

Hypnotically Induced Dissociation (HID) as a strategic intervention for enhancing OCD treatment

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Abstract

To date, cognitive behavioral therapy has been designated the most efficient evidence-based psychotherapeutic approach for OCD management. This is mainly due to its ability to effectively address the constitutional and developmentally acquired emotional and cognitive deficiencies of OCD, which express themselves through behavioral compulsions and intrusive thoughts. Yet some reports indicate that from 30 to 60 percent of OCD patients are not responsive to psychotherapeutic interventions. As a consequence, broader therapeutic models have been considered. These models encompass multifactorial etiologies of OCD and take intrapsychic stressogenic factors into consideration as well. Some of these models have adopted hypnotherapeutic approaches. In the present article, we introduce a therapeutic tool that utilizes hypnotically induced dissociation (HID) to identify and address the intrapsychic etiology of OCD. The result is a therapeutic intervention that in our view can complement existing OCD treatment strategies. Clinical cases are presented to illustrate implementation of the approach.

Keywords: OCD, Hypnosis, Dissociation, HID, Psychotherapy, Hypnotherapy.

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OCD is characterized by unbidden obsessive thoughts and/or compulsory physical activities that are experienced as ego-dystonic (American Psychiatric Association, 1994). Although the *DSM-IV* definition implies that OCD is a unitary syndrome, an increasing number of investigators believe that OCD has discrete subtypes (e.g., Calamari, Wiegartz, & Janeck, 1999; Calamari et al., 2004; Swedo et al., 1998; Zohar et al., 1997). These subtypes can be divided into three etiological dimensions: cognitive, biological and emotional. In the cognitive-functional dimension, investigators have proposed that the repetitive nature of thoughts and behaviors characterizing the disorder can be explained by certain information-processing deficits and/or biases (e.g., Chamberlain, Blackwell, N.A. Fineberg, Robbins, & Sahakian, 2005; Tallis, 1997). In the biological dimension, genetic research has demonstrated the significant role played by heredity (Hettema, Neale, & Kendler, 2001; Jonnal, Gardner, Prescott, & Kendler, 2000). Moreover, neuroimaging studies have revealed neural pathway disturbances in the form of elevated metabolic activity in the basal ganglia, the subcortical areas of the brain and the orbito-frontal cortex (Cottraux & Gerald, 1998; Freidlander & Derocher, 2005; Van der Wee et al., 2004). With respect to the emotional dimension, some authors have pointed to the traumatic-dissociative, existential and developmentally acquired etiology of OCD witnessed in certain patients (Erickson & Kubie, 1939/1980; Naomi Fineberg, Marazziti, & Stein, 2001; Frederick, 1990, 2002, 2007; Ross & Anderson, 1988; Schneider, 2007; Meyerson & Konichezy, 2009; Yalom, 1980).

In an attempt to overcome the complexity involved in conceptualizing, understanding and treating OCD, Frederick (2002, 2007) proposed that the etiology of OCD should be best viewed according to the stress diathesis model. This integrative model encompasses biological and socio-psychological factors (Alexopoulos, 2004) and suggests that hidden intrapsychic conflicts and traumas together with external stressors are responsible for the emergence of OCD symptoms in constitutionally predisposed patients. Accordingly, clinicians should be aware of and address the multiple dimensions of the disorder so as to achieve better and enduring therapeutic results.

Although hypnosis has been acknowledged as an effective psychotherapeutic tool (Heap & Aravind, 2001; Nash & Barnier, 2008) with the potential to address both the constitutional and the intrapsychic factors contributing to OCD (Brown & Fromm, 1986; Edgette & Edgette, 1995; Frederick 1990, 2002, 2007), to date it has played a very restricted role in treating OCD patients (Frederick 1990, 2002; Heap & Aravind, 2001; Nash & Barnier, 2008). Consequently, this article aims to grant hypnotherapy a proper and appropriate role in the treatment of OCD patients, in particular by stressing the special contribution of Hypnotically Induced Dissociation (HID) as a therapeutic mode of intervention (Kluft, 1993b; Edgette & Edgette, 1995; Yapko 1985; Alladin, 2008; Spiegel, 2003; Meyerson & Gelkopf, 2004).

Psychotherapeutic strategies in OCD Treatment

Over the years, a variety of treatments have been reported for OCD. Cognitive-Behavioral Therapy (CBT) has been demonstrated to be the most efficacious treatment, with a lower incidence of dropout than E\RP (Abramowitz et al. 2005; Steketee et al. 2003). Such combined cognitive- and behavioral-oriented therapeutic interventions focus mainly on identifying and confronting the deficiencies in cognitions and information processing and the tendencies toward anxiety exhibited by OCD patients (van Oppen & Arntz, 1994; Tata, Leibowitz, Pmnty, Cameron, & Pickering, 1996;) with the aim of improving their self-regulatory functioning (Muller & Roberts, 2005). In the field of hypnotherapy, Frederick (1990; 2002; 2007) and others (Fineberg et al., 2001; Schneider, 2007; Yalom, 1980) have suggested

that in order to enhance management of OCD symptoms, therapists should also address intrapsychic and developmentally acquired stressogenic factors, including conflicts, existential traumas and occasionally even dissociated personality elements.

Using hypnosis to enhance treatment of OCD patients

The literature on the use of hypnosis in treating OCD is limited. One of the most classic clinical cases reported in the hypnosis literature is that of Milton Erickson's treatment of an "obsessional neurosis" in a young woman (Erickson & Kubie, 1980/1939). By means of automatic writing (that can be seen as a classical hypno-dissociative intervention), Erickson guided the patient to the traumatic grounds of her difficulty and eventually to the resolution of her obsessions. In another clinical account, Frederick (1990, 2002, 2007) reported the rapid treatment of severe, longstanding OCD with ego-state therapy based on hypnotically enhanced therapeutic dissociations and association of personality parts (Watkins & Watkins, 1979). McNevin and Rivera (2001) also presented three cases in which dissociation was linked with the pathology of OCD. These patients did not respond adequately to CBT with adjunctive medication, yet their obsessions and compulsions improved when dissociation was handled with psychodynamically-oriented issues. As a result, McNevin & Rivera recommended "psychodynamic understanding . . . within a cognitive-behavioral context" (p. 129).

Other successful hypnotically facilitated interventions for OCD have also been reported. Kroger and Fezler (1976) integrated hypno-imagery protocols and recommended the routine use of hypnosis for deep relaxation to neutralize the anxiety of OCD patients. Several types of hypnotic ego-strengthening techniques have also been described as useful interventions capable of producing robust and enduring relief for obsessive and compulsive symptoms (Frederick & McNeal 1999; Johnson & Hallenbeck, 1985).

In conclusion, it can be argued that some of the hypnotic interventions presented above utilized basic characteristics of the hypnotic trance (Yapko, 2003) to control and regulate the anxiety as well as the cognitive and attentional processes characteristic of OCD, thus directly reinforcing cognitive behavioral treatment strategies. Other approaches presented were used to make a change in personality factors that were seemingly supporting and reinforcing OCD symptoms and behaviors. In general, the dissociative techniques illustrated above have been successfully implemented in addressing a larger spectrum of pathogenic factors that appear to be overshadowed by OCD symptoms.

Hypnotically induced dissociation (HID) as a therapeutic tool

Contemporary psychological and psychiatric literature usually focuses on the pathological aspects of dissociation, viewing it as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception" (APA, 1994), or as a "lack of normal integration" of thoughts, feelings and experiences into the stream of consciousness and memory (Putnam, 1985; Atkinson et al., 2000; van der Hart & Friedman, 1989; Kluft, 1996; Van der Kolk et al., 1996; Nijenhuis et al, 1997). Accordingly, some modern theorists view dissociation as existing along a continuum, ranging from such normal everyday experiences as daydreaming to psychiatric disorders such as psychogenic amnesia and dissociative identity disorder (Bernstein and Putnam, 1986). Watkins and Watkins (1997), the developers of ego-state therapy, offered a new perspective on dissociation. They proposed that dissociation and differentiation are both natural organizing principles of the psyche that give human beings the ability to adapt, think, act and respond. *Hence, it can be asserted that healthy dissociation is a crucial element in human development and differs from pathological dissociative processes in terms of the flexibility and controllability of the borders between the dissociated parts.* In the context of hypnotic literature, Yapko (1995)

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defined dissociation as “the ability to break a global experience into its component parts, amplifying awareness for one part while diminishing awareness for the others.” These properties of dissociation can be used in hypnotherapy for separating “conscious” from “unconscious” functioning, for regulating the sensitivity of the patient to internal or external stimulation, and for diverting attention from negative ruminations (Lynn, Rhue, & Kirsch, 2010).

Other authors in the field of hypnotherapy have discussed the concept of “Hypnotically Induced Dissociation” or “Hypnotic Dissociation” as a useful instrument for hypnotic pain reduction (Freeman, 2004), for dissociation of self-defeating ruminations in depressed patients to manage anxiety (Alladin, 2007; Edgette & Edgette, 1995), for treating PTSD symptoms (Roy, 2006), and for treating people with obstinate mental disorders (Meyerson & Konichezky, 2009).

Three main areas of HID therapeutic implementation can be specified (Meyerson, 2010) and applied to OCD treatment:

1. Rehabilitation or establishment of natural/positive dissociations (Meyerson, 2010): One of the major problems in the cognitive processing of patients with OCD is their failure to inhibit or shift their attention away from ongoing obsessive thoughts or activities toward other more pleasant, or less distressing, cognitions. During repetitive HID experiences, patients can learn to promote such shifts and inhibition by rehabilitating or acquiring natural/positive dissociation processes. Using such processes, patients are able to align their psychological resources, become more hopeful, set appropriate therapeutic goals and secure therapeutic results (Lemke, 2005; Meyerson & Gelkopf, 2004; Edgette & Edgette, 1995; Broun & Fromm, 1986).
2. Regulation and control of existing pathological dissociation (Alladin, 2007; Frederick, 2007): Due to the association between certain OCD symptom dimensions and dissociation, especially “amnesic dissociation” related to compulsions (Rufer, Fricke, Held, Cremer, & Hand, 2006), regulation and control of existing pathological dissociations can be a very valuable asset. Such regulation can enable the patient to reintegrate dissociated elements that appear in the form of ritualistic actions and thus gain greater control over them.
3. Utilization of temporary dissociation for therapeutic purposes (Meyerson & Gelkopf, 2004; Meyerson & Konichezy, 2009): This last dimension is concerned with the intrapsychic etiology of OCD. Intrapsychic factors can be uncovered during a temporary absence of OCD symptoms resulting from the mounting of temporary dissociation. Thus, these symptoms can receive appropriate therapeutic attention. Frequently intrapsychic problems may promote anxiety reactions that will consequently augment the appearance of obsessive symptoms, creating a “vicious circle” of anxiety reactions that can enhance the manifestation of OCD symptoms and in turn obstruct therapeutic interventions aimed at addressing these underlying psychological problems. Hypnotically induced dissociation (HID) can be used to “break” the aforementioned “vicious circle.”

All the aforementioned HID implementations can help treat OCD patients. Nevertheless, in the current article we attempt to stress the specific contribution of HID with respect to developmentally acquired personality factors in these patients. By temporarily

enhancing dissociation between OCD symptoms and the patient's personality and generating a temporary absence of OCD symptoms, HID may offer an opportunity to uncover underlying intrapsychic psychological conflicts that can be subsequently addressed in therapy. The following clinical cases were chosen to illustrate this feature of HID implementation in hypnotic psychotherapy.

Clinical Cases

Case 1: The use of HID in promoting development of a non-pathological identity in a teenage girl.

Jill, a 14-year-old girl, was diagnosed with OCD and referred for treatment by her high school psychologist. The younger of two girls, Jill was described by her parents as having been very "tidy and clean" ever since she was a baby. According to her parents, Jill never enjoyed play activities that involved coloring or playing in the sandbox with other children. At the age of four, she had trouble separating from her mother in kindergarten, and even now she refuses to stay alone at home after dark. Her father described her as very sensitive and very fond of order and symmetry. Her OCD symptoms consist of obsessive thoughts revolving around her family, especially her mother. She expressed a fear that "something bad will happen to my mother" if she (Jill) fails to perform one of her many rituals. She is preoccupied with her recurrent thoughts for the greater part of the day. During the past year she began missing school because she prefers to stay home and engage in compulsive behaviors, such as repeating a "special" sentence in her head every time she notices the digit 6 showing on her watch. She also imagines a string attaching her body to her mother's. Every time someone crosses behind her, she is afraid the string might rip and her mother might stop loving her. Because of this thought, she would rather stay at home alone most of the day, thus eliminating the danger of someone ripping her imaginary connection to her mother. Jill remembers having these thoughts since she was 7 or 8 years old. Upon arrival at the therapy session, she expressed high motivation since she feels her condition has exacerbated during the past year.

After completing a five-month cognitive behavioral therapy protocol to treat her OCD (Salkovskis, 1988), Jill showed significant improvement. The treatment included a psychoeducation phase, followed by weekly E/RP tasks, such as looking at the digit 6 without saying her "special sentence" and refraining from repetitive reassurance-seeking from her mother. She began to attend school regularly and was able to overcome most of her compulsive behaviors and reduce the intensity of her obsessive thinking by using a variety of mindfulness techniques (Kabat-Zinn, 1990) conveyed to her by the therapist. These techniques enabled her to identify "OCD thoughts" without identifying with them, so she was able to refrain from performing the associated compulsive behavior. Jill felt satisfied by her accomplishment, but at the same time she was worried that because her OCD has been "a part of her personality since she was very young" she would not be able to go any further in her struggle against her symptoms.

In one of the sessions, Jill pointed out that she could not recognize herself without her OCD. At this stage, the therapist (A.K.) decided to introduce hypnosis to consolidate treatment achievements by converting them to stable identity elements. A hypnotic trance was induced using Jill's love for the ocean. She was encouraged to imagine herself diving into the sea, "...deeper and deeper feeling relaxed and calm..." She was led to believe that the deeper she submerged herself, the more her OCD would be washed away until it completely

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vanished. She was then instructed to swim to a nearby island and sit on its beautiful beach so she could experience life without her OCD. While sitting on the beach during the hypnotic experience, Jill began to cry, commenting that she had never felt as “free and light as I feel now.”

At this point she was instructed to “cue” this feeling so she could recreate it at will after the session was over. That is, with the goal of using a purposeful cue or trigger to elicit and achieve this desired feeling out of hypnotic state, she was instructed to make this feeling a conditioned response to a physical signal of her choosing. The following week Jill reported another improvement in her condition and said that her mind was much more at ease. This HID procedure was recreated in two more consecutive sessions during which Jill, in a trance, was allowed to talk about her identity as a teenager, her fear of being rejected by her schoolmates and her conflicted feelings toward her mother. Dissociating herself from OCD symptoms during the hypnotic trance and generalizing this experience to out-of-trance functioning not only helped her diminish her OC symptoms, but also assisted her in dealing with age-specific topics in therapy and thus engaging in normal adolescent development. In a scheduled follow-up session six months after she completed therapy, Jill reported to the therapist that she was doing well and that although some obsessive thoughts appeared from time to time she managed to deal with them. She also reported that she had been free of compulsions for the last six months.

Case II: The use of HID for accessing deep existential fears that sustained OCD symptoms

David, a 34-year-old engineer, was referred for psychotherapy by his psychiatrist, who had been treating him for OCD for the past month using medications. David had exhibited OCD symptoms since childhood. He perceived the world as a very dangerous place and was preoccupied with thoughts of catastrophic events. His main concern was his inability to detach himself from things he had bought in the past, thus creating a situation at home that was unbearable for him and his wife. The couple was not able to buy new furniture for their apartment or even decide on renovations because David felt extremely anxious whenever his wife wanted to throw something away. In the month prior to seeking therapy, David was not even able to bring himself to take out the garbage, so his wife had to do it whenever he was away. At work David would feel anxious because he feared that something of importance would be thrown out while he was away from home. At the beginning of therapy, David claimed he could not distinguish between his obsessive attachment to the objects in his life and his “normal” connection to the things around him.

After two sessions, which included cognitively oriented psychoeducation for OCD, David was able to differentiate mentally between what he termed “OCD thoughts” and other ways of thinking. As part of exposure therapy, he was instructed to keep a diary in which he wrote down any thoughts and feelings that erupted as he prepared to dispose of some old and useless artifact. Although David was able to understand his obsessive way of thinking, he was unable to carry out his between-session assignments due to his obsessive doubt. He claimed not to know whether his fear was part of his OCD or whether he was being justifiably cautious in not throwing away something that would be essential for his survival in the “impending dangers of the future.” At this point, the therapist (A.K.) decided to introduce HID to create a new experience for David. David was instructed to imagine he was “deep sea diving... that he had all the necessary equipment for a comfortable and relaxing dive....” As he dove deeper and deeper, he was asked to leave all his obsessive thoughts, feelings and sensations behind. “Note how they are being washed away from you...and cast upon the shore by the sea... And as you continue to dive, you enter a place where OCD does not

exist... You can enter this place only after the screening door does not detect any obsessive thoughts and behavior in you..." After several trials, David was able to go through the screening door and experience himself without his obsessive thoughts and anxious feelings. He was then asked to imagine himself throwing away a big bag of garbage and was eventually asked to describe what he felt. While still in a deep hypnotic trance and after a prolonged silence, David said he understands that the real problem is his fear of life and that he now can derive comfort from his wife and family instead of obtaining security from things. In the following sessions, David was gradually able to complete his exposure therapy (beginning with throwing out newspapers from previous years) and eventually reduce his obsessive and compulsive symptoms to a great extent. The therapeutic effects were preserved at his follow-up session one year later.

Case III: Using HID to uncover childhood trauma

Jennifer, a 25-year-old art student, was referred to the clinic after her physician diagnosed her with OCD. She had a very active social life and an excellent academic record, but was troubled by obsessive thoughts all day long. Her symptoms had first appeared in high school when she began to date a boy from her class. Whenever she thought or heard what she considered to be a "forbidden" word, such as "passion," "hate," "sorrow," or "sadness," she was afraid of "getting stuck in that feeling forever." To avert this anxiety-provoking possibility, she had to erase the word in her mind several times until she felt it was safe to stop. After some months of therapy Jennifer was responding well to CBT and able to manage most of her compulsions and obsessive thoughts, but then her improvement came to a halt. At this point, the therapist (A.K.) decided to introduce HID to enhance what had already been achieved in therapy. Jennifer was asked to imagine herself going into a peaceful and serene lake and allowing the water to wash away her obsessive thoughts. Then she was told to rest for a while on the other side of the lake and enjoy the feelings that emerged. She was encouraged to imagine herself diving into the lake, "...deeper and deeper feeling relaxed and calm..." She was led to believe that the deeper she submerged herself, the more her OCD would be washed away, until it completely vanished. She was then instructed to swim to the shore and sit on the beautiful beach so she could feel and experience how life could be without her OCD. At first she had difficulty experiencing the hypnotic trance and allowing herself to relax. After several HID sessions, Jennifer started to free herself of her obsessions and was able to enjoy sitting on the shore of the peaceful lake while in the hypnotic trance. During the following session, Jennifer told the therapist that when she practiced HID at home she began feeling very anxious and remembering a face that seemed familiar to her but that she did not quite recognize. Using an age-regression technique while following appropriate guidelines for working with traumatic memories (Hammond et al., 1995), the therapist helped Jennifer recall the disturbing face, which gradually emerged as the face of her next-door neighbor. As the disturbing memories continued to be restored, the neighbor's face became associated with a traumatic event. When she was 9 years old, she had been sexually molested by this individual on her way home from school. As she recalled this traumatic event, Jennifer commented to the therapist that her greatest fear at the time had been of "being stuck forever with him without anyone coming to the rescue." After Jennifer recalled the event and processed the trauma in therapy, her OCD symptoms gradually began to disappear. At the end of approximately nine months of therapy, Jennifer reported a significant lessening of obsessive thoughts. She was able to concentrate better on her academic work, and her general level of anxiety diminished. There was no follow-up session with this patient.

Discussion

In psychotherapy for people with OCD, one of the essential problems involves the multifactorial genesis and features of their psychopathology. Within the field of hypnotherapy, a number of successful hypnotically facilitated interventions with OCD have been reported. Not only have these addressed constitutional factors (Kroger & Fezler 1976; Frederick Y McNeal 1999; Johnson & Hallenbeck, 1985) that contribute to the development of OCD, they have addressed developmentally acquired personality factors as well (Kluft, 1993a; Shusta, 1999; McNevin & Rivera, 2001; Yalom, 1980). These last researchers all concluded that such patients should be treated by complementarily addressing the relevant intrapsychic, existential and identity issues that underlie OCD symptoms. The stress diathesis model (Frederick, 1990, 2002; 2007) proposes a treatment paradigm that classifies the factors responsible for OCD genesis and persistence as constitutional or stressogenic. According to this model, hidden intrapsychic conflicts and traumas along with external stressors are responsible for the emergence of predisposed OCD symptoms.

As stated previously, cognitive behavioral therapy seems to refer mainly to constitutional factors and also helps in managing externally imposed stress. Rarely, if at all, does it address intrapsychic conflicts and developmental psychodynamic issues that may also serve as stressogenic factors. This state of affairs can explain the high percentage of refractoriness in cognitive behavioral therapy of OCD patients (Pato & Zohar, 2001; Schruers, Koning, Luermans, Haack, & Griez, 2005; Steketee et al., 2003). The problem may arise even when the therapist recognizes and aspires to address these intrapsychic problems underlying the OCD symptoms. Focusing on the aforementioned issues during therapy may promote anxiety reactions that will consequently increase the appearance of obsessive symptoms. This leads to the generation of a “vicious circle” comprised of stressogenic factors that, if not treated, enhance the manifestation of constitutional elements. This in turn obstructs therapeutic interventions aimed at addressing these underlying problems.

To improve the effectiveness of psychotherapy with this group of OCD patients, the need to refer to intrapsychic factors to “break” the aforementioned “vicious circle” must be taken into consideration. In the current article, we proposed the use of hypnotically induced dissociation (HID) as a major therapeutic resource appropriate for this complex task.

Hypnosis has been used for centuries as a natural, non-traumatic and stress-free procedure for inducing prolific psychological dissociation. Hypnotically induced dissociation can be elicited using direct and indirect suggestions. Direct suggestion should emphasize different types of divisions (Yapko, 1995) and promote the dissociative use of language (Edgette & Edgette, 1995). Indirect strategies include metaphors, confusion techniques, and other Ericksonian methods “such as seeding, presuppositions, double binds, etc.” (Edgette & Edgette, 1995, pp. 151-152). A greater degree of dissociation can also be achieved throughout trance deepening (Yapko, 1995). It should be noted that these dissociative techniques should be used with care by a therapist with expertise in hypnosis and psychotherapy (Meyerson & Gelkopf, 2004; Edgette & Edgette, 1995; Brown & Fromm, 1986).

In this paper, three clinical cases were presented to show the effects of HID. The case of Jill demonstrates how HID, implemented during hetero-hypnotic sessions and self-hypnotically at home, liberated the patient of habitual OCD symptomatology and enabled her to focus on felicitous age-related identity issues so she could engage in normative adolescent development. Prior to HID application, this normative developmental task was blocked and overshadowed by OCD symptoms. The case of David reveals how HID enabled

the patient to access existential fears that sustained his OCD symptoms and created conflicts in his marital relations and relationships in general. During the hypnotic session, David left his OCD symptoms “behind” and was able to experience his fears of living and eventually acquire some important existential insight into how to cope with his fears. In the case of Jennifer, HID allowed her to uncover a repressed childhood sexual trauma and subsequently address it in therapy. Before the implementation of HID, this repressed traumatic experience reinforced pathological expressions of Jennifer’s constitutional obsessive predisposition, which in turn masked her trauma, thus creating a “vicious circle.”

Summarizing these cases while taking the theoretical background into consideration leads to formulating some major guidelines for using HID as a hypnotherapeutic tool in treating OCD patients.

1. In this paper, HID has been presented as a strategic intervention aimed at bridging and complementing a widely accepted evidence-based psychotherapeutic approach for managing OCD.
2. The paper points to three ways in which HID can promote OCD treatment (Meyerson, 2010): by rehabilitating adaptive dissociative strategies, by regulating and controlling pathological or excessive dissociation, and by using temporary HID to access underlying psychological problems. This last application was emphasized in the present article.
3. Well known hypnotic techniques can be used to achieve HID, and the whole procedure can be adapted to a specific patient. One of the possibilities for inducing dissociation during the hypnotic trance is by using enclosed protocols that combine metaphorical-symbolic and deepening qualities of experience, such as diving into open water (Appendix 1).
4. After HID is implemented, additional hypnotic strategies, among them age regression, future progression, and hypno-dynamic or hypno-cognitive techniques, can be used to promote hypnotic psychotherapy in which psychological problems are uncovered.

In conclusion, we found HID to be a powerful therapeutic tool that enhances psychotherapeutic outcomes in the treatment of OCD patients. It can be used hetero-hypnotically and subsequently during patients’ self-hypnotic experiences. Cautious and skilled implementation of HID for OCD patients can help address psychological issues that have been neglected during major parts of the patients’ development, thus facilitating both psychological growth and well being.

Appendix 1

“Now, you can imagine that you are deep-sea diving. . . .Can you?. . .You have all the equipment you need and you can dive naturally and easily. . . deep. . . deep. . . down. . . . And as you go deeper and deeper, everything changes... the lighting is different, the temperature of the water changes, the plants are different, the fish are different... And now you can see, feel, and hear that all your former problematic thoughts, feelings, and sensations are being washed away from you body from your mind . . washed to the surface. And as you continue to dive, you access a place that is “symptom- free.” You can enter this place only when the “screening door” no longer detects any the obsessive and troubling thoughts, feelings and behaviors in you ... And now, as you enter the symptom-free place, experience yourself without any problematic thoughts, feeling and sensations.... “

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