - Neurosis was eliminated from the diagnostic system in 1980 because it was too vague

**SOMATOFORM DISORDERS**

**Somatoform Disorders**
- DSM-IV lists 5 basic somatoform disorders
  - i. Hypochondriasis
  - ii. Somatization disorder
  - iii. Conversion disorder
  - iv. Pain disorder
  - In each, individuals are pathologically concerned with the appearance of functioning of their
v. Body dysmorphic disorder

(1) Hypochondriasis

- "hypochondria" in Greek - refers to the region below the ribs, and the organs in this region affected by the mental state
  - Ulcers and abdominal disorders believed to be part of hypochondriac syndrome
  - As a result, such disorders that had physical complaints with no clear cause were labeled "hypochondriasis"
- Sever anxiety is focused on the possibility of having a serious disease
  - Reassurance from physicians is of no help

Clinical Description

- Shares many features with anxiety and mood disorders, particularly panic disorder
- Anxiety and mood disorders are frequently comorbid with hypochondriasis
  - Characterized by anxiety or fear that one has a serious disease
    - Individual is preoccupied with bodily symptoms, misinterpreting them as indicative of illness or disease
    - Individuals with hypochondriasis almost always go see physicians
    - Reassurance from numerous doctors that all is well only has a short term effect
- Individuals that believed they have a disease are diagnosed with hypochondriasis
  - Disease conviction has become the core feature of hypochondriasis
    - Individuals that fear they are developing a disease are classified with illness phobia
- Differences between Panic Disorder and Hypochondriasis
  - Panic Disorder: fear immediate symptom - related catastrophes that may occur during the few minutes they are having a panic attack; most learn that going to the doctors does not help; tends to focus on the specific set of 10 to 15 sympathetic nervous system symptoms associated with panic disorder
  - Hypochondriasis: focus on long term process of illness and disease (cancer of aids); they also continue to seek aid from doctors in the disease process;
- Hypochondriac concerns are common in young children, who frequently complain about abdominal aches and pains that seem to have no physical basis - very few cases turn into full-blown chronic hypochondriacal syndrome

Statistics

- Very little known about its prevalence
- Approximately 3% of medical patients
- Sex ratio: 50/50
- Spread across various phases of adult hood but may emerge at any point in life
  - Peak ages are in adolescence, middle age (40s and 50s) and after age 60

Culturally Specific Examples

- Koro
  - A belief, accompanied by severe anxiety and sometimes panic that the genitals are retracting into the abdomen
  - Typically Chinese males, very few reports in western cultures
    - Guilty feelings, "maybe cause is excess masturbation, unsatisfactory intercourse, or promiscuity"
- Dhat
  - Prevalent in India
  - Anxious concern about losing semen

Causes

- Disorder of cognition or perception with strong emotional contributions
- Individuals experience same physical sensations common to all of us, but they focus their attention on these sensations, increasing arousal and making them seem more intense then what they really are
  - This turns into a vicious cycle
Show enhanced perceptual sensitivity to illness cue
- Tend to interpret ambiguous stimuli as threatening - [Ex: I have a headache...must be a brain tumor]
- Runs in families/possible genetic contribution
- (1) develop in context of a stressful life event (death/illness)
- (2) Disproportionate incidence of disease in their family when they were children
- (3) Operating (social and interpersonal influence - come from a family that had one member who was constantly sick, and learn the "benefits" of being sick - receiving more attention, and taking on a "sick role"
  - Note: Point (3) is also heavily found in somatization disorder

**Treatment**
- Know very little about treatment
- CBT focused on identifying and challenging illness-related misinterpretations (75% improvement)
- Stress management
- Doctors reassurance - take the time out of their schedule to thoroughly explain what the disease/condition is and why they don’t have it...

(2 Somatization Disorder)
- Originally named Briquet's syndrome after French physician Pierre Briquet in 1859
- Case of Linda (pg 174); has been experiencing many problems, lots of visits to the hospital and many different doctors...begins to loose function of her legs (paralysis) and was then admitted to a psychiatric hospital

**Clinical Description**
- Concerned with symptoms but not with the actual disease
  - [hypocondriasis more concerned with the disease and not the symptoms]
- Do not feel urgency to call a physician or go see a doctor, continue to feel weak/ill, and cease exercising thinking it will make things worse
  - [hypocondriasis immediately go to the hospital]
- Symptoms define who they are
- Typically have a "symptom of the week"

**Statistics**
- Require 8 or more symptoms from list of 35
  - Fewer then 8 symptoms then classified as undifferentiated somatoform disorder
- In large city...
  - 4.4% general population
  - 20% patients in primary care
- Tend to be
  - (a) Women (non-culture specific; more women then men in other cultures to)
  - (b) Unmarried
  - (c) Lower socioeconomic groups
  - (d) Chronic
- Frequent suicidal attempts that appear to be more manipulative gestures then true attempts at death

**Causes**
- History of family illness
- Injury during childhood
- Strongly linked in family and genetic studies to antisocial personality disorder (ASPD)
  - ASPD
    - Occurs primarily in males
    - Chronic course
    - Lower socioeconomic class
- (a) Female dominant
- (b) appears early in life
- (c) chronic
- (d) lower socioeconomic class
- (e) associated with
  - Marital discord
  - Drug and alcohol abuse
  - Suicide attempts
- Possibly neurobiological based disinhibition syndrome characterized by impulsive behavior
  - Reflect the impulsive characteristics of short-term gratification; novelty-seeking and provocative sexual behavior

**Treatment**

- Difficult to treat - no proven effective treatments
- Concentrate on providing reassurance, reducing stress and frequency of help-seeking behaviors
- *Gatekeeper Physician* - screen all physical complaints and address future action
- Reducing supportive consequences of relating to significant others on the basis of physical symptoms alone

(3) Conversion Disorder

I. **Intro**
   a. Conversion: Popularized by Freud, believed anxiety resulting from unconscious conflicts somehow was "converted" into physical symptoms to find expression
      i. Allowed individual to discharge some anxiety without actually experiencing it
      ii. Anxiety resulting from unconscious conflicts would be "displaced" onto another object

II. **Clinical Description**
   a. Physical malfunctioning, such as paralysis, blindness, or difficulty speaking (aphonia) without any physical or organic pathology to account for the malfunction
   b. Most suggest neurological disease that affects the sensory-motor systems
   c. May experience total loss of touch, seizures, globus hystericus (sensation of a lump in the throat that makes swallowing impossible or talking)

III. **Closely Related Disorders**
   a. **Malingering** - faking
   b. **Conversion Reactions**
      i. Have the same quality of indifference to the symptoms that is present in somatization disorder
         1) "la belle indifference" considered hallmark of conversion reactions, but is not a foolproof sign
         2) "blasé" attitude toward illness is sometimes displayed
         3) Some become quite distressed
      ii. Precipitated by marked stress
         1) Ford (1985) noted 52-92% of all cases are marked by stress preceding the symptoms
         iii. They seem truly unaware either of this ability or of sensory input
            1) Ex: individuals with conversion symptom of blindness can usually avoid objects in their visual field, but they will tell you they can't see the objects
      iv. Misdiagnosis of conversion disorder that are really physical problems is between 5% and 10%
   v. **Factitious Disorders**
      1) Fall somewhere between malingering and conversion disorders
      2) Symptoms: fall under voluntary control, but there is no obvious reason for voluntarily producing symptoms except, possibly, to assume the sick role and receive increased attention
      3) When an individual deliberately makes someone else sick the condition is called fictitious disorder by proxy or "Munchausen syndrome by proxy"
         a) An atypical form of child abuse
         b) Helpful procedures to assess the possibility of Munchausen syndrome by proxy
include a trial separation of the mother and the child or video surveillance of the child while in the hospital

vi. Catharsis (purging or releasing) - has been proven to be an effective intervention with emotional disorders

IV. Statistics
a. Occur in conjunction with other disorders, particularly somatization disorder
b. Comorbid anxiety and mood disorders are also common
c. Relatively rare in mental health settings
   i. 10–20% patients referred to epilepsy centers have nonepileptic seizures
d. Found primarily in women
e. Occur relatively frequently in males at times of extreme stress
f. Symptoms often disappear after a time, only to return later in the same or similar form when a new stressor occurs
g. 20% attempted suicide in one study
h. In another study, 85% of 40 children had recovered 4 years after initial diagnoses
   i. In other cultures, some conversion disorders are very common aspects of religious or healing rituals; seizures, trances, and paralysis are common to some cultures and religious practices
      i. These symptoms to not meet the criteria for a disorder unless they persist and interfere with an individuals normal functioning

V. Causes
a. Freud describe four basis processes in development of conversion disorder
   i. (1) Traumatic Event (an unacceptable, unconscious conflict)
   ii. (2) Person then represses the conflict, putting it in the unconscious because the conflict brings anxiety to the consciousness and is viewed by it (the conscious) as unacceptable
   iii. (3) Anxiety continues to increase and threatens to emerge into consciousness, and the person converts it into physical symptoms - reliving pressure of having to deal directly with the conflict
      1) This reduction if anxiety is considered a primary gain or reinforcing event that maintains the conversion symptom
   iv. (4) Individual receives greatly increased attention and sympathy from loved ones
      1) This attention or avoidance is the secondary gain, the secondary reinforcing set of events

Primary: conversion to physical symptoms
Secondary: receiving special attention

b. Those experiencing conversion disorder have experienced a traumatic event that must be escaped at all costs
c. Patients typical had substantial stressors:
   i. sexual abuse
   ii. recent parental divorce
   iii. death of a close family member
   iv. physical abuse
d. Tend to occur in less educated, lower socioeconomic groups where knowledge about disease and medical illness is not well developed
   e. Prior experience with real physical problems (perhaps among family), tends to influence the later choice of specific conversion symptoms
      i. Patients tend to adopt symptoms with which they are familiar
   f. Many conversion symptoms seem to be part of a larger constellation of psychopathology
g. Biological contributory factors seem to be less important than the overriding influence of interpersonal factors

VI. Treatment
a. Because conversion disorder has much in common with somatization disorder, many of the treatment principles are similar
b. Principle strategy: identify and attend the traumatic/stressful life event and remove the sources of "secondary gain"
   i. Therapeutic assistance n re-experiencing or "reliving" the event (catharsis) is a responsible
first step

c. Therapist MUST work very hard to reduce any reinforcing/supportive consequences of conversion symptoms (secondary gain)

(4) Pain Disorder

a. Pain Disorder: there may have been a clear physical reason for pain, at least initially, but psychological factors play a major role in maintaining it
b. THREE subtypes of pain disorder run the gamut from pain judged to be due primarily to psychological factors to pain judged to be due primarily to a general medical condition
c. Germany study
   a. 5-12% population meets criteria
   b. Fairly common
d. Pain is real and it hurts, regardless of the causes

(5) Body Dysmorphic Disorder (BDD)

I. Intro
   a. BDD: preoccupation with some imaged defect in appearance by someone who actually looks reasonable normal
      i. Imagined ugliness

II. Clinical Description
   a. 61% focus on skin
   b. 55% on hair
   c. Fixation on mirrors
   d. Suicidal ideation, suicide attempts, and suicide completions are frequent consequences of this disorder
   e. "Ideas of Reference"
      i. Belief that everything that goes on in their world is somehow related to them
   f. Previously known as dysmorphophobia which translated to fear of ugliness
   g. Study in 1993/1996
      i. Half the subjects were absolutely convinced their imagined bodily defect was real and a reasonable source of concern

III. Statistics
   a. Hard to estimate relevance within population
   b. CHRONIC - lifelong course
   c. College Student Study
      i. Suggested as many as 70% report some dissatisfaction with bodies
      ii. With 28% meeting criteria for BDD
   d. Another Study of Adolescence
      i. 2.2% occurrence in group
      ii. Girls more dissatisfied with bodies
      iii. African Americans of both genders were less dissatisfied with their bodies than white, Asians, and Latinos
   e. Higher proportion of individuals with BDD are interested in art or design, perhaps reflecting strong interest in aesthetics or appearance
   f. NOT STRONGLY associated with SEX
      i. In America: slightly more females
      ii. In Japan: more males (62%) then females
   g. The degree of (EXTREME) psychological stress and impairment was generally worse than people who have experienced/are or have
      i. Depression
      ii. Diabetes
      iii. Myocardial infection
   h. Extreme measures can be taken by these people to correct their "defect"
      i. Nine patients who could not afford surgery, or were turned down for other reasons had attempted by their own hand to alter their appearance dramatically
1) One had used a knife to cut her thighs and attempted to squeeze out the fat
   i. The psychopathology lies in their reacting to a deformity that others cannot perceive
j. Examples
   i. Uganda: common to insert large disk/plate in lower lip
   ii. New Guinea: knock out two top front teeth to celebrate adulthood
   iii. Burma: women wear brass neck rings
   iv. China: women feet binding
   1) These people though, who simply conform to the expectations of their culture do not
      have a disorder

IV. Causes and Treatment
   a. Mechanism of displacement - an underlying unconscious conflict would be too anxiety provoking
      to admit into consciousness, so the person displaces it onto a body part
   b. BDD - focus is on physical appearance; Hypochondriasis - focus is on physical sensations
   c. Body dysmorphic disorder typically DOES NOT CO-OCCUR with other SOMATOFORM disorder
      i. It DOES OCCOR with OCD (obsessive compulsive disorder)
      1) BDD and OCD both have approximately same age of onset and run the same course
d. 2 Effective treatments
   i. (1) DRUGS - Clomipramine (anafranil) and fluvoxamine (luvox), fluoxetine (prozac)
   ii. (2) CBT - Cognitive Behavior Therapy; exposure and response prevention as used with OCD
   iii. Both BDD and OCD have similar rates of response to these treatment methods

V. Plastic Surgery and Other Medical Treatments
   a. Dermatology treatment (45.2%) - 11.9% met criteria for BDD
   b. Plastic surgery (23.2%)
      i. Common procedures
         1) Rhinoplasties
         2) Face-lifts
         3) Eyebrow elevations (increased 139%)
         4) Liposuction
         5) Breast augmentation (increased 413%)
         6) Jawline
   c. Severity of the disorder and accompanying distress actually increased after surgery (in case study)

DISSOCIATIVE DISORDERS

- Might happen when you are very tired or under physical or mental pressure
- Study: journalists viewing execution
   ○ 40-60% experienced several dissociative symptoms (environment seemed dreamlike, and they felt
     time that stopped)
- Two types of "dissociation"
   ○ (1) Depersonalization: temporarily lose the sense of your own reality
   ○ (2) Derealization: your sense of the reality of the external world is lost
- FOUR Dissociative Disorders
   ○ (i) Depersonalization disorder
   ○ (ii) Dissociative amnesia
   ○ (iii) Dissociative fugue
   ○ (iv) Dissociative trance disorder
   ○ (v) Dissociative identity disorder

(1) Depersonalization Disorder

- RARE
- May occur during an intense panic attack; 50% of those experiencing feeling of unreality
  ○ But when severe depersonalization and Derealization are the primary problem, the individual
    meets criteria for depersonalization disorder
Mean onset age: 16.1 years
- Chronic (lasting at least 15.7 years)
- 50% suffer from additional mood and anxiety disorders
- **Distinct Cognitive Profile:**
  - defect of attention
  - defect of short-term memory
  - defect of spatial reasoning
- Reports of TUNNEL VISION or MIND EMPTINESS
- Reduction in emotional responding

### (2) Dissociative Amnesia

- Includes several different patterns
  - Unable to remember anything, including who they are, are said to suffer from **generalized amnesia**
    - Generalized amnesia may be lifelong or may extend from a period in the more recent past such as 6 months to a year previously
  - Much more common is **localized or selective amnesia**
    - Failure to recall specific events usually traumatic that occurred during a specific period of time
- In most cases, the forgetting is very selective for traumatic events or memories rather than generalized

### (3) Dissociative Fugue

- Fugue: literally meaning “flight” (fugitive is from the same root)
- Memory loss revolves around a **specific incident** - ex: an unexpected trip or trips
  - Person sometimes assumes a new identity or at least becomes confused about the old identity
- Fugue states seldom appear before adolescence and usually occur in adulthood
  - Once they appear they usually continue well into old age
- Fugue states end abruptly, and the individual returns home recalling most, if not all, of what happened
- Generally tend to happen more in FEMALES (exception: amok)
- Fugue disorder not found in western cultures is called **amok** (running amok) - **running disorder**
  - Tends to be males
  - Trancelike state
  - Brutally assault or kill another person or animal
- Among native people of Arctic, running disorder is termed **pivloktoq**
- Among Navajo tribe is called **frenzy witchcraft**

### (4) Dissociative Trance Disorder

- Most common in women
- Associated with stress or trauma
- Sudden changes in personality are attributed to possession by a spirit important in the particular culture
  - Often this spirit demands favors form family and friends of victim
- Commonly occur in
  - India
  - Nigeria (**called vinvusa**)
  - Thailand (**phiipob**)
  - Asia
  - Africa
- Commonly occur in
  - African American prayer meeting
  - Native American rituals
    - African Americans from south, syndromes referred to as “falling out”
  - Puerto Rican spirits sessions
- Trance and possession are almost never seen in western culture
(5) Dissociative Identity Disorder (DID)

I. Intro
   a. Dissociative identity disorder (DID) may adopt as many as 100 NEW IDENTITIES
   b. Only a few characteristics are distinct, because the identities are only partially independent
   c. Name of the disorder was changed in the DSM IV from 'multiple personality disorder' to DID

II. Clinical Description
   a. Alters: shorthand term for the different identifies or personalities in DID
   b. DSM-IV-TR criteria for DID include amnesia (as in dissociative amnesia and dissociative fugue)
      i. Identity has also fragmented into 3, 4, or even 100 personalities
      ii. Certain aspects of the person's identity are dissociated, this corrects the notion that multiple people somehow live inside one body

III. Characteristics
   a. Person who becomes the patients and asks for treatment is usually a host identity
      i. Host personalities attempt to hold various fragments of identity together but end up getting stressed out/overwhelmed
      ii. The host personality develops later
   b. The first personality to seek treatment is SELDOM the original personality
   c. Cross-gendered alters are not uncommon
   d. Transition from one personality to another is called a switch
      i. Switch is instantaneous
      ii. Physical transformations may occur during switches, such as posture, facial expressions, patterns of facial wrinkling, and even physical disabilities

IV. Can DID be faked?
   a. It is very difficult to answer this question
   b. Evidence indicates individuals with DID are very suggestible
   c. Studies suggest that the symptoms of DID could, for the most part, be accounted for by therapists who inadvertently suggest the existence of alters to suggestible individuals, model known as sociocognitive model - because the possibility of identity fragments and early trauma is socially reinforced by the therapist
   d. DID subjects had 4.5 times the average number of changes in optical functioning (hard to fake) in their alter identities than control subjects who simulated alter personalities
      i. Real DID patients also show changes in
         1) Sweat gland activity
         2) EEG - electroencephalogram brain wave scans
         3) Changes in brain function
         4) Galvanic skin response (GSR)

V. Statistics
   a. Alter personalities is reported by clinicians as close to 15 on average
   b. More common in FEMALES - ration of 9:1
   c. Onset: often as young as 4 years old, but it usually found 7 years after the appearance of symptoms before the disorder is identified
   d. CHRONIC - tends to last lifetime in absence of treatment
   e. DID between 3-6% in U.S
   f. DID approx. 2% in Holland
   g. Large percentage of DID patients have simultaneous psychological disorders that may include
      i. Substance abuse
      ii. Depression
      iii. Somatization disorder
      iv. Borderline personality disorder
      v. Panic attacks
      vi. Eating disorders
         ♦ On average, 7 additional diagnoses were noted on average
   h. Some cases this high rate of comorbidity may reflect the fact that certain disorders (such as borderline personality disorder) share many features with DID as such self-destructive or suicidal behavior and emotional instability
   i. DID simply reflects an intensely sever reaction to what seems to be in almost all cases horrible
childhood abuse
j. DID seems to occur in a variety of cultures throughout the world
   i. As in many as 21 other cultures

VI. Causes
a. Life circumstances that encourage DID development seem quite clear in one aspect: *almost every patient presenting with this disorder reports that he or she was horribly abused as a child*
   i. Putman et al. examined 100 cases and found that 97% of the patients had experienced significant trauma, usually sexual or physical abuse
b. DID is rooted in a natural tendency to escape or "dissociate" from the unremitting negative affect associated with severe abuse
c. Variances in dissociative experience could be attributed to a chaotic, non-supportive family environment
d. Dissociative amnesia and fugue states are clearly reactions to severe life stress
e. DID seems very similar in its etiology to *posttraumatic stress disorder* (PTSD)
   i. Both condition feature strong emotional reactions to experiencing a severe trauma
   ii. Growing body of opinion that DID is a very extreme subtype of PTSD with a much greater emphasis on the process of dissociation than on symptoms of anxiety
   iii. "Developmental Window" of vulnerability to the abuse that leads to DID closes at approximately at 9 years old
1) After that DID is unlikely to develop, PTSD might occur if severe enough

VII. Suggestibility
a. Those who had imaginary childhood playmates, seems to correlate with being suggestible or easily hypnotized
   i. A hypnotic trance is also very similar to dissociation
   ii. 50% of DID patients clearly remember imaginary playmates in childhood
b. There is also the phenomenon of self-hypnosis, in which individuals can dissociate from most of the world around them and "suggest" to themselves that, for example they feel no pain
c. Dissociation is a defense mechanism against extreme trauma
d. When the trauma becomes unbearable, the person's identity splits into multiple dissociated identities
   i. People who are less suggestible may develop a severe PTSD reaction but not a dissociate reaction

VIII. Biological Conditions
a. There is certainly a biological vulnerability to DID, but it is difficult to pinpoint
b. 6% of patients with TEMPORAL LOBE epilepsy reported "out of body" experiences
c. 50% of another series of patients with TEMPORAL LOBE epilepsy displayed some kinds of dissociative symptoms, including alternative identities or identity fragments
d. Seizure patients that develop dissociative symptoms in adulthood that are not associated with trauma, are in clear contrast to DID patients without seizure disorders

IX. Real memories and false memories, the controversy
a. Field of abnormal psychology today is concerned with the extent to which memories of early trauma, particularly sexual abuse, are really accurate or not
b. There is incontrovertible evidence that false memories *can* be created by reasonably well understood psychological processes
c. There is also very good evidence that early traumatic experiences can cause selective dissociative amnesia
   i. Study successfully convinced a number of individuals that they had been lost for an extended period of time when they were approximately 5 years old, which was not true
d. False memories can be created through strong repeated suggestions by an authority figure, therapists must be fully aware of the conditions under which this is likely to occur, particularly when dealing with young children
   i. In other words, is there two kinds of memories: (1) traumatic memories that can be dissociated, and (2) "normal" memories that cannot? At this time, this is the scientific crux of the issue

X. Treatment
a. Individuals who experience *dissociative amnesia or a fugue state* usually get better on their own and remember what they have forgotten
There therapy focuses on recalling what happened during the amnesic or fugue states, often with the help of friends of family who know what happened

Also may use hypnosis or use of benzodiazepines (minor tranquilizers)

DID Treatment is not so easy, reintegrating the personality might seem hopeless

Coon (1986) found that 5 out of 20 patients achieved full integration of their identities

Another study found that 12 out of 54 (22.2%) patients had achieved integration after 2 years

Fundamental goal: Identify case or triggers that provoke memories of trauma and/or dissociation and to neutralize them

1) Patient must confront and relive the early trauma and gain control over the horrible events

2) Help the patient to visualize and relive aspects of the trauma until it is simply a terrible MEMORY instead of a current event

Hypnosis is often used to access unconscious memories and bring various alters into awareness